

Proposed Changes to Existing Measures for HEDIS^{®1} MY 2024: Expansion of Race and Ethnicity Stratification In Select HEDIS Measures

NCQA seeks comments on the proposed expansion of the Race and Ethnicity Stratification (RES) for select HEDIS measures in MY 2024. 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 where gaps exist and highlighting plans that reduce disparities in care and outcomes.

NCQA introduced the RES to five HEDIS measures in MY 2022 and to an additional eight measures in MY 2023. Refer to Table 1 for a list of all currently stratified measures. Based on feedback from public comment, advisory panels and internal teams, NCQA developed a list of candidate measures (Table 2) to expand stratification to in MY 2024. NCQA plans to add the stratification to at least five additional measures from the candidate list this year.

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

1. *Measures listed as candidates for stratification in MY 2024.* Measures were prioritized for inclusion if they represented a high-priority population for disparities, included multiple product lines or were digital measures that relied on electronic clinical data. Measures were excluded from consideration if they were in first-year status, slated for retirement or known to have small denominators.
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 31*. For more information, refer to NCQA's Health Equity Resource Center [here](#).

NCQA acknowledges the contributions of the Behavioral Health, Geriatric and Technical Measurement Advisory Panels, and of the Health Equity Expert Work Group.

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Table 1. Measures Stratified by Race/Ethnicity in MY 2022 and MY 2023

| Domain | Measure | Product Lines |
|--|---|--------------------------------|
| Prevention and Screening | Colorectal Cancer Screening (COL, COL-E) | Commercial, Medicaid, Medicare |
| | Adult Immunization Status (AIS, AIS-E) | Commercial, Medicaid, Medicare |
| | Immunizations for Adolescents (IMA, IMA-E) | Commercial, Medicaid |
| | Breast Cancer Screening (BCS-E) | Commercial, Medicaid, Medicare |
| Respiratory | Asthma Medication Ratio (AMR) | Commercial, Medicaid |
| Cardiovascular | Controlling High Blood Pressure (CBP) | Commercial, Medicaid, Medicare |
| Diabetes | Hemoglobin A1c Control for Patients With Diabetes (HBD) | Commercial, Medicaid, Medicare |
| Behavioral Health | Follow-Up After Emergency Department Visits for Substance Use (FUA) | Commercial, Medicaid, Medicare |
| | Pharmacotherapy for Opioid Use Disorder (POD) | Commercial, Medicaid, Medicare |
| Access and Availability of Care | Prenatal and Postpartum Care (PPC) | Commercial, Medicaid |
| | Initiation and Engagement of Substance Use Disorder Treatment (IET) | Commercial, Medicaid, Medicare |
| Utilization | Child and Adolescent Well Care Visits (WCV) | Commercial, Medicaid |
| | Well-Child Visits in the First 30 Months of Life (W30) | Commercial, Medicaid |

Table 2. RES Candidate Measures for MY 2024

| Domain | Measure | Product Lines |
|-----------------------------------|--|--------------------------------|
| Behavioral Health | Follow-Up After Emergency Department Visit for Mental Illness (FUM) | Commercial, Medicaid, Medicare |
| | Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E) | Commercial, Medicaid, Medicare |
| | Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) | Commercial, Medicaid, Medicare |
| | Follow-Up After Hospitalization for Mental Illness (FUH) | Commercial, Medicaid, Medicare |
| | Prenatal Depression Screening and Follow-Up (PND-E) | Commercial, Medicaid |
| | Postpartum Depression Screening and Follow-Up (PDS-E) | Commercial, Medicaid |
| | Risk of Continued Opioid Use (COU) | Commercial, Medicaid, Medicare |
| | Use of Opioids at High Dosage (HDO) | Commercial, Medicaid, Medicare |
| | Use of Opioids from Multiple Providers (UOP) | Commercial, Medicaid, Medicare |
| Prevention & Screening | Cervical Cancer Screening (CCS-E) | Commercial, Medicaid |
| | Childhood Immunization Status (CIS-E) | Commercial, Medicaid |
| | Prenatal Immunization Status (PRS-E) | Commercial, Medicaid |
| Diabetes | Kidney Health Evaluation for Patients With Diabetes (KED) | Commercial, Medicaid |
| | Eye Exam for Patients with Diabetes (EED) | Commercial, Medicaid |
| Care Coordination | Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) | Medicare |

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2024

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

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

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 stratifications 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 6 years and older as of the date of discharge. Report three age stratifications and a total rate:

- 6–17 years.
- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

Date of discharge through 30 days after discharge.

Allowable gap

None.

Anchor date

None.

Benefits

Medical and mental health (inpatient and outpatient).

Event/diagnosis

An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

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

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).
4. Identify the discharge date for the stay.

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

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim), exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

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.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

**Required
exclusions**

Exclude members who meet either of the following criteria:

- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members*.

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

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** a mental health provider.
- 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).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) **with** (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) **with** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** a mental health provider.
- An observation visit (Observation Value Set) **with** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), **with** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) **with** a mental health provider.

- Psychiatric collaborative care management (Psychiatric Collaborative Care Management 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 (e.g., within 30 days after discharge or within 7 days after discharge).*
- *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 FUH-A-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

| Metric | Age | Data Element | Reporting Instructions |
|---------------|-------|-------------------------|--|
| FollowUp30Day | 6-17 | Benefit | Metadata |
| FollowUp7Day | 18-64 | EligiblePopulation | For each Stratification, repeat per Metric |
| | 65+ | ExclusionAdminRequired | For each Stratification, repeat per Metric |
| | Total | NumeratorByAdmin | For each Metric and Stratification |
| | | NumeratorBySupplemental | For each Metric and Stratification |
| | | Rate | (Percent) |

Table FUH-B-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Race

| Metric | Race | Source | Data Element | Reporting Instructions | A |
|---------------|--------------------------------------|-----------|--------------------|--|---|
| FollowUp30Day | White | Direct | CollectionMethod | Repeat per Metric and Stratification | ✓ |
| FollowUp7Day | BlackOrAfricanAmerican | Indirect | EligiblePopulation | For each Stratification, repeat per Metric | ✓ |
| | AmericanIndianorAlaskaNative | Unknown** | Denominator | For each Stratification, repeat per Metric | |
| | Asian | Total | Numerator | For each Metric and Stratification | ✓ |
| | NativeHawaiianorOtherPacificIslander | | Rate | (Percent) | ✓ |
| | SomeOtherRace | | | | |
| | TwoOrMoreRaces | | | | |
| | AskedButNoAnswer* | | | | |
| | Unknown** | | | | |

Table FUH-C-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Ethnicity

| Metric | Ethnicity | Source | Data Element | Reporting Instructions | A |
|---------------|---------------------|-----------|--------------------|--|---|
| FollowUp30Day | HispanicOrLatino | Direct | CollectionMethod | Repeat per Metric and Stratification | ✓ |
| FollowUp7Day | NotHispanicOrLatino | Indirect | EligiblePopulation | For each Stratification, repeat per Metric | ✓ |
| | AskedButNoAnswer* | Unknown** | Denominator | For each Stratification, repeat per Metric | |
| | Unknown** | Total | Numerator | For each Metric and Stratification | ✓ |
| | | | Rate | (Percent) | ✓ |

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

**Race/Ethnicity=Unknown is only reported for Source='Unknown' and Source='Unknown' is only reported for Race/Ethnicity=Unknown.

Race and Ethnicity Stratification Candidate Measures for HEDIS^{®1} MY 2024 Measure Workup

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

NCQA recommends stratification at the highest reported measure rate (i.e., not within existing stratifications or sub-rates), with one potential exception: Childhood Immunization Status (CIS-E), which is noted and discussed.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Description

The percentage of emergency department (ED) visits for members 6 years of age and older who had a principal diagnosis of mental illness or intentional self-harm, and had a follow-up visit for mental illness. Two rates are reported:

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

Product lines Commercial, Medicaid, Medicare.

Domain Behavioral Health.

Reporting method Administrative.

Evidence on disparities Based on national performance data on quality measures for racial/ethnic groups covered by Medicare in 2020, the percentage of Black and Hispanic enrollees who had an ED visit for mental illness and had appropriate follow-up care within 30 days of the ED visit was significantly below the national average (Martino, 2022).

The highest rates of ED visits for psychiatric crisis are seen among African Americans, persons with Medicaid and the uninsured. For these patients, lack of access to or poor engagement with outpatient psychiatric services might significantly contribute to ED visits for psychiatric crisis (Hazlett et al., 2004).

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² 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.

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 who had a diagnosis of major depression or dysthymia, and 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. |
| Reporting method | Electronic clinical data systems. |
| Evidence on disparities | <p>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).</p> <p>Minoritized 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, minoritized 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).</p> |

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.

- *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument.
- *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

| | |
|--------------------------------|--|
| Product lines | Commercial, Medicaid, Medicare. |
| Domain | Behavioral Health. |
| Reporting method | Electronic clinical data systems. |
| Evidence on disparities | <p>Prevalence information by race and ethnicity showed that depression was highest among persons reporting two or more races (15.9%), while rates for single race groups were 9.5% among Whites, 7.0% among Hispanic or Latinos, 4.2% among American Indians or Alaska Natives, 6.0% among Black or African Americans and 4.2% among Asians (SAMHSA, 2022).</p> <p>Minoritized children are one-third to one-half less likely to receive mental health care as White children, despite a similar overall prevalence of disease. Moreover, of those who do receive care, minoritized groups are less likely to receive complete services and are more likely to receive treatment that is</p> |

inappropriate, fragmented or inadequate (Holm-Hanse, 2006; Algeria et al., 2008; Cummings et al., 2019).

Algeria et al. (2008) discovered that among people with a diagnosed depressive disorder, 63.7% of Latinos and 58.8% of African Americans did not access any mental health treatment in the past year, compared to 40.2% of non-Latino Whites. Hispanic and uninsured children have especially high rates of unmet need for mental health services, relative to other children (Kataoka et al., 2002).

Follow-Up After Hospitalization for Mental Illness (FUH)

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses, and had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Product lines Commercial, Medicaid, Medicare.

Domain Behavioral Health.

Reporting method Administrative.

Evidence on disparities Based on national performance data on quality measures for racial/ethnic groups covered by Medicare in 2020, the percentage of Asian American/ Pacific Islanders, Hispanic and White enrollees who were hospitalized for mental illness and had appropriate follow-up care within 30 days of discharge was significantly above the national average of 47.6% (Martino, 2022). The percentage of Black enrollees who were hospitalized for mental illness and had appropriate follow-up care within 30 days of discharge was significantly below the national average (Martino, 2022).

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, Medicare.

Domain Behavioral Health.

Reporting method Electronic clinical data systems.

Evidence on disparities

Race, ethnicity, age and socioeconomic status are predictors of maternal depression (NIHCM, 2010). According to self-reported prevalence data from 27 states, younger women, women with lower educational attainment, unmarried women and women whose infants were low birthweight or required neonatal intensive care were more likely to report postpartum depressive symptoms (Ko et al., 2017).

The risk of untreated perinatal depression is higher among low-income, ethnic minority mothers (Abrams, 2009). Even when care is provided, variation in depression care management has been documented, particularly among minoritized women (Yamamoto, 2015). In one study, African-American and Latina women were less likely to receive follow-up treatment or continued care (Kozhimannil, 2011).

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.

- *Depression Screening.* The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.
- *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, Medicare.

Domain Behavioral Health.

Reporting method Electronic clinical data systems.

Evidence on disparities Race, ethnicity, age and socioeconomic status are predictors of maternal depression (NIHCM, 2010). According to self-reported prevalence data from 27 states, younger women, women with lower educational attainment, unmarried women and women whose infants were low birthweight or required neonatal intensive care were more likely to report postpartum depressive symptoms (Ko et al., 2017).

The risk of untreated perinatal depression is higher among low-income, ethnic minority mothers (Abrams, 2009). Even when care is provided, variation in depression care management has been documented, particularly among minoritized women (Yamamoto, 2015). In one study, African-American and Latina women were less likely to receive follow-up treatment or continued care (Kozhimannil, 2011).

Childhood Immunization Status (CIS-E)

Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one

hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.

| | |
|--------------------------------|--|
| Product lines | Commercial, Medicaid. |
| Domain | Prevention and Screening. |
| Reporting method | Electronic clinical data systems. |
| Evidence on disparities | According to data collected through the National Immunization Survey, of children born in 2017 and 2018, Black children and Hispanic children were significantly less likely to receive recommended vaccines by age 24 months than White children (Hill et al., 2021). |

Cervical Cancer Screening (CCS-E)

Description

The percentage of women 21–64 years of age who were screened for cervical cancer using any 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.

| | |
|--------------------------------|---|
| Product lines | Commercial, Medicaid. |
| Domain | Prevention and Screening. |
| Reporting method | Electronic clinical data systems. |
| Evidence on disparities | <p>Data from the National Health Interview Survey from 2005–2019 found significantly higher rates of overdue screening among Asian women than among non-Hispanic White women; among women identifying as LGBTQ+ than heterosexual; among women living in rural than in urban areas; and among women without insurance than women with private insurance (Suk et al. 2022).</p> <p>One study found that of women receiving care at three health systems from 2016–2019, 75% were up to date with cervical cancer screening, but screening use was lower among non-Hispanic Black patients than among non-Hispanic White patients (Spencer et al., 2022).</p> |

Prenatal Immunization Status (PRS-E)

Description

The percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

| | |
|--------------------------------|--|
| Product lines | Commercial, Medicaid. |
| Domain | Prevention and Screening. |
| Reporting method | Electronic clinical data systems. |
| Evidence on disparities | Data from an internet panel survey conducted by the Centers for Disease Control and Prevention in April 2020 found that Hispanic and Black pregnant women had lower Tdap and influenza vaccination coverage, compared to White women and women of other races (Razzaghi et al., 2020). |

Kidney Health Evaluation for Patients With Diabetes (KED)

Description

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

| | |
|--------------------------------|--|
| Product lines | Commercial, Medicaid, Medicare. |
| Domain | Diabetes. |
| Reporting method | Administrative. |
| Evidence on disparities | There are disparities in the prevalence of chronic kidney disease (CKD) by race, age, gender and socioeconomic status. CKD is more common in the non-Hispanic Black population than other racial/ethnic populations. Based on 2019 data, the percentage of CKD in the adult (18 and older) non-Hispanic Black population was 16%, 14% in the Hispanic population, 13% in the non-Hispanic White population and 12% in the non-Hispanic Asian population (CDC, 2019). |

Eye Exam for Patients with Diabetes (EED)

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

| | |
|-------------------------|---|
| Product lines | Commercial, Medicaid, Medicare. |
| Domain | Diabetes. |
| Reporting method | Hybrid. Refer to Diabetes Care Memo for proposed removal of hybrid reporting. |

Evidence on disparities

Research has shown that minoritized individuals had consistently lower eye examination rates, compared to non-Hispanic White individuals (Hutton, 2022). Additionally, adults 45 years and older were more likely to receive an eye examination than adults between 18 and 45 years of age (Shi et al., 2014; Canedo et al., 2018).

Research estimates that approximately 19% of individuals with diabetes have diabetic eye complications, with Hispanics having the highest rate, followed by African Americans (Li et al., 2022).

Risk of Continued Opioid Use (COU)

Description

The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

1. The percentage of members with at least 15 days of prescription opioids in a 30-day period.
2. The percentage of members with at least 31 days of prescription opioids in a 62-day period.

Product lines Commercial, Medicaid, Medicare.

Domain Overuse/Appropriateness.

Reporting method Administrative.

Evidence on disparities Populations more likely to be prescribed opioids include industrial workers, patients with advanced age, White patients and those with a diagnosis of low back pain or osteoarthritis (Pensa et al, 2017). A recent study found that low-income, White populations were more likely to receive opioid prescriptions. Specifically, 44.2% of adults in areas with the lowest-income and highest proportion-White population received at least one opioid each year, compared to 16.1% of adults in areas with the highest-income and lowest proportion-White population (Friedman et al., 2019).

In 2018, non-Hispanic White adults had the highest rates per 100,000 population of natural and semisynthetic overdose mortality, and non-Hispanic Black adults had the highest rates of heroin and synthetic opioid overdose mortality (Hoopsick et al., 2021). Overdose trends from 2018–2019, found that overall opioid overdose death rates leveled off but increased among non-Hispanic Black individuals (Larochelle et al., 2021).

Use of Opioids at High Dosage (HDO)

Description

The percentage of members 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year.

| | |
|--------------------------------|--|
| Product lines | Commercial, Medicaid, Medicare. |
| Domain | Overuse/Appropriateness. |
| Reporting method | Administrative. |
| Evidence on disparities | Among Medicare enrollees, annual prevalence of any opioid receipt differed slightly between Black and White patients (50.2% vs. 52.2%), whereas the mean annual dose was 36% lower among Black patients than among White patients (5190 MME vs. 8082 MME) (Morden et al., 2021). Among dually eligible and Medicare enrollees, the highest proportions of high-dose chronic opioid use were among American Indian/Alaska Native and White enrollees (Anderson et al., 2018). |

Use of Opioids from Multiple Providers (UOP)

Description

The percentage of members 18 years and older, receiving prescription opioids for ≥ 15 days during the measurement year, who received opioids from multiple providers. Three rates are reported.

1. *Multiple Prescribers*. The percentage of members who received prescriptions for opioids from four or more different prescribers during the measurement year.
2. *Multiple Pharmacies*. The percentage of members who received prescriptions for opioids from four or more different pharmacies during the measurement year.
3. *Multiple Prescribers and Multiple Pharmacies*. The percentage of members who received prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the percentage of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

| | |
|--------------------------------|--|
| Product lines | Commercial, Medicaid, Medicare. |
| Domain | Overuse/Appropriateness. |
| Reporting method | Administrative. |
| Evidence on disparities | <p>Between 1999 and 2018, prescription opioid misuse was significantly higher among non-Hispanic White individuals than among Black, Hispanic and Asian individuals across all time periods, yet was highest among Native American individuals in every time period (Schuler et al., 2021).</p> <p>Between 1999 and 2018, the relative difference in prescription opioid misuse between White and both Hispanic and Asian individuals significantly widened over time, whereas the gap between Black and White individuals significantly decreased (Schuler et al., 2021).</p> |

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. |
| Reporting method | Administrative. |
| Evidence on disparities | There is little research on potential disparities in follow-up after ED transitions; however, 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 are more likely to visit the ED in a 12-month period (Garcia et al., 2010). Another study found that non-Hispanic Whites were more likely than Hispanic and Asian Medicare beneficiaries to have an inpatient readmission after an ED discharge (Gabayan et al., 2015). |

References

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31. Race and Ethnicity Stratification

The following measures instruct the organization to categorize Medicare, Medicaid and Commercial members by the race and ethnicity stratification (RES):

- Immunizations for Adolescents (including IMA-E).
- Asthma Medication Ratio.
- Controlling High Blood Pressure.
- Hemoglobin A1c Control for Patients With Diabetes.
- Follow-Up After Emergency Department Visit for Substance Use.
- Pharmacotherapy for Opioid Use Disorder.
- Initiation and Engagement of Substance Use Disorder Treatment.
- Prenatal and Postpartum Care.
- Well-Child Visits in the First 30 Months of Life.
- Child and Adolescent Well-Care Visits.
- Breast Cancer Screening.
- Colorectal Cancer Screening.
- Adult Immunization Status.

Refer to *Appendix 7: Logical Measure Groups* for measures that include RES, by logical measure group.

Reporting categories

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.

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

- “Race & Ethnicity – CDC” (CDCREC) is used to report distinct OMB race and ethnicity categories.
- “Some Other Race,” “Asked but No answer” and “Unknown” use the HL7 version 3 NullFlavor code system.

Determining race reporting category

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 or 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 or 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.

Notes:

- *The “Asked but No Answer” category is only reported using direct data.*
- *The “Unknown” category is only reported using unknown data.*

Determining ethnicity reporting category

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

- *Hispanic or Latino*: Identification with one or more nationalities or ethnic groups originating in Mexico, Puerto Rico, 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 or 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- [\(including “I don’t know”\)](#).
- *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.

Notes:

- *The “Asked but No Answer” category is only reported using direct data.*
- *The “Unknown” category is only reported using unknown data.*

Data source

Approved data sources include data collected directly from members or data obtained through indirect methods, or in cases where the race or ethnicity value is Unknown, unknown source. 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 the race and ethnicity stratification, plans will report each race and ethnicity value by data source. Plans will report the number of members in the eligible population from direct, indirect and unknown data sources, and the number of members in the numerator from direct, indirect and unknown data sources. IDSS will calculate the total number of members in the eligible population and numerator (combining direct, indirect and unknown data sources).

Supplemental data may be used as a data source for RES.

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 a member 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).
- CCDs.

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 alternate 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 considered the gold standard and is highly preferred to indirectly assigned race and ethnicity. For plans choosing to use indirect methods to report the HEDIS race and ethnicity stratification, NCQA emphasizes the following:

- 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 in 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.

Unknown data When the reported category value for race or for ethnicity is Unknown, the source must be recorded as unknown data source. The Unknown data source may only be used for race or ethnicity category values reported as "Unknown."

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

Reporting Reporting of the race and ethnicity stratification follows the parameters for denominator size outlined in *General Guideline 9: Reporting*.

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

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

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

| Race/Ethnicity Combined Category | HEDIS/OMB Race | HEDIS/OMB Ethnicity |
|--|---|------------------------|
| White | White | Not Hispanic or Latino |
| Black | Black | Not Hispanic or Latino |
| American Indian/Alaska Native | American Indian or Alaska Native | Not Hispanic or Latino |
| Asian | Asian | Not Hispanic or Latino |
| Native Hawaiian and Other Pacific Islander | Native Hawaiian or Other Pacific Islander | Not Hispanic or Latino |
| Hispanic/Latino/White | White | Hispanic or Latino |
| Hispanic/Latino/Black | Black | Hispanic or Latino |
| Other | Some Other Race | Unknown |
| Multiple races marked | Two or more races | Unknown |
| Unknown | Unknown | Unknown |

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

| HEDIS/OMB Race | CDCREC OMB Category Direct Reference Code | CDCREC Detailed Category: Value Set |
|---|---|--|
| White | 2106-3 | <u>White Detailed Race Value Set</u> |
| Black | 2054-5 | <u>Black or African American Detailed Race Value Set</u> |
| American Indian or Alaska Native | 1002-5 | <u>American Indian or Alaska Native Detailed Race Value Set</u> |
| Asian | 2028-9 | <u>Asian Detailed Race Value Set</u> |
| Native Hawaiian or Other Pacific Islander | 2076-8 | <u>Native Hawaiian or Other Pacific Islander Detailed Race Value Set</u> |
| Some Other Race | OTH* | NA |
| Two or more races | NA** | NA |

| HEDIS/OMB Race | CDCREC OMB Category Direct Reference Code | CDCREC Detailed Category: Value Set |
|---------------------|---|-------------------------------------|
| Asked but No Answer | ASKU* | NA |
| Unknown | UNK* | NA |

* HL7 v3 Code System NullFlavor.

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

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

| HEDIS/OMB Race | CDCREC OMB Category Direct Reference Code | CDCREC Detailed Category: Value Set |
|------------------------|---|--|
| Hispanic or Latino | 2135-2 | <u>Hispanic or Latino Detailed Ethnicity</u> |
| Not Hispanic or Latino | 2186-5 | NA |
| Asked but No Answer | ASKU* | NA |
| Unknown | UNK* | NA |

* The NullFlavor concepts 'Asked but no answer' and 'Unknown' are not included in the terminology binding for the US Core Ethnicity FHIR extension on which this digital logic is structured. NCQA allows these concepts to express ethnicity data to align with bound values for the US Core Race extension.

Note

- *Race is a social construct, not biological; stratifying HEDIS measures by race and ethnicity is intended to be used 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, unknown). 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.*