BCBS ACO Quality Metrics Details- 2021

The information below is provided at a summary level. For more details, please refer to AHRQ and NCQA specifications.

#5: PLAN ALL-CAUSE READMISSIONS (PCR) - ACTUAL TO EXPECTED

DESCRIPTION: For members 18 to 64 years old, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days of the member's discharge and the predicted probability of an acute readmission

RATIONALE:

- Readmissions are costly and sometimes preventable
- Readmissions can indicate quality concerns or opportunities for improved coordination of post discharge care

RATE CALCULATION

NUMERATOR	DENOMINATOR
Number of HEDIS-defined acute inpatient and observation stays during the measurement year that were followed by an observed unplanned acute readmission for any diagnosis within 30 days of the index discharge date	All acute inpatient and observation stays for members 18 to 64 years old (as of the discharge date) with a discharge date on or between January 1 and December 1 of the measurement year; include acute admissions to behavioral health care facilities

BCBSIL ENROLLMENT CRITERIA

365 days prior to the index discharge date through 30 days after the index discharge date with no more than 45 days gap in coverage

EXCLUSIONS

- Planned re-admissions within 30 days (maintenance chemotherapy, principal diagnosis of rehabilitation, organ transplant, potentially planned procedure without a principal acute diagnosis)
- Stays for the following reasons:
    - Inpatient stays with discharges for death
    - Acute inpatient discharge with a principal diagnosis for pregnancy

ADDITIONAL INFORMATION

Data are reported for the following indicators:

1. Count of index hospital stays (denominator)
2. Count of observed 30-day readmissions (numerator)
3. Expected readmissions rate

From this data, the ratio of the actual readmission rate to the expected readmissions rate is calculated

#6: BREAST CANCER SCREENING (BCS)

DESCRIPTION: The percentage of women 50 to 74 years old who had a mammogram to screen for breast cancer

RATIONALE:

- HEDIS
- Plan required to report
- Requested by employer groups

RATE CALCULATION

NUMERATOR	DENOMINATOR
One or more mammograms any time on or between October 1 two years prior to the Measurement Period and the end of the Measurement Period.	Women 52 to 74 years old as of December 31 of the measurement year

BCBSIL ENROLLMENT CRITERIA

October 1 two years prior to the measurement year through December 31 of the measurement year with an allowed gap up to 45 days per calendar year

EXCLUSIONS

• Members in hospice or using hospice services during the Measurement Period.
• Members who had a bilateral mastectomy or two separate unilateral mastectomy procedures any time during the member's history through the end of the Measurement Period.
• Medicare members 66 years of age and older by the end 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.
• Members 66 years of age and older by the end of the Measurement Period, with frailty and advanced illness.
• Members receiving palliative care during the Measurement Period.

#7: CERVICAL CANCER SCREENING

DESCRIPTION: The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

RATIONALE:

- HEDIS
- Plan required to report
- Requested by employer groups

RATE CALCULATION

NUMERATOR	DENOMINATOR
The number of women who were screened for cervical cancer. Either of the following meets criteria: • Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year. • Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year ***and*** who were 30 years or older on the date of the test.	Women 24 to 64 years old as of December 31 of the measurement year

BCBSIL ENROLLMENT CRITERIA

The measurement year and two years prior to the measurement year with no more than one gap of up to 45 days during each year of continuous enrollment

EXCLUSIONS

Women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix; members with at least one hospice claim or encounter during the measurement year

#8: COLORECTAL CANCER SCREENING

DESCRIPTION: The percentage of members 50 to 75 years old who had appropriate screening for colorectal cancer

RATIONALE:
- HEDIS
- Plan required to report
- Requested by employer groups

RATE CALCULATION

NUMERATOR	DENOMINATOR
One or more screenings for colorectal cancer: • Fecal occult blood test (FOBT) during the measurement year • Flexible sigmoidoscopy or CT colonography during the measurement year or the four years prior to the measurement year • Colonoscopy during the measurement year or the nine years prior to the measurement year • FIT-DNA test during the measurement year or the two years prior to the measurement year	Members 51 to 75 years old as of December 31 of the measurement year

BCBSIL ENROLLMENT CRITERIA

The measurement year and the year prior to the measurement year with no gaps more than 45 days during each year

EXCLUSIONS

• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.

• Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:

1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
– At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
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 discharge date for the stay.
– At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).

– At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
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.

- A dispensed dementia medication (Dementia Medications List).

#9: CHILDHOOD IMMUNIZATION STATUS (CIS) - (MMR only)

DESCRIPTION: The percentage of children two years old who had one measles, mumps and rubella (MMR) immunization on or between their 1st and 2nd birthday

RATIONALE:

- HEDIS
- Plan required to report
- Requested by employer groups

RATE CALCULATION

NUMERATOR	DENOMINATOR
Evidence of the antigen or combination vaccine *OR* Documented history of the illness *OR* A seropositive test result for each antigen	Children who turn two years old during the measurement year

BCBSIL ENROLLMENT CRITERIA

12 months prior to the child's second birthday with no more than 45 days gap in coverage

EXCLUSIONS

Children who had a contraindication for a specific vaccine by the second birthday; children with a diagnosis of HIV Type 2; members with at least one hospice claim or encounter during the measurement year

#10: WELL CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE

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:

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

RATIONALE:

- HEDIS
- Measure for pediatric population

RATE CALCULATION

NUMERATOR	DENOMINATOR
Rate 1: Six or more well-child visits (Well-Care Value Set) on different dates of service on or before the 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. **Rate 2:** Two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.	**Rate 1:** Children who turn 15 months old during the measurement year. **Rate 2:** Children who are 15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.

BCBSIL ENROLLMENT CRITERIA

Members must be continually enrolled through 31 days–30 months of age, with no more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled); must have Medical benefit during the measurement year.

EXCLUSIONS

Members with at least one hospice claim or encounter during the measurement year

#11: CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)

DESCRIPTION: The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

RATIONALE:
- HEDIS
- Measure for pediatric population

RATE CALCULATION

NUMERATOR	DENOMINATOR
The number of members with one or more well-care visits (Well-Care Value Set) during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.	Members between the ages of 3–21 years as of December 31 of the measurement year. Report three age stratifications and total rate: • • 3–11 years. • • 12–17 years. • • 18–21 years. • • Total. The total is the sum of the age stratifications for each product line.

BCBSIL ENROLLMENT CRITERIA

Members must be continuously enrolled for the measurement year with no more than one gap in enrollment of up to 45 days during the measurement year. Must have Medical benefit during the measurement year.

EXCLUSIONS

Members with at least one hospice claim or encounter during the measurement year

#12: IMMUNIZATIONS FOR ADOLESCENTS (IMA) – COMBO 2

DESCRIPTION: The percentage of adolescents 13 years of age who had a combination 2 immunization by their 13th birthday

RATIONALE:
- HEDIS
- Measure for pediatric population

RATE CALCULATION

NUMERATOR	DENOMINATOR
The number of members who had: • At least one meningococcal serogroups A, C, W, Y vaccine with a date of service on or between the member's 11th and 13th birthdays • At least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine with a date of service on or between the member's 10th and 13th birthdays • HPV Vaccine (one of two below) o At least two HPV vaccines with dates of service at least 146 days apart on or before the member's 9th and 13th birthdays **OR** o At least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays	Adolescents who turn 13 years of age during the measurement year

BCBSIL ENROLLMENT CRITERIA

Members must be continuously enrolled for 12 months prior to the member's 13th birthday, with no more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. Must have Medical benefit during the measurement year.

EXCLUSIONS

Members with an anaphylactic reaction to the vaccine or its components any time on or before the member's 13th birthday; members with encephalopathy with a vaccine adverse effect code anytime on or before the member's 13th birthday; members with at least one hospice claim or encounter during the measurement year.

#13:PRENATAL CARE AND POSTPARTUM CARE (PPC) – TIMELINESS OF PRENATAL CARE

DESCRIPTION: The percentage of deliveries of live births 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.

RATIONALE:
- HEDIS
- Measure for pediatric population

RATE CALCULATION

NUMERATOR	DENOMINATOR
The number of members who received a prenatal care visit in the time period of 280-176 days prior to delivery (or expected delivery date)	Women who delivered a live birth in any setting between October 8 of the year prior to the measurement year through October 7 of the measurement year. Women who had two separate deliveries (different dates of service) during that time period count twice. Women who had multiple live births during one pregnancy count once.

BCBSIL ENROLLMENT CRITERIA

Members must be continually enrolled 43 days prior to delivery through 60 days after delivery, with no allowable gap during the continuous enrollment period; must have Medical benefit during the measurement year.

EXCLUSIONS

Exclude non-live births; members with at least one hospice claim or encounter during the measurement year

#13:PRENATAL CARE AND POSTPARTUM CARE – POSTPARTUM CARE

DESCRIPTION: The percentage of deliveries of live births that had a postpartum visit on or between 7 and 84 days after delivery

RATIONALE:
- HEDIS
- Measure for pediatric population

RATE CALCULATION

NUMERATOR	DENOMINATOR
The number of members who received a postpartum care visit in the time period of 7 and 84 days after delivery	Women who delivered a live birth in any setting between October 8 of the year prior to the measurement year through October 7 of the measurement year. Women who had two separate deliveries (different dates of service) during that time period count twice. Women who had multiple live births during one pregnancy count once.

BCBSIL ENROLLMENT CRITERIA

Member must be continuously enrolled 43 days prior to delivery through 60 days after delivery, with no gaps

EXCLUSIONS

Exclude non-live births; members with at least one hospice claim or encounter during the measurement year

#14: COMPREHENSIVE DIABETES CARE (CDC) – HbA1c TEST (ANNUAL)

DESCRIPTION: Percentage of members 18 to 75 years old with diabetes mellitus who had an HbA1c test

RATIONALE:
- HEDIS
- High prevalence of diabetes in population

RATE CALCULATION

NUMERATOR	DENOMINATOR
HbA1C test during measurement year	Number of eligible members 18 to 75 years old as December 31 of the measurement year with diagnosis of type 1 or type 2 diabetes based on claims or pharmacy data BCBSIL receives from its pharmacy benefit manager

INCLUSION CRITERIA

Members who meet the age requirement in the measurement year and meet at least one of the following during the measurement year or the year prior to the measurement year:
- At least one ambulatory prescription for insulin or an oral hypoglycemic/ anti-hyperglycemic drug
- At least two encounters with different dates of service in an outpatient setting (one of which can be telehealth or online assessment), or face to face encounters in an emergency room, observation visit, or non-acute inpatient setting with a diagnosis of diabetes.
- At least one face-to-face encounter in an inpatient setting with a diagnosis of diabetes

EXCLUSIONS

Exclude members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:

– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.

• Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:

1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):

– At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
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 discharge date for the stay.

– At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).

– At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
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.

- A dispensed dementia medication (Dementia Medications List).

#15: COMPREHENSIVE DIABETES CARE (CDC) – HbA1c CONTROL (<8.0%)

DESCRIPTION: Percentage of members 18 to 75 years old with diabetes mellitus with most recent HbA1c <8%

RATIONALE:

- HEDIS
- CMS ACO measure
- High prevalence of diabetes in population

RATE CALCULATION

NUMERATOR	DENOMINATOR
Most recent HbA1C result during the measurement year <8%	Number of eligible members 18 to 75 years old as December 31 of the measurement year with diagnosis of type 1 or type 2 diabetes based on claims or pharmacy data BCBSIL receives from its pharmacy benefit manager

BCBSIL ENROLLMENT CRITERIA

Members must be continually enrolled through the measurement year, with no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage; must have Medical benefit during the measurement year.

INCLUSION CRITERIA

Members who meet the age requirement in the measurement year and meet at least one of the following during the measurement year or the year prior to the measurement year:

- At least one ambulatory prescription for insulin or an oral hypoglycemic/ anti-hyperglycemic drug
- At least two encounters with different dates of service in an outpatient setting (one of which can be telehealth or online assessment), or face to face encounters in an emergency room, observation visit, or non-acute inpatient setting with a diagnosis of diabetes

At least one face-to-face encounter in an inpatient setting with a diagnosis of diabetes

EXCLUSIONS

Exclude members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:

1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
   - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
     7. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
     8. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
     9. Identify the discharge date for the stay.
   - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
   - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
     7. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
     8. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
     9. Identify the discharge date for the stay.
   - A dispensed dementia medication (Dementia Medications List).

#16: COMPREHENSIVE DIABETES CARE (CDC) – Eye Exam performed (Retinal)

DESCRIPTION: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had Eye exam (retinal) performed

RATIONALE:

- HEDIS
- High prevalence of diabetes in population

RATE CALCULATION

NUMERATOR	DENOMINATOR
Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. • Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.	Number of eligible members 18 to 75 years old as December 31 of the measurement year with diagnosis of type 1 or type 2 diabetes based on claims or pharmacy data BCBSIL receives from its pharmacy benefit manager

BCBSIL ENROLLMENT CRITERIA

Members 18–75 years as of December 31 of the measurement year, with no more than one gap in enrollment for up to 45 days during the measurement year

EXCLUSIONS

Exclude members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:

– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.

• Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:

1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):

– At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

10. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
11. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
12. Identify the discharge date for the stay.

– At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
– At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
10. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
11. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
12. Identify the discharge date for the stay.

– A dispensed dementia medication (Dementia Medications List).

#17: CONTROLLING HIGH BLOOD PRESSURE - CBP

DESCRIPTION: The percentage of members 18-85 years of age who had a diagnosis of hypertension of whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year

RATIONALE:

- HEDIS
- High prevalence of hypertension in population

RATE CALCULATION

NUMERATOR	DENOMINATOR
Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during an outpatient visit (Outpatient Without UBREV Value Set), telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year. The BP reading must occur *on or after* the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).	Members who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year (count services that occur over both years). Visit type does not need to be the same for both visits. This can include: • Outpatient visit • Outpatient visit with telehealth modifier • Telephone visit • Online assessment

BCBSIL ENROLLMENT CRITERIA

Members must be continually enrolled through the measurement, with no more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled); must have Medical benefit during the measurement year.

EXCLUSIONS

****Required Exclusions**

Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

****Exclusions**

• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:

– Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.

• Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet *both* of the following frailty and advanced illness criteria to be excluded:

1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):

– At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

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 discharge date for the stay.

– At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).

– At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:

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.

– A dispensed dementia medication (Dementia Medications List).

Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

****Optional Exclusions**

• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.

• Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

• Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. 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.

Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.

• Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

• Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:

4. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
5. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
6. Identify the admission date for the stay.

#18: APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

DESCRIPTION: The percentage of episodes when members 3 years and older were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode

RATIONALE:

- HEDIS
- Acute care measure
- Antibiotic overuse

RATE CALCULATION

NUMERATOR	DENOMINATOR
A group A streptococcus test (Group A Strep Tests Value Set) in the seven-day period from three days prior to the Episode Date through three days after the Episode Date.	All members, 3 years of age or older who had an outpatient, telephone, online assessment, observation, or emergency department encounter with a diagnosis of pharyngitis and were dispensed an antibiotic

BCBSIL ENROLLMENT CRITERIA

Member must be continuously enrolled 30 days prior to the episode date through three days after the episode date, with no gaps in enrollment; must have pharmacy benefit during measurement year; negative history is checked to exclude some members from the denominator

INCLUSION CRITERIA

All members 3 years of age and older during the intake period, who had a pharyngitis encounter with:

- • An antibiotic prescribed within three days of the encounter
- • No antibiotic medication prescribed or refilled within 30 days prior to the encounter or still active on the date of the encounter

The intake period is from six months **prior** to the beginning of the measurement year to six months **prior** to the end of the measurement year. The earliest episode during the intake period is the index episode start date.

EXCLUSIONS

Members with at least one hospice claim or encounter during the measurement year

#19: APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

DESCRIPTION: The percentage of episodes when a member 3 months of age and older was given a diagnosis of upper respiratory infection (URI) and was not dispensed an antibiotic prescription

RATIONALE:

- HEDIS
- Acute care measure
- Antibiotic overuse

RATE CALCULATION

NUMERATOR	DENOMINATOR
Dispensed prescription for an antibiotic medication from the CWP Antibiotic Medications List on or 3 days after the Episode Date.	All episodes incurred by members 3 months of age and older as of the episode date who had an outpatient, telephone, online assessment, observation, or ED visit with a URI diagnosis

BCBSIL ENROLLMENT CRITERIA

30 days prior to the index episode start date through three days after the index episode start date with no gaps in enrollment

INCLUSION CRITERIA

All members, 3 months of age and older during the intake period, who had a URI encounter with:

- No antibiotic medication prescribed or refilled within 30 days prior to the encounter or still active on the date of the encounter
- No specified competing diagnosis on or within three days following the encounter

The intake period is from six months prior to the beginning of the measurement year to six months prior to the end of the measurement year. The earliest episode during the intake period is the index episode start date.

EXCLUSIONS

Members with at least one hospice claim or encounter during the measurement year

#20: AVOIDANCE OF ANTIBIOTIC TREATMENT WITH ACUTE BRONCHITIS/BRONCHIOLITIS

DESCRIPTION: The percentage of episodes when a member 3 months of age or older with a diagnosis of acute bronchitis/bronchiolitis was not dispensed an antibiotic prescription

RATIONALE:

- HEDIS
- Acute care measure
- Antibiotic overuse

RATE CALCULATION

NUMERATOR	DENOMINATOR
Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the Episode Date	All members, 3 months of age or older, who had an outpatient, telephone, online assessment, observation, or emergency department encounter with a diagnosis of acute bronchitis/bronchiolitis

BCBSIL ENROLLMENT CRITERIA

Member must be continuously enrolled 30 days prior to the episode date through three days after the episode date, with no gaps in enrollment; must have pharmacy benefit during measurement year; negative history is checked to exclude some members from the denominator.

INCLUSION CRITERIA

Members who meet the denominator criteria with none of the diagnostic codes that describe comorbid conditions (such as tuberculosis, tracheostomy, lung abscess, pneumothorax, etc.) during the 12-month period prior to the encounter, no prescription for an antibiotic medication filled 30 days prior to the encounter or active on the episode date, and none of the specified competing diagnoses during the period from 30 days prior to the encounter to seven days after the encounter.
The intake period is from six months prior to the beginning of the measurement year to six months prior to the end of the measurement year. The earliest episode during the intake period is the episode date.

EXCLUSIONS

Members with at least one hospice claim or encounter during the measurement year

#21: USE OF IMAGING STUDIES FOR LOW BACK PAIN

DESCRIPTION: The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

RATIONALE:

- HEDIS
- Imaging for low back is high utilization/high cost factor
- Unnecessary imaging exposes members to unnecessary radiation

RATE CALCULATION

NUMERATOR	DENOMINATOR
An imaging study (Imaging Study Value Set) with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) on the IESD or in the 28 days following the IESD	All members, 18 years old as of January 1 of the measurement period to 50 years old as of December 31 of the measurement period, who had an outpatient or emergency department encounter with a principal diagnosis of uncomplicated low back pain

BCBSIL ENROLLMENT CRITERIA

180 days (six months) prior to the index episode start date through 28 days after the index episode start date without gaps

INCLUSION CRITERIA

Members, 18 years old as of the beginning of the measurement year to 50 years as of the end of the measurement year, who had:

- At least one outpatient visit, observation visit, osteopathic/chiropractic manipulative treatment, physical therapy visit, telephone visit, online assessment, or emergency department encounter with a principal diagnosis of uncomplicated low back pain during the intake period
- No low back pain diagnosis during the six-month (180-day) period prior to the first low back pain encounter
- Had no diagnosis for which an imaging study in the presence of low back pain is clinically indicated

The intake period is from the beginning of the measurement year to 28 days prior to the end of the measurement year

EXCLUSIONS

Members who had a diagnosis of cancer at any time during the member's history through 28 days after the episode start date; recent trauma, intravenous drug abuse or neurologic impairment; any trauma during the 3 months prior to the episode start date through 28 days after the episode start date; diagnosis of HIV, spinal infection, or neurologic impairment; kidney or other organ transplant; prolonged use of corticosteroids; members with at least one hospice claim or encounter during the measurement year.