California Quality Collaborative

CalHIVE BHI

Technical Specifications Manual

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Overview

This document includes the technical specifications for use in collecting data for CalHIVE BHI.

The CalHIVE BHI specifications are based primarily on HEDIS measures and are consistent with IHA's Align. Measure. Perform. (AMP) program but have been adapted to support collection at the clinician-practice-product line level for the purposes of supporting quality improvement. Differences between the HEDIS specifications and the CalHIVE BHI specifications are clearly noted under each measure's "*Modifications From HEDIS"* section. All measures are collected using administrative data systems, including claims/encounter or billing data, electronic health records, registries, and other clinical databases. Your full patient population should be included. Hybrid Methodology or medical chart review *is not* permitted.

The CalHIVE BHI measure set includes the following measures:

Measure	Required	Electronic Clinical Data Systems (ECDS)	Non-HEDIS	Differs From HEDIS
Enrollment	✓		✓	
Depression Screening and Follow-Up for Adolescents and Adults	✓	✓		
Depression Remission or Response for Adolescents and Adults	✓	✓		
Glycemic Status Assessment for Patients with Diabetes – Glycemic Status (>9%)	✓			

To obtain the **Guidelines for Measures Reported Using Electronic Clinical Data Systems (ECDS)** and **Value Sets** for programming the ECDS measures, please contact Jose Ordonez at jordonez@pbgh.org:

- Depression Remission or Response for Adolescents and Adults

The **Value Sets** for programing Glycemic Status Assessment for Patients with Diabetes – Glycemic Status (>9%) **and** Depression Screening and Follow-Up for Adolescents and Adults are available electronically at no charge. To access visit the NCQA store to create an account or login and download them here: https://store.ncqa.org/my-2025-align-measure-perform-amp-product-bundle.html

Some of the information in the Data Collection section (pages 13-32) of the General Guidelines in the Integrated Healthcare Association (IHA) Align. Measure. Perform. (AMP) Program's manual may be helpful, and are available for your reference: https://www.iha.org/wp-content/uploads/2024/01/MY-2025-Align.-Measure.-Perform.-AMP-Technical-Specifications-_-2024-10-07.pdf

Please Note:

Provider organizations (PO) are required to report on **ALL** required measures each reporting cycle.

Attribution of Member to Clinicians

- Every member should be assigned to a Primary care provider (PCP).
    - PCP types include Family Medicine, General Medicine, Internal Medicine, and Obstetrics/ Gynecology (see Data Fields" tab in the Enrollment File Template).
    - You can use health plan assignment for managed care members.
    - You may also use an algorithm, like "most frequent, most recent."
- Report **ALL** required measures for all PCPs.
- There will be double counting of some members—this is ok!

Measure Codes and Validations

Below is the list of CalHIVE BHI measures, including all of the sub-measures and measure identifiers. The measure identifiers must be used in the CalHIVE BHI measurement file exactly as shown below, including case and underscores (_).

Files will undergo two levels of validations:

1. Files will be checked for naming conventions and formatting. Files that contain measure identifiers different than below will be returned for correction before moving to the second level of validation.

2. The "Edit checks" from the table below will be implemented on the applicable measure results. Any results that don't meet the edit checks will be flagged for your PO to review and correct as appropriate.

Measure	Measure ID	Description	Edit Checks
1	ENR	Enrollment as of last day of measurement period	Only report the denominator. Numerator should be left blank.
Behavioral Health Digital Quality Measures			
2	DSF1	Depression Screening and Follow-Up for Adolescents and Adults: Depression Screening	The numerator should never be higher than the denominator. The denominator should never be higher than the ENR denominator
	DSF2	Depression Screening and Follow-Up for Adolescents and Adults: Follow-Up on Positive Screen	The numerator should never be higher than the denominator. The denominator for DSF2 should never be higher than the denominator of DSF1 The denominator should never be higher than the ENR denominator
3	DRR1	Depression Remission or Response for Adolescents and Adults: Follow-Up PHQ-9	The numerator should never be higher than the denominator. The denominator should never be higher than the ENR denominator
	DRR2	Depression Remission or Response for Adolescents and Adults: Depression Remission	The numerator should never be higher than the denominator. The denominator should never be higher than the ENR denominator
	DRR3	Depression Remission or Response for Adolescents and Adults: Depression Response	The numerator should never be higher than the denominator. The denominator should never be higher than the ENR denominator
Clinical Measure			
4	HPC	Glycemic Status Assessment for Patients with Diabetes – Glycemic Status (>9%)	The numerator should never be higher than the denominator. The denominator should never be higher than the ENR denominator

Products

Below are the product descriptions and codes that can be used when reporting results. Based on the products that your PO has decided they will include in CalHIVE BHI, you will report on each product as follows:

- You should include a separate row in the CalHIVE BHI Measurement File for each clinician-practice-product combination. In each product field, there should be one product code which indicates the specific product included in that result.

  For example, if a clinician at a practice serves Managed Medi-Cal and Commercial HMO patients, then there would be two rows for each measure.
  - One row for Commercial HMO reporting the product with the code "HMOPOS".
  - One row for Managed Medi-Cal reporting the product with the code "MC".

Code	Name	Notes
HMOPOS	Commercial HMO and POS	includes marketplace HMO
PPO	Commercial PPO	includes marketplace PPO
MA	Medicare Advantage	
MAFFS	Medicare FFS	
MC	Managed Medi-Cal	
MCFFS	Medi-Cal FFS	
DUAL	Medi-Medi	
UNINS	Uninsured	
VA	Military	
OTHER	Other or unknown	e.g., Medicare Supplement

Rolling 12-Month Measurement Periods

The CalHIVE BHI program includes the collection and analysis of performance measure data to understand the impact of participants' quality improvement (QI) efforts. PBGH utilizes a moving average (rolling average) approach to collect performance measure data by applying a rolling 12-month measurement period. After establishing a performance baseline, progress is monitored with each new rolling 12-month measurement period, dropping the earliest month of the previous period and adding a new one. Examples of a rolling 12-month measurement period are provided below:

- January 1, 2023 to December 31, 2023
- February 1, 2023 to January 31, 2024
- March 1, 2023 to February 28, 2024

There are several advantages to utilizing a moving average to understand performance trends:

- Reflective of how patient care is delivered longitudinally.
- Stability in how your performance rates are trended overtime, instead of showing large fluctuations which can be difficult to interpret.
- Flexibility to make time-sensitive changes along the way (allowing you to track quality improvement activities) rather than giving you only one opportunity annually (it can reduce the number of care gaps to close by the end of the year).

Continuous Enrollment and Allowable Gaps

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

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

An **allowable gap** can occur at any time during continuous enrollment. For example, the Child and Adolescent Well-Care Visits measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap of up to 45 days. A member who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled 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).

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.

Anchor Dates

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

Members in Hospice for Digital Measures

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

Organizations should attempt to remove these members prior to determining a measure's eligible population and drawing the sample for hybrid measures. If a member is found to be in hospice or using hospice services during medical record review, the member is removed as a valid data error from the sample and replaced by a member from the oversample. Documentation that a member is near the end of life (e.g., comfort care, DNR, DNI) or is in palliative care does not meet criteria for the hospice exclusion.

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

Note

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

Members in Hospice for IHA A.M.P. Measures

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

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

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

Note

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

Deceased Members for IHA A.M.P. Measures

Exclude members who die any time during the measurement year. These members may be identified using various methods that may include, but are not limited to, enrollment data, claims/encounter data, or supplemental data for this required exclusion. Organizations should attempt to remove these members prior to determining a measure's eligible population.

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

Exclusion of deceased members is subject to auditor review.

Note

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

Enrollment (ENR)

All POs must submit ENR for data validation purposes.

MODIFICATIONS FROM HEDIS

This is not a HEDIS measure.

Description

The number of members enrolled as of the last day of the measurement period. This is a point-in-time number.

Eligible Population

Stratification	All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Ages	All ages.
Continuous Enrollment	Continuously enrolled in the PO for the measurement period.
Anchor date	Enrolled in the PO and attributed to the clinician/practice on the last day of the measurement period.
Benefit	Medical.
Measurement Period	Rolling 12-Months: • E.g., January 1, 2023 – December 31, 2023 • E.g., February 1, 2023 – January 31, 2024

Administrative Specification

Denominator	The eligible population.
Numerator	Leave blank.

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

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

MODIFICATIONS FROM HEDIS

- None

Refer to the Guidelines for Measures Reported Using Electronic Clinical Data Systems (ECDS) in the Clinical Quality Domain, and to the measure-specific information below. To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification

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

Rolling 12-Months:

- E.g., January 1, 2024 – December 31, 2024
- E.g., February 1, 2024 – January 31, 2025

Clinical Recommendation Statement

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (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)

Citations

U.S. Preventive Services Task Force. Et al. “Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement.” JAMA vol. 329,23 (2023): 2057–67

U.S. Preventive Services Task Force. et al. “Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement.” JAMA vol. 328,15 (2022): 1534–42.

Characteristics

Scoring	Proportion.
Type	Process.
Continuous Enrollment	Continuously enrolled in the PO for the measurement period.
Stratification	Depression Screening. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately. Follow-Up on Positive Screen. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Risk Adjustment	None
Improvement Notation	A higher rate indicates better performance.

Guidance

General Rules:

This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the 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, 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.

Allocation:
The member was enrolled with a medical benefit throughout the measurement period.

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

The member must be enrolled on the last day of the measurement period.

Reporting:
Product line stratifications are not included in the measure calculation logic and need to be programmed manually.

Definitions

Participation The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the participation period.

Participation Period The measurement period.

Depression Screening Instrument A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤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

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

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 (M-3)®	71777-7	Total score ≥5
PROMIS Depression	71965-8	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	**Initial population 1** Members 12 years of age and older at the start of the measurement period who also meet criteria for participation. **Initial population 2** Same as the initial population 1.
Exclusion	**Exclusions 1** • Members with a history of bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) any time during the member's history through the end of the measurement period prior to the current measurement period. Do not include laboratory claims (claims with POS code 81). • Members with depression (Depression Value Set) that starts during the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81). • 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 to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. **Exclusions 2** Same as exclusions 1.
Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** All members from numerator 1 with a positive depression screen finding between the first date of the first month and the first date of last month 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 the first date of the first month and the first date of last month of the measurement period (e.g., 1/1/2022 – 12/1/2022 or 2/1/2022 – 1/1/2023)

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). Do not include laboratory claims (claims with POS code 81).
- 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.

Note: *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*

Depression Remission or Response for Adolescents and Adults (DRR-E)*

***Adapted with financial support from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, and with permission from the measure developer, Minnesota Community Measurement.**

MODIFICATIONS FROM HEDIS

- None

Description

The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120-240 days (4–8 months) of the elevated score.

- ***Follow-Up PHQ-9*.** The percentage of members who have a follow-up PHQ-9 score documented within 120-240 days (4–8 months) after the initial elevated PHQ-9 score.
- ***Depression Remission*.** The percentage of members who achieved remission within 120-240 days (4–8 months) after the initial elevated PHQ-9 score.
- ***Depression Response*.** The percentage of members who showed response within (120-240 days (4–8 months) after the initial elevated PHQ-9 score.

Measurement Period

Rolling 12-Months:

- E.g., January 1, 2024 – December 31, 2024
- E.g., February 1, 2024 – January 31, 2025

Clinical Recommendation Statement

The Institute for Clinical Systems Improvement recommends that clinicians establish and maintain follow-up with adult patients who have depression. Appropriate, reliable follow-up is highly correlated with improved response and remission scores (Trangle, 2016).

The American Academy of Pediatrics recommends that adolescents with depression be assessed for treatment response and remission of symptoms using a depression assessment tool such as the PHQ-9 Modified for Teens (Cheung, 2018).

Citations

Cheung, A.H., Zuckerbrot, R.A., Jensen, P.S., Laraque, D., Stein, R.E., Levitt, A., Birmaher, B., Campo, J., Clarke, G., Emslie, G. and Kaufman, M., 2018. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management." Pediatrics 141(3).

Trangle, M., J. Gursky, R. Haight, J. Hardwig, T. Hinnenkamp, D. Kessler, N. Mack, M. Myszkowski. Institute for Clinical Systems Improvement. **Adult Depression in Primary Care**. Updated March 2016.

Characteristics	
Scoring	Proportion.
Type	Outcome
Continuous Enrollment	Continuously enrolled in the PO for the measurement period.
Stratification	Depression Follow-Up. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately. Depression Remission. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately. Depression Response. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Risk Adjustment	None
Improvement Notation	A higher rate indicates better performance.

Guidance	**General Rules:** The PHQ-9 assessment does not need to occur during a face-to-face encounter; it may be completed over the telephone or through a web-based portal. **Allocation:** The member was enrolled with a medical benefit throughout the participation period. A gap in enrollment is allowed only in the measurement period. No gaps in enrollment are allowed in calendar year measurement periods from May 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period (8 months). No gaps in enrollment logic should apply to rolling 12-months measurement periods just like calendar years (e.g., For a rolling 12-months measurement period from 2/1/2024 to 1/31/2025, no gaps in enrollment are allowed from June 1 of the year prior to the measurement period through January 31 of the year prior to the measurement period). The member must be enrolled on the last day of the measurement period. **Reporting:** Product line stratifications are not included in the measure calculation logic and need to be programmed manually.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.

Participation Period	For a calendar year measurement period (1/1/2024 to 12/31/2024) the participation period starts on May 1 of the year prior to the measurement period through December 31 of the measurement period (20 months). Adjust participation period for rolling 12-months measurement periods. (e.g., For a rolling 12-months measurement period from 2/1/2024 to 1/31/2025, the participation period would be from June 1 of the year prior to the measurement period through January 31 of the measurement period).
Intake period	For a calendar year measurement period (1/1/2023 to 12/31/2023) the participation period starts on May 1 of the year prior to the measurement period through April 30 of the measurement period (12 months). Adjust intake period for rolling 12-months measurement periods. (e.g., For a rolling 12-months measurement period from 2/1/2023 to 1/31/2024, the intake period would be from June 1 of the year prior to the measurement period through May 31 of the measurement period).
Depression follow-up period	The 120–240-day period after the IESD.
IESD	Index episode start date. The earliest date during the intake period when a member has a PHQ-9 total score (LOINC code 44261-6 for members 12 years of age and older; LOINC code 89204-2 or 44261-6 for members 12–17 years of age) >9 documented within a 31-day period, including and around (15 days before and 15 days after) an interactive outpatient encounter (Interactive Outpatient Encounter Value Set) with a diagnosis of major depression or dysthymia (Major Depression or Dysthymia Value Set).
Interactive outpatient encounter	A bidirectional communication that is face-to-face, phone based, an e-visit or virtual check-in, or via secure electronic messaging. This does not include communications for scheduling appointments.
Initial population	**Initial population 1** Members 12 years and older as of the start of the intake period who meet **both** of the following criteria: • The depression encounter and PHQ-9 total score requirements as described by the IESD. • Participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1.

Exclusion	**Exclusions 1** Members with any of the following any time during the member's history through the end of the measurement period. Do not include laboratory claims (claims with POS code 81): • Bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set). • Personality disorder (Personality Disorder Value Set). • Psychotic disorder (Psychotic Disorders Value Set). • Pervasive developmental disorder (Pervasive Developmental Disorder Value Set). 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 to determine if the member elected to use a hospice benefit during the measurement period. Members who die any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1.
Denominator	**Denominator 1** Initial population, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** Same as denominator 1.

Numerator	**Numerator 1—Depression Follow-Up** A PHQ-9 total score (LOINC code 44261-6 for members 12 years of age and older; LOINC code 89204-2 or 44261-6 for members 12–17 years of age) in the member's record during the depression follow-up period. **Numerator 2—Depression Remission** Members who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 total score (LOINC code 44261-6 for members 12 years of age and older; LOINC code 89204-2 or 44261-6 for members 12–17 years of age) of <5 during the depression follow-up period. **Numerator 3—Depression Response** Members who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score (LOINC code 44261-6 for members 12 years of age and older; LOINC code 89204-2 or 44261-6 for members 12–17 years of age) of at least 50% lower than the PHQ-9 score associated with the IESD, documented during the depression follow-up period.

Data Criteria (element level)

- Reach out to Jose Ordonez to obtain the value sets.

Glycemic Status Assessment for Patients with Diabetes: Glycemic Status (>9.0%) (HPC)

MODIFICATIONS FROM HEDIS

The 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.

Description

The percentage of members 18–75 years of age with diabetes (type 1 and 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 >9.0%.

Eligible Population

Stratification	All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Ages	18–75 years as of the last date of the measurement period.
Continuous enrollment	The measurement period in the PO.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement period. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Enrolled in the PO and attributed to the clinician/practice on the last day of the measurement period (e.g., December 31).
Benefit	Medical.
Measurement Period	Rolling 12-Months: • e.g., January 1, 2024 – December 31, 2024 • e.g., February 1, 2024 – January 31, 2025

Event/diagnosis

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

Claim/encounter data. Members who had 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. Do not include laboratory claims (claims with POS code 81).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement period or the year prior to the measurement period (Diabetes Medications List) and had at least one diagnosis of diabetes (Diabetes Value Set) during the measurement period or the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose • Miglito		
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Description	**Prescription**		
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine	• Insulin glulisine • Insulin isophane human	

	• Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide	• Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides Biguanides Glucagon-like peptide-1 (GLP1) agonists	• Nateglinide • Metformin • Albiglutide • Dulaglutide • Exenatide	• Repaglinide • Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide	• Tirzeepatide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding Farxiga®)	• Empagliflozin • Ertugliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Pioglitazone • Alogliptin • Linagliptin	• Rosiglitazone • Saxagliptin • Sitagliptin	

Required exclusions

Exclude members who meet any of the following criteria:

- 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 to determine if the member elected to use a hospice benefit during the measurement period.
- Members who died any time during the measurement period.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS code 81).
- Medicare Advantage members 66 years of age and older as of the last date of the measurement period who meet either of the following:
    - 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 as of the last date of the measurement period (all product lines) with frailty **and** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
    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. Do not include laboratory claims (claims with POS code 81).
    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. Do not include laboratory claims (claims with POS code 81).
- Dispensed dementia medication (Dementia Medications List).

Dementia Medications

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

Administrative Specification

Denominator	The eligible population.
Numerator 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. Do not include CPT Category II codes (HbA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set) or from laboratory claims (claims with POS code 81). The member is numerator compliant if the most recent glycemic status assessment has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement period. The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement period is ≤9.0%. If there are multiple glycemic status assessments on the same date, use the lowest result. 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. Note: A lower rate indicates better performance for this indicator (i.e., low rates of Glycemic Status >9% indicate better care).

Note: If a combination of administrative and supplemental data is used, the most recent glycemic status assessment must be used, regardless of data source.