NCQA seeks comments on the proposed expansion of the race and ethnicity stratification to select HEDIS measures in MY 2023. NCQA's goal is to advance health equity by leveraging HEDIS to hold health plans accountable for disparities in care among their patient populations. This includes bringing transparency to where gaps exist (or do not exist) and highlighting plans that successfully invest in strategies to reduce disparities in care and outcomes.

NCQA introduced the race and ethnicity stratification to 5 HEDIS measures in MY 2022 (Table 1). Based on feedback from expert panels and external stakeholders, the NCQA team developed a list of candidate measures to which to expand the stratification in MY 2023 (Table 2). NCQA aims to add the stratification to at least 5 more measures this year.

**NCQA seeks general feedback on the proposal above and on the following:**

1. *Measures listed as candidates for stratification in MY 2023.* Measures listed in Table 2 were excluded from consideration if they were risk-adjusted, in first-year status, slated for retirement or known to have small denominators. Measures were prioritized for inclusion if they represented a high-priority population for disparities (including those identified in prior public comment and stakeholder feedback), covered multiple product lines and were digital measures that relied on electronic clinical data.

2. *Thoughts on additional measures* that should be prioritized for future stratification.

Supporting documents include a draft measure specification, evidence workup and HEDIS General Guideline 33. For additional background information, refer to NCQA's issue brief, *Health Equity and Social Determinants of Health in HEDIS: Data for Measurement*, which can be downloaded for free from NCQA's website [here](#).

NCQA acknowledges the contributions of the Health Equity Expert and Care Coordination Work Groups, and the Geriatric, Technical, Behavioral Health and Adult Immunization Measurement Advisory Panels.
Table 1. Measures Stratified by Race/Ethnicity in MY 2022.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Product Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of Care</td>
<td>Colorectal Cancer Screening (COL, COL-E)</td>
<td>Commercial, Medicare</td>
</tr>
<tr>
<td></td>
<td>Controlling High Blood Pressure (CBP)</td>
<td>Commercial, Medicaid, Medicare</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin A1c Control for Patients With Diabetes (HBD)</td>
<td>Commercial, Medicaid, Medicare</td>
</tr>
<tr>
<td>Utilization</td>
<td>Child and Adolescent Well Care Visits (WCV)</td>
<td>Commercial, Medicaid</td>
</tr>
<tr>
<td>Access and Availability of Care</td>
<td>Prenatal and Postpartum Care (PPC)</td>
<td>Commercial, Medicaid</td>
</tr>
</tbody>
</table>

Table 2. Race/Ethnicity Stratification (RES) Candidate Measures for MY 2023

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Product Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>Follow-Up After Emergency Department Visits for Substance Use Disorder (FUA)</td>
<td>Commercial, Medicaid, Medicare</td>
</tr>
<tr>
<td></td>
<td>Pharmacotherapy for Opioid Use Disorder (POD)</td>
<td>Commercial, Medicaid, Medicare</td>
</tr>
<tr>
<td></td>
<td>Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)</td>
<td>Commercial, Medicaid, Medicare</td>
</tr>
<tr>
<td></td>
<td>Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)</td>
<td>Commercial, Medicaid, Medicare</td>
</tr>
<tr>
<td></td>
<td>Prenatal Depression Screening and Follow-Up (PND-E)</td>
<td>Commercial, Medicaid</td>
</tr>
<tr>
<td></td>
<td>Postpartum Depression Screening and Follow-Up (PDS-E)</td>
<td>Commercial, Medicaid</td>
</tr>
<tr>
<td>Prevention &amp; Screening</td>
<td>Breast Cancer Screening (BCS-E)</td>
<td>Commercial, Medicaid, Medicare</td>
</tr>
<tr>
<td></td>
<td>Adult Immunization Status (AIS-E)</td>
<td>Commercial, Medicaid, Medicare</td>
</tr>
<tr>
<td></td>
<td>Immunizations for Adolescents (IMA, IMA-E)</td>
<td>Commercial, Medicaid</td>
</tr>
<tr>
<td></td>
<td>Prenatal Immunization Status (PRS-E)</td>
<td>Commercial, Medicaid</td>
</tr>
<tr>
<td>Utilization</td>
<td>Well-Child Visits in the First 30 Months of Life (W30)</td>
<td>Commercial, Medicaid</td>
</tr>
<tr>
<td>Access and Availability of Care</td>
<td>Initiation and Engagement of Substance Use Disorder Treatment (IET)</td>
<td>Commercial, Medicaid, Medicare</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Asthma Medication Ratio (AMR)</td>
<td>Commercial, Medicaid</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)</td>
<td>Medicare</td>
</tr>
</tbody>
</table>

Measure abbreviations that include “-E” indicate that the measure is reported using Electronic Clinical Data Systems (ECDS). Some measures are only reported using ECDS, while others may also (or only) rely on traditional measure reporting methods. NCQA included measures that use ECDS, with the intention of capitalizing on the expansive information available in electronic clinical datasets used for patient care and quality improvement.
Follow-Up After Emergency Department Visit for Substance Use (FUA)*

*Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added instructions to report rates stratified by race and ethnicity for each product line.

Description

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

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

Eligible Population

Product lines
- Commercial, Medicaid, Medicare (report each product line separately).

Stratifications
- For each product line, report the following stratifications by race and total and by ethnicity and total:
  - Race:
    - White.
    - Black or African American.
    - American Indian or Alaska Native.
    - Asian.
    - Native Hawaiian or Other Pacific Islander.
    - Some Other Race.
    - Two or More Races.
    - Asked but No Answer.
    - Unknown.
    - Total.
  - Ethnicity:
    - Hispanic or Latino.
    - Not Hispanic or Latino.
    - Asked but No Answer.
    - Unknown.
    - Total.

Note: Stratifications are mutually exclusive and the sum of all categories in each stratification is the total population.
Ages

13 years and older as of the ED visit. Report two age stratifications and a total rate:

- 13–17 years.
- 18 and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

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

Allowable gap

None.

Anchor date

None.

Benefit

Medical, chemical dependency and pharmacy.

Note: Members with detoxification-only chemical dependency benefits do not meet these criteria.

Event/diagnosis

An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.

Multiple visits in a 31-day period

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

Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

ED visits followed by inpatient admission

Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

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

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusion

Members in hospice or using hospice services any time during the measurement year. Refer to General Guideline 17: Members in Hospice.
Administrative Specification

Denominator  
The eligible population.

Numerators

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

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

For both indicators, any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider.

- An outpatient visit (BH Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- An outpatient visit (BH Outpatient Value Set) with a mental health provider.

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with a mental health provider.

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a mental health provider.
A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with a mental health provider.

A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with a mental health provider.

An observation visit (Observation Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

An observation visit (Observation Value Set) with a mental health provider.

A peer support service (Peer Support Services Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider.

A telephone visit (Telephone Visits Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

A telephone visit (Telephone Visits Value Set), with a mental health provider.

An e-visit or virtual check-in (Online Assessments Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
An e-visit or virtual check-in (Online Assessments Value Set), **with** a mental health provider.

A substance use disorder service (Substance Use Disorder Services Value Set).

A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set).

A substance use service (Substance Use Services Value Set).

A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).

**Note**

- Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).

- Refer to Appendix 3 for the definition of mental health provider. Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.

**Data Elements for Reporting**

Organizations that submit HEDIS data to NCQA must provide the following data elements.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Age</th>
<th>Data Element</th>
<th>Reporting Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>FollowUp30Day</td>
<td>13-17</td>
<td>Benefit</td>
<td>Metadata</td>
</tr>
<tr>
<td>FollowUp7Day</td>
<td>18+ Total</td>
<td>EligiblePopulation</td>
<td>For each Stratification, repeat per Metric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ExclusionAdminRequired</td>
<td>For each Stratification, repeat per Metric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NumeratorByAdmin</td>
<td>For each Metric and Stratification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NumeratorBySupplemental</td>
<td>For each Metric and Stratification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rate</td>
<td>(Percent)</td>
</tr>
</tbody>
</table>
### Table FUA-B-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use: Stratifications by Race

<table>
<thead>
<tr>
<th>Metric</th>
<th>Race</th>
<th>Source</th>
<th>Data Element</th>
<th>Reporting Instructions</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>FollowUp30Day</td>
<td>White</td>
<td>Direct</td>
<td>EligiblePopulation</td>
<td>For each Stratification, repeat per Metric</td>
<td>✓</td>
</tr>
<tr>
<td>FollowUp7Day</td>
<td>BlackOrAfricanAmerican</td>
<td>Indirect</td>
<td>Numerator</td>
<td>For each Metric and Stratification</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>AmericanIndianorAlaskaNative</td>
<td>Total</td>
<td>Rate (Percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NativeHawaiianorOtherPacificIslander</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SomeOtherRace</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TwoOrMoreRaces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AskedButNoAnswer*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unknown**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*AskedButNoAnswer is only reported for Source = 'Direct.'

**Unknown is only reported for Source = 'Indirect.'

### Table FUA-C-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use: Stratifications by Ethnicity

<table>
<thead>
<tr>
<th>Metric</th>
<th>Ethnicity</th>
<th>Source</th>
<th>Data Element</th>
<th>Reporting Instructions</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>FollowUp30Day</td>
<td>HispanicOrLatino</td>
<td>Direct</td>
<td>EligiblePopulation</td>
<td>For each Stratification, repeat per Metric</td>
<td>✓</td>
</tr>
<tr>
<td>FollowUp7Day</td>
<td>NotHispanicOrLatino</td>
<td>Indirect</td>
<td>Numerator</td>
<td>For each Metric and Stratification</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>Rate (Percent)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Unknown is only reported for Source = 'Indirect.'
Race and Ethnicity Stratifications
Candidate Measures for HEDIS®¹ MY 2023
Measure Workup

The following table provides a high-level overview of each measure on the candidate list, including the measure description, product lines, HEDIS domain, evidence on disparities and unique considerations for stratification and status of Electronic Clinical Data System reporting, where applicable.

NCQA recommends stratification at the highest reported measure rate (i.e., not stratifying within existing stratifications or sub-rates), with one potential exception: Asthma Medication Ratio (AMR), which is noted and discussed below.

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Product Lines</th>
<th>Domain</th>
<th>Programs Used In</th>
<th>ECDS Reporting Status</th>
<th>Evidence on Disparities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Breast Cancer Screening (BCS-E²)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Between 2010 and 2014, breast cancer mortality for African American women was 41% higher than for White women (Richardson et al 2016). One potential contributing factor is access to mammography screening services (Rust et al., 2015). One study found that mammography use in 2006 was 65% among White women and 59% among Black women (CDC, 2012). Additionally, African American women are more likely than White women to have longer intervals between screening mammograms, which may lead to an increase in later-stage cancer diagnoses (CDC, 2012).</td>
</tr>
<tr>
<td>Description: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.</td>
<td>Commercial, Medicaid, Medicare</td>
<td>Prevention and Screening</td>
<td>Exchange Quality Rating System (QRS), Medicaid Core Set, Medicare Shared Savings Program, Merit-Based Incentive Payment System (MIPS) Program, Physician Compare.</td>
<td>Originaly specified as a traditional measure; has also been specified for optional ECDS reporting. Will be in ECDS-reporting-only status beginning measurement year (MY) 2023.</td>
<td></td>
</tr>
<tr>
<td>2. Well-Child Visits in the First 30 Months of Life (W30)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>In 2014, White children had a higher probability of attending an annual well-child visit than Hispanic children (85.3% vs. 78.9%) (AHRQ, 2016). A study on children born between 2007 and 2009 examined the frequency of well-child visits in infants in relation to their demographics. This study found that White children were more likely to have the recommended number of well-child visits compared to other groups (White: 68.1%; Black: 46.1%; Asian: 66.3%; Hawaiian/Pacific</td>
</tr>
<tr>
<td>Description: The percentage of members who had all recommended well-child visits with a PCP during the last 15 months.</td>
<td>Commercial, Medicaid</td>
<td>Utilization</td>
<td>Exchange QRS, Medicaid Core Set, HEDIS Quality Measure Rating System (QMRS)</td>
<td>NA; this measure is only offered for traditional reporting.</td>
<td></td>
</tr>
</tbody>
</table>

¹HEDIS is a registered trademark of the National Committee for Quality Assurance.
²Measure abbreviations that include “-E” indicate that the measure is reported using Electronic Clinical Data Systems (ECDS). Some measures are only reported using ECDS, while others may also (or only) rely on traditional measure reporting methods. NCQA included measures that use ECDS, with the intention of capitalizing on the expansive information available in electronic clinical datasets used for patient care and quality improvement.
Islander: 53.4%; Other: 52.4%). When the authors controlled for insurance status, Black children only received 42% of well-child visits, compared to White children, who received 58% (Dabney et al., 2012).

3. Adult Immunization Status (AIS-E)

Description: The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.

Product Lines: Commercial, Medicaid, Medicare

Domain: Prevention and Screening

Programs Used In: HEDIS QMRS

ECDS Reporting Status: Developed for ECDS reporting; will be publicly reported beginning MY 2022.

Evidence on Disparities: An analysis of trends in adult vaccination coverage from 2010–2019 found that vaccine uptake differed by race and ethnicity for influenza, pneumococcus, tetanus and zoster vaccinations (Kawai and Kawai, 2021). Another analysis of national vaccination coverage found that racial and ethnic differences in adult vaccinations persist for all vaccines (Lu, 2021). The authors note that coverage is consistently higher in White and Asian adults. For instance, in the 2017–2018 influenza season, 50.7% of Asian adults and 49.3% of White adults received an influenza vaccine, while 39% of Black adults and 37.5% of Hispanic adults received it (Lu, 2021). The same study also found that vaccine rates are generally lower among foreign-born persons.

4. Immunizations for Adolescents (IMA, IMA-E)

Description: The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Product Lines: Commercial, Medicaid

Domain: Prevention and Screening

Programs Used In: Exchange QRS, HEDIS QMRS, Medicaid Core Set, MIPS

ECDS Reporting Status: Originally specified as a traditional measure; has also been specified for optional ECDS reporting. NCQA does not have a timeline to fully transition this measure to ECDS-only, so it will continue to be available for optional ECDS reporting for MY 2023.

Evidence on Disparities: Literature points to a number of racial and ethnic disparities in adolescent immunization rates. Rates for receiving at least one or two doses of the HPV vaccine are higher among non-Hispanic Black female adolescents (66.9%) than non-Hispanic White female adolescents (59.2%) (Reagan-Steiner, 2015). In addition, HPV and meningococcal immunization rates are higher among Hispanic and non-Hispanic Native American adolescents than non-Hispanic White and non-Hispanic Black adolescents.

5. Prenatal Immunization Status (PRS-E)

Description: The percentage of deliveries in the Measurement Period in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

Product Lines: Commercial, Medicaid

Domain: Prevention and Screening

Programs Used In: HEDIS QMRS

ECDS Reporting Status: Developed for ECDS reporting; has been publicly reported since MY 2020.
### Evidence on Disparities:

Prenatal immunization rates vary based on patient race, ethnicity, age, insurance status and adequacy of prenatal care. A CDC panel survey of women who were pregnant any time between October 2014 and January 2015 found that 39% of non-Hispanic Black women had received the influenza immunization after July 2014, compared with 52% of non-Hispanic White women (Ding et al., 2015). Pregnancy Risk Assessment Monitoring System survey data from the 2009–2010 influenza season revealed that influenza vaccination coverage among women with live births was 51% for non-Hispanic White women, compared with 30% for non-Hispanic Black women and 42% for Hispanic women (Ahluwalia et al., 2014). A study from 2011–2013 using administrative claims data and statewide immunization registry data of Medicaid-enrolled pregnant women in Michigan found that 8% of non-Hispanic Black women, 12% of Asian women and 7% of Arab women received the Tdap immunization during pregnancy, compared with 18% of non-Hispanic White women (Housey et al., 2014).

### 6. Initiation and Engagement of Substance Use Disorder Treatment (IET)

**Description:** The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.

**Product Lines:** Commercial, Medicaid, Medicare

**Domain:** Access and Availability of Care

**Programs Used In:** Medicaid Core Set

**ECDS Reporting Status:** NA

**Evidence on Disparities:** In 2017 the rate of illicit drug use among persons 12 years of age or older differed by race and ethnicity. Non-Hispanic or non-Latino persons had higher rates of illicit drug use than Hispanic or Latino persons (19.3% vs. 17.5%) (SAMHSA, 2018). Among non-Hispanic or non-Latino persons, American Indian/Alaskan Natives had the highest rate of illicit drug use (29.3%) compared to Black persons (20.5%), White persons (19.7%), Native Hawaiian/Other Pacific Islander persons (12.7%) and Asian persons (9.5%) in the past year (SAMSHA, 2018).

CMS data show that in 2014, Asian or Pacific Islander patients and Hispanic patients with a new episode of SUD and who initiated treatment were less likely than White patients to have had two or more additional services within 30 days of the initiation visit (CMS, 2018). The same report notes that overall, 1.6% of Asian and Pacific Islander persons, 1.9% of Hispanic persons and 2.2% of White persons had two or more additional services for a new diagnosis of SUD after initiation of treatment. Conversely, Black persons (27.0%) were more likely than White persons (26.1%) to initiate treatment within 14 days of an SUD diagnosis, but were less likely than White persons (1.9% vs. 2.2%) to engage in treatment (two or more additional services with a diagnosis of SUD within 30 days of the initiation of treatment), according to 2014 findings (CMS, 2018).

### 7. Follow-Up After Emergency Department Visits for Substance Use Disorder (FUA)

**Description:** The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.

**Product Lines:** Commercial, Medicaid, Medicare

**Domain:** Behavioral Health

**Programs Used In:** Medicaid Core Set

**ECDS Reporting Status:** NA

**Evidence on Disparities:** Substance Abuse Mental Health Services Administration 2019 data indicate that across different racial and ethnic groups, past-year misuse of opioids among individuals 12 years of age and older was most common among individuals identifying with two or more races (5.2%).

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3 NCQA recognizes that not all people who become pregnant or give birth identify as women or mothers. However, we use the term “women” in several places to avoid editing of cited data.
followed by American Indian or Alaskan Native (5.1%), White (3.8%), Black or African American (3.4%) and Hispanic or Latino (3.7%) (SAMHSA, 2020) people. Individuals identifying as Asian or Native Hawaiian/Other Pacific Islander reported the lowest past year misuse of opioids (1.6% and 2.8% respectively) (SAMHSA, 2020).

Research has also shown that despite having later age of first exposure to alcohol and drinking less alcohol, African American people, and African American women in particular, tend to be at higher risk of experiencing adverse outcomes attributed to alcohol use disorders than White people (Zapolski et al., 2014; Ransome et al., 2017; Williams et al., 2017).

A study examining the incidence of follow-up treatment following an ED discharge for non-fatal opioid overdose among commercially insured patients found that between 2011 and 2016, Black patients were half as likely to obtain follow-up than non-Hispanic White patients (Kilaru et al., 2020). The same study found that women and Hispanic patients were also less likely to obtain follow-up than non-Hispanic White patients.

8. Pharmacotherapy for Opioid Use Disorder (POD)

Description: The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members 16 years of age and older with a diagnosis of OUD.

Product Lines: Commercial, Medicaid, Medicare

Domain: Behavioral Health

Programs Used In: None

ECDS Reporting Status: NA

Evidence on Disparities: Although use of pharmacotherapy in the treatment of OUD is low across all populations, several groups are particularly vulnerable to negative opioid-related outcomes due to lack of treatment, including pregnant and postpartum women; people with psychiatric comorbidities; individuals with a history of interaction with law enforcement or who have recently been released from incarceration; and the elderly (NASEM, 2018). Additionally, adolescents, uninsured individuals, African American individuals and other minority populations (native Hawaiian, Pacific Islander, Asian American) have been found to have lower odds of using OUD treatment (Wu, 2016).

9. Asthma Medication Ratio (AMR)

Description: The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Product Lines: Commercial, Medicaid

Domain: Respiratory

Programs Used In: HEDIS QMRS, Exchange QRS, Medicaid Core Set

ECDS Reporting Status: NA

Evidence on Disparities: A 2018 literature review summarized factors playing a role in development, treatment and prevention of childhood asthma, including racial and ethnic disparities in management of childhood asthma (Naja, et al., 2018). The authors found that racial and ethnic minorities exhibit a disproportionate rate of asthma morbidity in the U.S., with the highest rate of asthma found in the Puerto Rican American population (13.1%), followed by the African American population (9.5%), the White population (7.2%) and the Mexican American population (3.6%). The review also notes considerable asthma care disparities for African American youths compared to White youths, with 4 times more ED visits, 3 times the hospitalization rate and 7.6 times the death rate.
A 2018 study of asthma in children used longitudinal analyses to show that African American race and Hispanic/Latino ethnicity were both significantly associated with worse asthma outcomes (Washington et al., 2018).

A 2020 study on the impact of the COVID-19 pandemic on asthma control found that differences in socioeconomic status and the effects of institutional racism influenced disparities for patients with asthma (Baptist et al., 2020).

**Unique consideration:** Although this measure captures members 5–64 years of age, literature highlights considerable disparities for people under 18; therefore, NCQA seeks GMAP feedback on whether we should stratify this measure at the highest level, if chosen (aligning with other measures on the candidate list), or by age band, in order to highlight disparities across age groups.

### 10. Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

**Description:** The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

**Product Lines:** Medicare

**Domain:** Care Coordination

**Programs Used In:** Forthcoming in the Medicare Stars Program

**ECDS Reporting Status:** NA

**Evidence on Disparities:** There is little research on potential disparities in follow-up after ED transitions, but research has evaluated potential disparities regarding ED visits and transitions more broadly. One study found that older adults, non-Hispanic Black patients, lower income patients and patients with multiple chronic conditions were more likely to visit the ED in a 12-month period (Garcia et al., 2010). Another study found that non-Hispanic White Medicare beneficiaries were more likely than Hispanic and Asian Medicare beneficiaries to have an inpatient readmission after an ED discharge (Gabayan et al., 2015).

### 11. Depression Screening and Follow-Up for Adolescents and Adults (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.

**Product Lines:** Commercial, Medicaid, Medicare

**Domain:** Behavioral Health

**Programs Used In:** HEDIS QMRS, Medicaid Promoting Interoperability Program for Eligible Professionals, MIPS, Physician Compare

**ECDS Reporting Status:** Originally developed for ECDS reporting; will be publicly reported beginning MY 2023.

**Evidence on Disparities:** A 2008 study found that minority individuals may present depressive symptoms differently than non-Latino White individuals, which causes difficulty for providers who are trained to recognize classic symptoms and screen appropriately. The same study discovered that among those with a diagnosed depressive disorder, 36.3% of Latino patients and 49.1% of African American patients accessed mental health treatment, compared to 59.8% of non-Latino White patients (Algeria et al., 2008).
## 12. Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

**Description:** The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.

**Product Lines:** Commercial, Medicaid, Medicare

**Domain:** Behavioral Health

**Programs Used In:** Physician Compare

**ECDS Reporting Status:** Originally developed for ECDS reporting; will be publicly reported beginning MY 2023.

**Evidence on Disparities:** Using data from a large national survey, researchers found that few Americans with recent major depression receive guideline-concordant therapies, but the lowest rates of use are found among the Mexican American and Black populations (Gonzalez et al., 2010). Minority children are one-third to one-half less likely to receive mental health care as White children, despite a similar overall prevalence of disease (Holm-Hansen, 2006). Moreover, of those who do receive care, minority patients are less likely than White patients to receive complete services, and are more likely to receive treatment that is inappropriate, fragmented or inadequate (Algeria et al., 2008; Cummings et al., 2019).

## 13. Prenatal Depression Screening and Follow-Up (PND-E)

**Description:** The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.

**Product Lines:** Commercial, Medicaid

**Domain:** Behavioral Health

**Programs Used In:** HEDIS QMRS

**ECDS Reporting Status:** Originally developed for ECDS reporting; will be publicly reported beginning MY 2022.

**Evidence on Disparities:** Even when depression care is provided for pregnant women, variation in depression care management has been documented, particularly among minority women. For instance, 3.1% of visits for non-Hispanic White women during pregnancy included a code for antidepressant use, while just 1.0% of all visits for non-White women included antidepressant codes (Yamamoto, 2015). In one study, African American and Latina women were less likely than White women to receive follow-up treatment or continued care for perinatal depression (Kozhimannil, 2011). Additionally, research highlights that the risk of untreated perinatal depression is higher among low-income ethnic minority mothers due to various cultural barriers, such as opting for self-help practices (e.g., “talking it out” with family and community members) in lieu of formal mental health care (Abrams, 2009).

## 14. Postpartum Depression Screening and Follow-Up (PDS-E)

**Description:** The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.

- **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.

- **Follow-Up on Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

**Product Lines:** Commercial, Medicaid

**Domain:** Behavioral Health
Programs Used In: HEDIS QMRS

ECDS Reporting Status: Originally developed only for ECDS reporting; will be publicly reported beginning MY 2022.

Evidence on Disparities: A study assessing postpartum depression screening rates found that African American, Asian and otherwise non-White (Native American, Native Hawaiian, multiracial) women were less likely to be screened than White women. The study notes that 5.5% of White women did not return for a postpartum visit, compared to 22.7% of Native American women, 11.5% of Black women and 8.8% of multiracial women (Sidebottom et al., 2021). In one study of racial and ethnic differences in mental health care utilization associated with postpartum depression, 9% of White women initiated mental health care within 6 months of delivery, while 5% of Latina women and 4% of Black women did. Additionally, in women who initiated antidepressant treatment postpartum, Black and Latina women were less likely to refill a prescription than their White counterparts (Kozhimannil, 2011).

References


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33. Race and Ethnicity Stratification

The following measures instruct the organization to categorize Medicare, Medicaid and commercial members by race and ethnicity stratification (RES):
- Colorectal Cancer Screening.
- Controlling High Blood Pressure.
- Hemoglobin A1c Control for Patients With Diabetes.
- Prenatal and Postpartum Care.
- Child and Adolescent Well-Care Visits.

NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.¹,²,³

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

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

**White**: Identification with one or more nationalities or ethnic groups originating in Europe, the Middle East or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun and Chaldean.

**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 and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian and Bahamian.

**American Indian and Alaska Native**: Identification with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as “American Indian” or “Alaska Native” and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government and Nome Eskimo Community.

**Asian**: Identification with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian, Vietnamese, Korean and

Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali or Mien.

Native Hawaiian and Other 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 and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese or Yapese.

Some Other Race: People whose race information has been collected but does not fit into any of the other seven race categories. This category includes people who may be Mulatto, Creole and Mestizo or another race not specified in the Census “Race” categories.

Two or More Races: People with any combination of races, including “Some Other Race.”

Asked but No Answer: 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 No Answer”).

Total: Total of all categories above.

Note: The “Asked but No Answer” category is not reported using indirect data.

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

Hispanic/Latino: Identification with one or more nationalities or ethnic groups originating in Mexico, Puerto Rico, Cuba, Central and South America and other Spanish cultures. Examples of these groups include, but are not limited to, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican and Colombian. “Hispanic, Latino or Spanish origin” also includes groups such as Guatemalan, Honduran, Spaniard, Ecuadorian, Peruvian or Venezuelan.

Not Hispanic/Latino: People not of Hispanic, Latino or Spanish culture or origin.

Asked but No Answer: People who 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 No Answer”).

Total: Total of all categories above.

Note: The “Asked but No Answer” category is not reported using indirect data.

Approved data sources include data collected directly from members or obtained through indirect methods. NCQA strongly encourages plans to report directly collected data when available, and emphasizes the importance of improving completeness of directly collected member race and ethnicity data. For each measure with RES, plans will report each race and ethnicity value by data source. Report both the number of members in the eligible population and the number of members in the numerator from direct and indirect data sources. IDSS will calculate the total number of members in the eligible population and numerator (combining both direct and indirect data sources).
**Direct data**  Data collected directly from members method 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 data collected directly from members by the health plan, as well as third-party data collected directly from members by another entity (e.g., the state or CMS). 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 Medicaid agencies, employers).

**Indirect data**  Plans may choose to report race and ethnicity data supplemented by indirect methods. Indirect assignment of race and ethnicity values include using an alternative data source, such as 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 indirect methods combine geographic data with additional imputation methods such as surname analysis.

NCQA reiterates that directly collected race and ethnicity is highly preferred to indirectly assigned race and ethnicity. NCQA emphasizes the following for plans that choose to use indirect methods to report the RES:

- When applying indirect 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.

- Indirect 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 to which it will be applied (e.g., age group, geography, product line).

- Indirect methods of race and ethnicity assignment are to be used for population-level reporting and analysis, but are not appropriate for member-level intervention.
Sampling

For measures collected using the Hybrid Method with RES, follow the guidelines for sampling outlined in Guidelines for Calculation and Sampling Guidelines for the Hybrid Method. RES are applied to the eligible population and denominator after hybrid sampling.

Reporting

Reporting of RES follows the parameters for denominator size outlined in General Guideline 10: Reporting.

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

<table>
<thead>
<tr>
<th>CMS Category</th>
<th>HEDIS/OMB Race</th>
<th>HEDIS/OMB Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>White</td>
<td>Unknown</td>
</tr>
<tr>
<td>Black</td>
<td>Black</td>
<td>Unknown</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>American Indian/Alaska Native</td>
<td>Unknown</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>Asian</td>
<td>Unknown</td>
</tr>
<tr>
<td>Hispanic</td>
<td>Unknown</td>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>Other</td>
<td>Some Other Race</td>
<td>Unknown</td>
</tr>
<tr>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>(No equivalent category)</td>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>Unknown</td>
</tr>
<tr>
<td>(No equivalent category)</td>
<td>Two or more races</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Race/Ethnicity Combined Category</th>
<th>HEDIS/OMB Race</th>
<th>HEDIS/OMB Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>White</td>
<td>Not Hispanic/Latino</td>
</tr>
<tr>
<td>Black</td>
<td>Black</td>
<td>Not Hispanic/Latino</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>American Indian/Alaska Native</td>
<td>Not Hispanic/Latino</td>
</tr>
<tr>
<td>Asian</td>
<td>Asian</td>
<td>Not Hispanic/Latino</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>Not Hispanic/Latino</td>
</tr>
<tr>
<td>Hispanic/Latino/White</td>
<td>White</td>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>Hispanic/Latino/Black</td>
<td>Black</td>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>Other</td>
<td>Some Other Race</td>
<td>Unknown</td>
</tr>
<tr>
<td>Multiple races marked</td>
<td>Two or more races</td>
<td>Unknown</td>
</tr>
<tr>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
Note

Race is a social construct, not a biological one; stratifying HEDIS measures by race and ethnicity is intended to further understanding of racial and ethnic disparities in care and to hold health plans 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 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.

Race and ethnicity data may come from different categories of data source (direct, indirect). 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 note above.