MCAS 2025

Provider Resource Guide

KERN HEALTH SYSTEMS

Kern Family Health Care™

Table of Contents

General MCAS Information

What Is MCAS?

Annually California's Department of Health Care Services (DHCS) selects a set of performance measures for reporting by Medi-Cal managed care health plans (MCPs) which becomes the Managed Care Accountablity Set or MCAS. MCAS MY 2025 has 18 measures that will be held to the minimum performance level (MPL) or 50th percentile.

MCAS Performance Measures can be selected from a variety of stewards including:

- National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)
- Centers for Medicare & Medicaid Services' (CMS) Child & Adult Core Sets
- The Joint Commission (TJC)
- Dental Quality Alliance (DQA)

Measures have several different data reporting metholologies including:

- Administrative data:
    - Obtained from claims (outpatient office visits, pharmacy data, lab/radiology services) via billing/diagnosis codes
    - Obtained from encounter data via electronic health record exchange and immunization registries
- Hybrid data is obtained from a combination of administrative data and data obtained through medical record review.
- Electronic Clinical Data Systems (ECDS) which is a network of data containing member PHI and records

MCAS MY 2025 has a total of 15 Administrative, 6 Hybrid/Administrative, and 10 ECDS only measures, including those that are Report Only. Held to the minimum performance levels alone, are 8 Administrative, 6 Hybrid/Administrative, 4 ECDS.

What is ECDS?

The National Committee for Quality Assurance (NCQA) defines **E**lectronic **C**linical **D**ata **S**ystems (ECDS) in this way:

> "HEDIS quality measures reported using ECDS inspire innovative use of electronic clinical data to document high-quality patient care that demonstrates commitment to evidence-based practices. Organizations that report HEDIS using ECDS encourage exchange of the information needed to provide high-quality services, ensuring that the information reaches the right people at the right time.
>
> The ECDS reporting standard represents a step forward in adapting HEDIS to accommodate the expansive information available in electronic clinical datasets used for patient care and quality improvement.
>
> **ECDS are the network of data containing a plan member's personal health information and records of their experiences within the health care system.** They may also support other care-related activities directly or indirectly, including evidence-based decision support, quality management and outcome reporting. Data in these systems are structured such that automated quality measurement queries can be consistently and reliably executed, providing results quickly and efficiently to the team responsible for the care of health plan members.
>
> Health plans that establish an enterprise network of interoperable electronic data systems will foster a member-centered, team-based approach to improving health care quality and better communication across health care service providers. Visit https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/ for more information and FAQs about ECDS reporting."

Types of ECDS Data:

Organizations may use several data sources to provide complete information about the quality of health services delivered to its members. Data systems that may be eligible for HEDIS ECDS reporting include, but are not limited to, member eligibility files, EHRs, PHRs, clinical registries, HIEs, administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.
The data within these systems come in a variety of formats. The format type determines how the source is audited. Member-reported services are acceptable if the information is recorded, dated and maintained in the member's legal health record. Please contact your Kern Family Quality Performance team if you would like further details on these data sources.

In measurement year (MY) 2025 DHCS requires health plans to submit four (4) MCAS measures using ECDS methodology from the Minimum Performance Level (MPL) measures, and six (6) additional from the Report Only measures.

It is anticipated that as NCQA transitions more HEDIS® measures into ECDS-only reporting, DHCS will likely require plans to submit more and more MCAS measures digitally as well. To aid this gradual transition, providers/practices can allow KHS a data feed to support ECDS. Connect with your Provider Relations Representative to set up a meeting with our Business Intelligence Department.

Contact Information

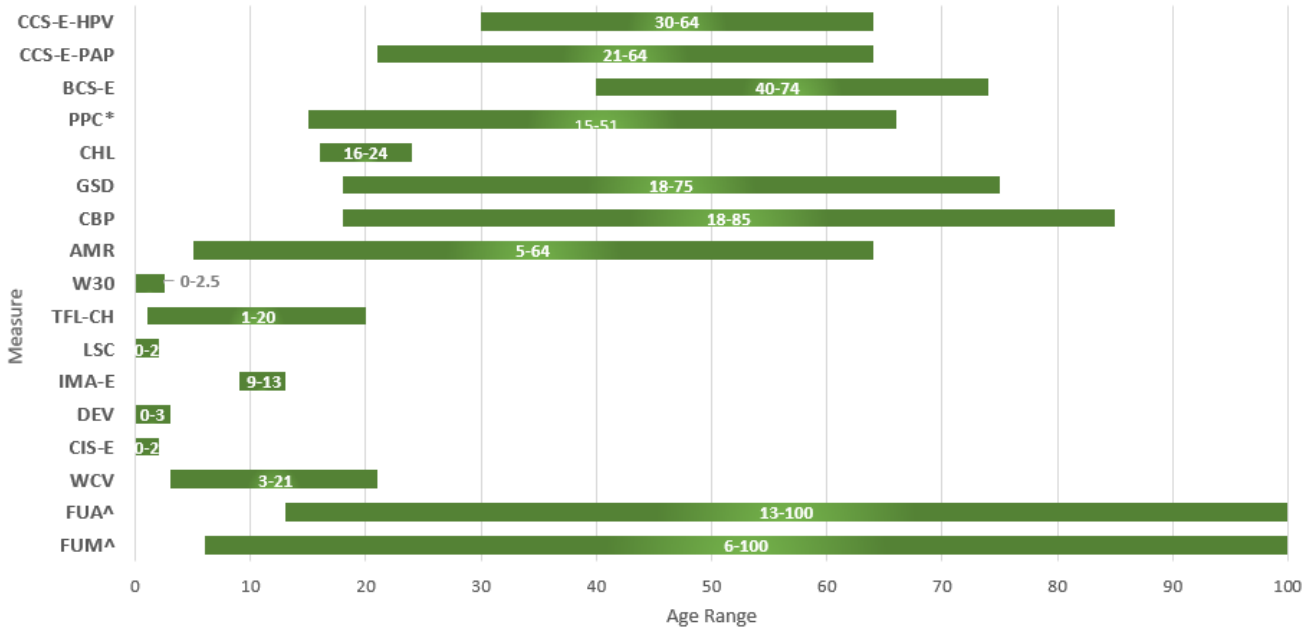
QUALITY PERFORMANCE MCAS TEAM	2900 Buck Owens Blvd. Bakersfield, Ca 93308 661.664.5000 (in Bakersfield) 800.391.2000 (outside of Bakersfield) KHSMCASTeam@khs-net.com
Aurora De La Torre, MCAS/HEDIS Program Manager	
Andrea Longoria, QP RN II	
Laura Mudge, QP RN I	
Gustavo Lopez, QP Operational Analyst	
Evangelina Ramirez, Senior QP Coordinator	
Isenia Calderon, MCAS Coordinator	

2025 MCAS Measures

Measures Held to Minimum Performance Level

Name	Acronym	Steward	Type
Follow-Up After ED Visit for Mental Illness- 30 days	**FUM**	**NCQA**	**Administrative**
Follow-Up After ED Visit for Substance Abuse- 30 days	**FUA**	**NCQA**	**Administrative**
Child and Adolescents Well-Care Visits	**WCV**	**NCQA**	**Administrative**
Childhood Immunizations Status- Combination 10	**CIS-10-E**	**NCQA**	**ECDS**
Developmental Screening in the First Three Years of Life	**DEV**	**CMS**	**Hybrid/Admin**
Immunizations for Adolescents- Combination 2	**IMA-2-E**	**NCQA**	**ECDS**
Lead Screening in Children	**LSC**	**NCQA**	**Hybrid/Admin**
Topical Fluoride for Children	**TFL-CH**	**DQA**	**Administrative**
Well-Child Visits in the First 30 Months of Life – 0 to 15 Months- Six or More Well-Child Visits	**W30-6+**	**NCQA**	**Administrative**
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Two or More Well-Child Visits	**W30-2+**	**NCQA**	**Administrative**
Asthma Medication Ratio	**AMR**	**NCQA**	**Administrative**
Controlling High Blood Pressure	**CBP**	**NCQA**	**Hybrid/Admin**
Glycemic Status Assessment for Patients with Diabetes	**GSD**	**NCQA**	**Hybrid/Admin**
Chlamydia Screening in Women	**CHL**	**NCQA**	**Administrative**
Prenatal and Postpartum Care: Timeliness of Prenatal Care	**PPC- Pre**	**NCQA**	**Hybrid/Admin**
Prenatal and Postpartum Care: Postpartum Care	**PPC- Post**	**NCQA**	**Hybrid/Admin**
Breast Cancer Screening	**BCS-E**	**NCQA**	**ECDS**
Cervical Cancer Screening	**CCS-E**	**NCQA**	**ECDS**

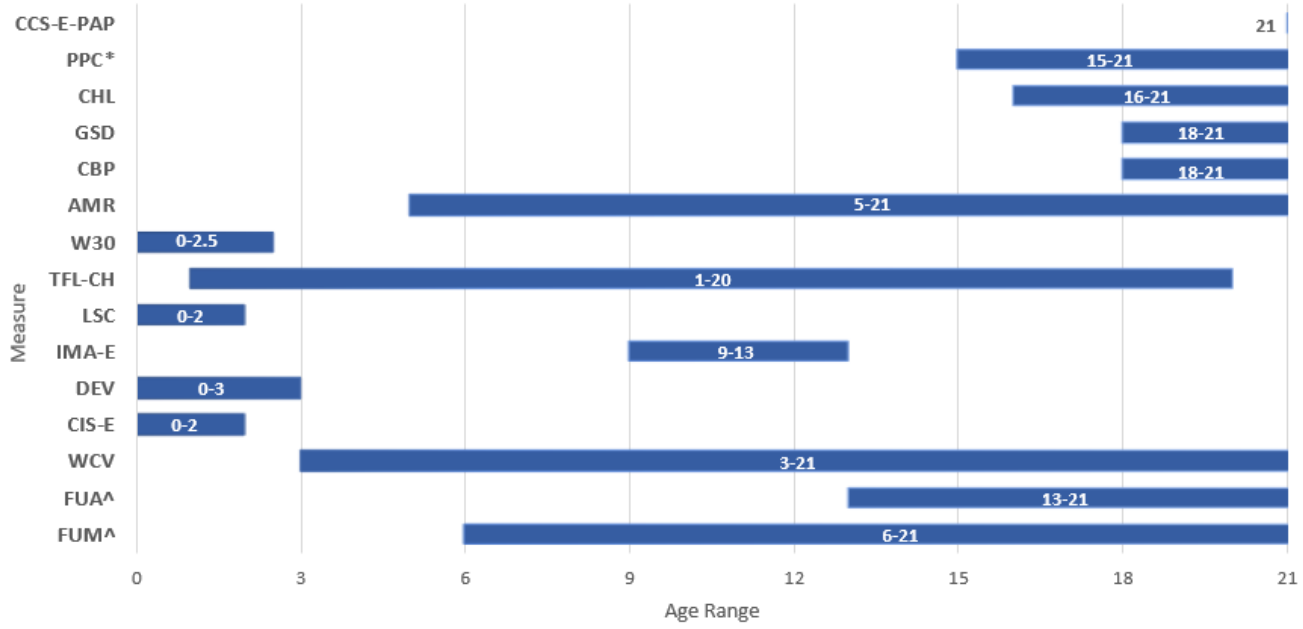
MY2025 Age Ranges- All Measures



*PPC measure does not have specified age range, it is estimated based on childbearing age.

^For FUA and FUM measures there is no age limit, 100 is an estimation

MY2025 Age Ranges- Pediatric



*PPC measure does not have specified age range, it is estimated based on childbearing age.

^For FUA and FUM measures there is no age limit, 21 is a max estimate for child domain.

Common Codes Reference

Common Medi-Cal Managed Care Accountability Set (MCAS) Codes MY2025

*This list is not all-inclusive. Highlights are Pay-for-Performance Measures. *Italics are Hybrid Measures requiring medical record review.*
Bolded are linked to Member Rewards.

Measure	Codes
AMR: Asthma Medication Ratio	Capture triggered by medication dispensing event(s)
BCS: Breast Cancer Screening	**CPT:** 77061, 77062, 77065, 77066, 77067
CCS: Cervical Cancer Screening	**CPT:** 88141-88143, 88147, 88150, 88175, 87624, 87625
CIS Combo 10: Childhood Immunization Status	**CPT:** **DTaP:** 90697, 90698*, 90700, 90723* **IPV:** 90697, 90698*, 90713, 90723* **MMR:** 90707, 90710* **Hib:** 90644, 90647, 90648, 90697, 90698*, 90748* **Hep B:** 90697, 90723*, 90740, 90744, 90747, 90748* **VZV:** 90710*, 90716 **PCV:** 90670, 90671, 90677 **Hep A:** 90633 **RV:** 90681 (2-dose), 90680 (3-dose) **Flu:** 90655, 90657, 90660, 90661, 90672, 90673, 90674, 90685-90689, 90756 **Indicates combination vaccines*
CHL: Chlamydia Screening in Women	**CPT:** 87110, 87270, 87320, 87490-87492, 87810
CBP: Controlling High Blood Pressure, Ages 18-85	**CPT II Codes:** Systolic: <130 mm Hg: 3074F 130-139 mm Hg: 3075F ≥140 mm Hg: 3077F Diastolic: <80 mm Hg: 3078F 80-89 mm Hg: 3079F
DEV: Developmental Screening in the First Three Years of Life	**CPT:** 96110
FUM: Follow-Up After Emergency Department Visit for Mental Illness **This measure contains extensive code sets for Diagnoses and Eligible Follow-Up Codes. Please contact Kern Family MCAS Team for more information.*	**ICD-10:** F20.0 intermittently through F94.9, T14.91, T36.0-T65.92, T71.112-T71.232, X71.0-X83.8 **CPT:** 90791, 90792, 90832-90834, 90836-90840, 99202-99205, 99211-99215, 99221-99223, 99231-99233, 99391-99397 **HCPCS:** H2010-H2020, T1015
FUA: Follow-Up After Emergency Department Visit for Substance Use **This measure contains extensive code sets for Diagnoses and Eligible Follow-Up*	**ICD-10:** F10.10 intermittently through F19.288, T40.0X1A intermittently through T51.0X4S **CPT:** 90791, 90792, 90832, 99202-99205, 99211-99215, 99221-99223, 99231-99233, 99238, 99391-99397 **HCPCS:** G0176, G0463, H0016, H0033H0046, H0049, T1015

Measure	Codes
Codes. Please contact Kern Family MCAS Team for information.	
GSD: Glycemic Status Assessment for Patients with Diabetes. *Formerly known as Hemoglobin A1C Control for Patients with Diabetes (HBD)* **Member reward for Hgb A1c only*	**CPT:** 83036, 83037 **CPT II:** Most recent A1C <7.0 = 3044F Most recent A1C ≥7.0 to <8.0 = 3051F Most recent A1C ≥8.0 to ≤9.0 = 3052F Most recent A1C >9.0 = 3046F
IMA Combo 2: Immunizations for Adolescents	**CPT:** **Meningococcal:** 90619, 90733, 90734 **Tdap:** 90715 **HPV:** 90649, 90650, 90651
LSC: Lead Screening in Children	**CPT:** 83655
PPC: Prenatal Care **This measure contains extensive code sets for Diagnoses and Eligible Visit Codes. Please contact Kern Family MCAS Team for information.*	**ICD-10:** Intermittently O09.00-O09.A3, O10.011-O10.919, O13.1-O13.9, O16.1-O16.9, O20.0-O20.9, O21.0-O21.9, O23.00-O23.93, O24.011-O24.919, O26.00-O26.93, O28.0-O28.9, O32.0XX0-O32.9XX9, O34.00-O34.93, O36.0110-O36.93X9, O42.92, O47.00-O47.9, O48.0, O60.03, O98.011-O98.919, O99.011-O99.891, Z32.01, Z34.00- Z34.93, Z36.0- Z36.9 **CPT:** 59425, 99202-99205, 99211-99215, 99242-99245, 99421, 99422, 99457, 99458, 99483 **CPT II:** 0500F-0502F **HCPCS:** G0463, T1015
PPC: Postpartum Care	**ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2, **CPT:** 58300, 59400, 59410, 59430, 59510, 59515, 59610, **CPT CAT II:** 0503F **HCPCS:** G0101
TFL-CH: Topical Fluoride for Children	**CPT:** 99188 (covered 3x's per year, up to and including age 5)
W30: Well-Child Visits in the First 30 Months of Life	**ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.129, Z00.2, Z76.1, Z76.2, Z00.3, Z01.411, Z01.419, Z02.5, **CPT:** 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 **HCPCS:** G0438, G0439, S0612, S0613 **Add Modifier 25 on a sick visit to capture the Well Child Visit*
WCV: Child & Adolescent Well-Care Visits, Ages 3-21	**ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2 **CPT:** 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 **HCPCS:** G0438, G0439, S0612, S0613 **Add Modifier 25 on a sick visit to capture the Well Child Visit*

Behavioral Health Domain Measures

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

Measure Description:

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

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

Required Exclusions:

Exclude members who meet ***any*** of the following criteria:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Ways To Improve MCAS Rates:

- Follow-up can be with *any* practitioner.
- Any of the following meet criteria for a follow-up visit:
    - An outpatient visit ***with*** any diagnosis of a mental health disorder
    - An intensive outpatient encounter or partial hospitalization ***with*** any diagnosis of a mental health disorder ***OR*** with POS code 52.
    - A community mental health center visit ***with*** POS code 53.
    - Electroconvulsive therapy ***with*** POS code 24, 52, or 53.
    - A telehealth visit ***with*** any diagnosis of a mental health disorder.
    - A telephone visit ***with*** any diagnosis of a mental health disorder.
    - An e-visit or virtual check-in ***with*** any diagnosis of a mental health disorder.
    - Psychiatric collaborative care management.
    - Peer support services ***with*** any diagnosis of a mental health disorder.
    - Psychiatric residential treatment ***with*** POS code 56.
    - A visit in a behavioral healthcare setting.
- Visits on the same day of the ED visit are considered compliant.
- Allow KHS a data feed to support ECDS. Contact your Provider Network representative to get connected with our Business Intelligence team.

Follow-Up After Emergency Department Visit for Substance Use (FUA)

Measure 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:

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

Required Exclusions:

Exclude members who meet ***any*** of the following criteria:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Ways To Improve MCAS Rates:

- Allow KHS a data feed to support ECDS. Contact your Provider Network representative to get connected with our Business Intelligence team.
- A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days), OR within 30 days after the ED visit (31 total days), respectively. You may include visits and pharmacotherapy events that occur on the date of the ED visit.

For both 7- and 30-day indicators, *any* of the following meet criteria for a follow-up visit:

- An outpatient visit ***with*** any diagnosis of SUD, substance use, or drug overdose.
- An outpatient visit ***with*** a mental health provider.
- An outpatient visit ***with*** any diagnosis of SUD, substance use, or drug overdose.
- An intensive outpatient encounter or partial hospitalization ***with*** POS code 52 ***with*** any diagnosis of SUD, substance use, or drug overdose.
- An intensive outpatient encounter or partial hospitalization ***with*** a mental health provider ***with*** POS code 52.
- An intensive outpatient encounter or partial hospitalization ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization ***with*** any diagnosis of SUD, substance use, or drug overdose.
- A non-residential substance abuse treatment facility visit ***with*** any diagnosis of SUD, substance use, or drug overdose.
- A non-residential substance abuse treatment facility visit ***with*** a mental health provider.

- A community mental health center visit ***with*** POS code 53 and ***with*** any diagnosis of SUD, substance use, or drug overdose.
- A community mental health center visit ***with*** POS code 53 and ***with*** a mental health provider.
- A peer support service ***with*** any diagnosis of SUD, substance use, or drug overdose.
- An opioid treatment service that bills monthly or weekly ***with*** any diagnosis of SUD, substance use, or drug overdose.
- A telehealth visit ***with*** any diagnosis of SUD, substance use, or drug overdose.
- A telehealth visit ***with*** a mental health provider.
- A telephone visit ***with*** any diagnosis of SUD, substance use, or drug overdose.
- A telephone visit ***with*** a mental health provider.
- An e-visit or virtual check-in ***with*** any diagnosis of SUD, substance use, or drug overdose.
- An e-visit or virtual check-in ***with*** a mental health provider.
- A substance use disorder service.
- Substance use disorder counseling and surveillance. Do not include laboratory claims (claims with POS code 81).
- A behavioral health screening or assessment for SUD or mental health disorders.
- A substance use service.
- A pharmacotherapy dispensing event or medication treatment event.

Children's Health Domain Measures

Child and Adolescent Well-Care Visits (WCV)

Measure Description:

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

*Please note changes made to MY2025 include removal of telehealth well visits from eligible ways to address gaps in care.

Required Exclusions:

Exclude members who meet either of the following criteria:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Ways To Improve MCAS Rates:

- Use appropriate billing codes.
- Check for gaps in care at every office visit.
- Sports/day care physicals can be used as an annual well-care visit by performing the required services and submitting appropriate codes.
- Use standardized templates in EMRs and charts that allow for easy documentation and review of health education, counseling, and/or anticipatory guidance.
- Outreach to members with gaps in care or who miss appointments with letters, emails, reminder calls, and/or text messages.
- Schedule appointments during school holidays/breaks; offer extended/weekend hours or events for annual well-care needs.

Childhood Immunization Status (CIS-E)

Measure 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.

*Please note the major change to this measure now being captured by ECDS methodology only. Refer to the ECDS section at the beginning of this guide for more information.

Measurement Period: January 1 – December 31

Clinical Recommendation Statement:

This measure looks for childhood vaccinations that should be completed by age 2, in accordance with the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommended child and adolescent immunization schedule (Wodi et al., 2024).

Exclusions:

Exclude children who meet ***any*** of the following criteria:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement period.
- Members who had a contraindication to a childhood vaccine on or before their second birthday.
- Organ and/or bone marrow transplants.

Numerator Compliance:

- DTaP:
  Children with any of the following on or before their second birthday meet criteria:
  - At least four DTaP vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine.
  - Encephalitis due to the diphtheria, tetanus or pertussis vaccine.

- IPV:
  Children with either of the following on or before their second birthday meet criteria:
  - At least three IPV vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the IPV vaccine.

- MMR:
  Children with any of the following meet criteria:
  - At least one MMR vaccination on or between the child's first and second birthdays.
  - All of the following any time on or before the child's second birthday (on the same or different date of service). Do not include laboratory claims (claims with POS code 81).
    - History of measles illness
    - History of mumps illness
    - History of rubella illness
  - Anaphylaxis due to the MMR vaccine on or before the child's second birthday.

- HiB:
  Children with either of the following on or before their second birthday meet criteria:
  - At least three HiB vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the HiB vaccine.

- Hepatitis B:
  Children with any of the following on or before their second birthday meet criteria:
  - At least three hepatitis B with different dates of service.
  - One of the three vaccinations may be a newborn hepatitis B vaccination during the 8-day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
  - History of hepatitis B illness. Do not include laboratory claims (claims with POS code 81).
  - Anaphylaxis due to the hepatitis B vaccine.

- VZV:
  Children with any of the following meet criteria:
  - At least one VZV with a date of service on or between the child's first and second birthdays.
  - History of varicella zoster (e.g., chicken pox) on or before the child's second birthday. Do not include laboratory claims (claims with POS code 81).

- Anaphylaxis due to the VZV vaccine on or before the child's second birthday.

- Pneumococcal Conjugate:
  Children with either of the following on or before their second birthday meet criteria:
  - At least four pneumococcal conjugate vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the pneumococcal vaccine.

- Hepatitis A:
  Children with any of the following meet criteria:
  - At least one hepatitis A vaccination with a date of service on or between the child's first and second birthdays.
  - History of hepatitis A illness on or before the child's second birthday. Do not include laboratory claims (claims with POS code 81).
  - Anaphylaxis due to the hepatitis A vaccine on or before the child's second birthday.

- Rotavirus:
  Children with any of the following meet criteria:
  - At least two doses of the two-dose rotavirus vaccine on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
  - At least three doses of the three-dose rotavirus vaccine on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
  - At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine all on different dates of service, on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the rotavirus vaccine on or before the child's second birthday.

- Influenza:
  Children with either of the following on or before their second birthday meet criteria:
  - At least two influenza vaccinations with different dates of service. Do not count a vaccination administered prior to 180 days after birth.
  - An influenza vaccination recommended for children 2 years and older (e.g., LAIV) administered on the child's second birthday meets criteria for one of the two required vaccinations.
  - Anaphylaxis due to the influenza vaccine.

Ways To Improve MCAS Rates:

- Set up a data exchange with Kern Family.
- Update the member's chart/EMR with any vaccines given at birth or by other providers.
- Utilize California's Immunization Registry (CAIR) to check for needed vaccinations and submit administered vaccines to the registry to ensure continuity of care.
- Check for needed vaccinations at every visit.
- Outreach to members with gaps in care or who miss vaccination appointments with letters, emails, reminder calls, and/or text messages.
- Schedule the 2-year well-child visit on or before the 2nd birthday – vaccines given after the 2nd birthday will not be compliant.

Developmental Screening in the First Three Years of Life (DEV)

Measure Description

Children 1 to 3 years of age who were screened for risk of developmental, behavioral, and social delays using a standardized screening tool on or **before** their 1st, 2nd, and 3rd birthdays as found through claims data or documented in the medical chart.

Document Requirements

Administrative Data:

Children for whom a claim of 96110 was submitted for services in the 12 months preceding or on their birthday.

Medical Record Review:

Children who had documentation in the medical record of developmental screening using a standardized, validated tool in the 12 months preceding or on their birthday. Documentation must include:

- A note indicating the standardized tool that was used
- The date of screening
- Evidence that the tool was completed and scored

Tools must meet the following criteria:

- Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional.
- Established Reliability: Reliability scores of approximately 0.70 or above.
- Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
- Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Example developmental screening tools that meet criteria for the measure:

The following tools meet the above criteria and are included in the Bright Futures Recommendations for Preventive Care (see here: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf), which reference the updated January 2020 American Academy of Pediatrics (AAP) Statement:

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

- Survey of Well-Being in Young Children (SWYC)

Tools included in the 2006 Statement that meet the above criteria but were not listed in the 2020 Statement (as they are not often used by primary care providers in the context of routine well-child care) include the following:

- Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
- Brigance Screens-II - Birth to 90 months
- Child Development Inventory (CDI) - 18 months to age 6
- Infant Development Inventory - Birth to 18 months

The tools listed above are not specific recommendations but are examples of tools cited in Bright Futures that meet the above criteria.

Tools that do NOT meet the criteria:

- M-Chat
- ASQ-SE

It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.

Ways To Improve MCAS Rates:

- Use appropriate billing codes.
- Assess developmental milestones at every office visit and conduct developmental screening at 9, 18, and 24-30 months.
- Screen more frequently for children with increased risk factors such as:
    - Preterm birth
    - Low birth weight
    - Lead exposure
    - Long lasting health problems or conditions
- Educate parents/guardians to monitor for developmental milestones such as:
    - Following movement with eyes
    - Reaching and rolling
    - First smiles
    - Crawling/pulling up
    - Imitating gestures like waving
    - Walking
    - Playing with other children

- Mail the questionnaire to parents/guardians prior to the visit or make it available online so it can be completed prior to the visit.

Immunizations for Adolescents (IMA-E)

Measure 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.

*Please note the major change to this measure is now being captured by ECDS methodology only. Refer to the ECDS section at the beginning of this guide for more information.

Measurement Period: January 1 – December 31

Clinical Recommendation Statement:

HPV: The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination for adolescents at age 11 or 12 years; vaccination may be given starting at age 9 years. In a two-dose schedule of HPV vaccine, the minimum interval between the first and second doses is 5 months. Persons who initiated vaccination with 9vHPV, 4vHPV or 2vHPV before their 15th birthday and received 2 doses of any HPV vaccine at the recommended dosing schedule (0, 6–12 months), or received three doses of any HPV vaccine at the recommended dosing schedule (0, 1–2, 6 months), are considered adequately vaccinated (Meites, Kempe, and Markowitz 2016).

Tdap: ACIP recommends a single dose of vaccine be administered at age 11 or 12 years (Liang et al. 2018).
Meningococcal: ACIP recommends routine vaccination with a quadrivalent meningococcal conjugate vaccine (MenACWY) for adolescents aged 11 or 12 years, with a booster dose at age 16 years (Mbaeyi et al. 2020), or vaccination with a pentavalent vaccine for adolescents ages 10 years and older when both meningococcal B and meningococcal A, C, W and Y are indicated (CDC, 2023).

Exclusions:

Exclude children who meet ***any*** of the following criteria:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement period.

Numerator Compliance:

- Meningococcal:
    - At least one meningococcal vaccine (serogroups A, C, W, Y or A, C, W, Y, B) with a date of service on or between the member's 10th and 13th birthdays.
    - Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the member's 13th birthday.
- Tdap:
    - At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine with a date of service on or between the member's 10th and 13th birthdays.
    - Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday.
    - Encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday.
- HPV:
    - At least two HPV vaccines on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.
    - At least three HPV with different dates of service on or between the member's 9th and 13th birthdays.
    - Anaphylaxis due to the HPV vaccine any time on or before the member's 13th birthday.

Ways To Improve MCAS Rates:

- Update the member's chart/EMR with any vaccines given at birth or by other providers.
- Utilize California's Immunization Registry (CAIR) to check for needed vaccinations and submit vaccines given to the registry to ensure continuity of care.
- Check for needed vaccinations at every visit.
- Outreach to members with gaps in care or who miss vaccination appointments with letters, emails, reminder calls, and/or text messages.
- Schedule a series of vaccination appointments.

Lead Screening in Children (LSC)

Measure Description:

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Required Exclusions:

Exclude members who meet either of the following criteria:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Medical Record Documentation:

Documentation in the medical record must include ***both*** of the following:

- A note indicating the date the test was performed.
- The result or finding.
- "Unknown" is not considered a result/finding.

Ways To Improve MCAS Rates:

- Educate parents/guardians about the dangers of lead poisoning and the importance of testing.
- Consider a standing order in-office (capillary) lead screening.
- Perform blood lead screening:
    - If there is no documented evidence of lead screening for children up to 72 months old,
    - Beginning at 6 months of age for children identified as high risk for lead exposure,
    - At 12 to 15 months of age for children identified as low risk for lead exposure,
    - If requested by a parent or guardian,
    - Whenever there is a change which increases the child's risk of lead exposure.
- Outreach to members with gaps in care or who miss appointments with letters, emails, reminder calls, and/or text messages.

Topical Fluoride for Children (TFL-CH)

Measure Description:

Children and adolescents from first tooth eruption through 20 years who received at least **two (2)** topical fluoride varnish applications during the measurement year.

- United States Preventive Services Task Force (USPSTF) recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
- American Academy of Pediatrics (AAP) recommends application of fluoride varnish at least once every 6 months, starting at eruption of first tooth.
- Because of the high efficacy of fluoride varnish, it is allowable for application in non-dental settings.
- The application is quick, easy, and painless, and can be delegated to nursing and medical assistant staff trained on the process.

Ways To Improve MCAS Rates:

- Dental services are carved out for Medi-Cal, however CPT code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional) is reimbursable for children through five years of age, up to three times per year by a non-dental medical provider.
- If you do not have the supplies or training to perform this in-office, or if the child is age six or older, you may refer the child to a dental provider. KHS receives this data, and your practice will be credited in closing the gap in care. If interested in obtaining supplies and training for your practice, contact your MCAS or Provider Relations Teams to learn more.
- Check for gaps in care at every office visit.
- Outreach to members with gaps in care or who miss appointments with letters, emails, reminder calls, and/or text messages.

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

Measure Description:

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

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

*Please note changes made to MY2025 include removal of telehealth well visits from eligible ways to address gaps in care.

Required Exclusions:

Exclude members who meet either of the following criteria:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Ways To Improve MCAS Rates:

- Use appropriate billing codes.
- Check for gaps in care at every office visit.
- Day care physicals can be used as an annual well-care visit by performing the required services and submitting appropriate codes.
- Use standardized templates in EMRs and charts that allow for easy documentation and review of health education, counseling, and/or anticipatory guidance.
- Outreach to members with gaps in care or who miss appointments with letters, emails, reminder calls, and/or text messages.
- Offer extended/weekend hours or events for annual well-care needs.

Chronic Disease Management Domain Measures

Asthma Medication Ratio (AMR)

Measure 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.

*Please note that for MY2025, albuterol-budesonide has been added as an asthma reliever medication.

Required Exclusions:

Exclude members who met any of the following criteria:

- Members who had a diagnosis that requires a different treatment approach than members with asthma, any time during the member's history through December 31 of the measurement year.
- Members who had no asthma controller or reliever medications dispensed during the measurement year.
- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Good to Know:

Please note, the AMR measure is based on clinical recommendations that for patients with an official diagnosis of asthma, at least 50 percent of their medications should be **controller** medications. Measuring the ratio looks at whether the member is receiving appropriate medication treatment to "control" the asthma.
Day's supply is used to count units of medication for oral medications, but not used to count inhalers or injections. Each inhaler or injectable medication dispensing event is seen as 1 unit of medication, regardless of day's supply.

NCQA derived at the 0.50 ratio in the measure based on feedback from experts on the Respiratory Measurement Advisory Panel and also from clinical evidence. Several studies have found that patients who have an asthma medication ratio of 0.50 or higher are less likely to be hospitalized or have an ED visit for asthma exacerbations and have fewer oral corticosteroid dispensing events, which is another indicator of poor asthma control.

Ways To Improve MCAS Rates:

- Avoid using asthma diagnosis codes for *asthma-like symptoms* (Ex: acute bronchitis and viral URI with wheezing) if not formally diagnosing.

- Educate patients on use of asthma medications and importance of using their prescribed asthma controller as prescribed.
- Educate patients on how to use asthma inhaler and have patient return demonstration.
- Educate patients on the difference between a rescue inhaler versus a long-term controller.
- Provide reminders to your patients to fill controller medications.
- Refer patients for health management interventions and coaching by contacting disease management and/or health education at Kern Health Systems.
- Through Community Support Services (CSS), KHS has an Asthma Remediation Program. The program helps members make necessary modifications to their home or living environment, to ensure they can maintain a healthy and supportive lifestyle while living with asthma. This may include the purchasing of air purifiers and other medical supplies. An authorization can be submitted though the KHS Provider Portal or on our main website, www.kernfamilyhealthcare.com, under the Providers tab, Community Support Services, and Submit a Referral: css-referral-form.pdf (cloudinary.com).

Controlling High Blood Pressure (CBP)

Measure Description:

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Required Exclusions:

Exclude members who meet ***any*** of the following criteria:

- Members who use hospice or palliative care services any time during the measurement year.
- Members who die any time during the measurement year.
- Members with a diagnosis that indicates end-stage renal disease (ESRD) any time during the member's history on or prior to December 31 of the measurement year.
- Members with a procedure that indicates ESRD: dialysis, nephrectomy, or kidney transplant any time during the member's history on or prior to December 31 of the measurement year.
- Members with a diagnosis of pregnancy any time during the measurement year.
- Members 66–80 years of age with at least two instances of frailty ***and*** advanced illness or disease within the measurement year.
    - Examples of Frailty include dependence on Durable Medical Equipment (DME), oxygen or respiratory devices. Diagnoses of pressure ulcers, falls, paralysis, need for skilled nursing visits or aide, failure to thrive, or any other abnormalities of gait and mobility.
- Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty.

Medical Record Documentation:

For purposes of MCAS reporting, the last blood pressure of the measurement year is identified, excluding readings occurring during acute inpatient stays, ED visits, or on the same day as diagnostic testing or therapeutic procedures.

Ways To Improve MCAS Rates:

- Use appropriate billing codes, including use of CPT II quality tracking codes to reduce the number of medical records your practice will need to provide KHS during MCAS audit season.
- Electronic BP readings reported by the member can be used for reporting. Consider utilizing home-use electronic cuffs with the member where feasible.
- BPs must be documented as a distinct numeric value and not a range/threshold.
- Recheck and document BPs later in the visit when an in-office result is higher than expected.

Glycemic Status Assessment for Patients with Diabetes (GSD)

*Formerly known as *Hemoglobin A1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (>9%)*

Measure Description:

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]- specifically a continuous glucose monitor (CGM)) was at the following levels during the measurement year:

- Glycemic Status <8.0%.
- Glycemic Status >9.0%.

FYI: For purposes of auditing glycemic status, there are two ways KHS will identify members with diabetes: by claim/encounter data, and by pharmacy data, per NCQA HEDIS technical specifications. Members will be brought into the eligible population for this measure using the following:

- Members with at least two diagnoses of diabetes on different dates during the measurement year or the year prior.
- Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year ***and*** have at least *one* diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Required Exclusion:

Exclude members who meet ***any*** of the following criteria:

- Members who use hospice services or receive palliative care any time during the measurement year.
- Members who die any time during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year with at least two instances of frailty ***and*** advanced illness or disease within the measurement year.
    - Examples of Frailty include dependence on Durable Medical Equipment (DME), oxygen or respiratory devices. Diagnoses of pressure ulcers, falls, paralysis, need for skilled nursing visits or aide, failure to thrive, or any other abnormalities of gait and mobility.
- Dispensed dementia medication.

Dementia Medications

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

Medical Record Documentation:

- At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment was performed and the result.
- When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. Per NCQA, clinical practice guidelines from the American Diabetes Association (ADA) recommend at least 14 days of continuous glucose monitor wear for calculation of standardized CGM metrics, including GMI. The terminal date in the range will be used to assign assessment date.
- If multiple glycemic status assessments were recorded for a single date, the lowest result will be used.
- GMI results collected by the member and documented in the member's medical record are eligible for use in reporting (provided the GMI does not meet any exclusion criteria). There is no requirement that there be evidence the GMI was collected by a PCP or specialist.
- Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. "Unknown" is not considered a result/finding.
- How providers document CGM data in a patient chart is outside the scope of HEDIS. NCQA does not have criteria related to how GMI is calculated, as it may depend on how data from CGM devices are shared with providers and included in the chart. For example, GMI may be an automated calculation of the EMR, calculated by the provider, or calculated by the CGM device manufacture and included in a standard report. The expectation is that the GMI value is included in the chart for medical record review.
- For administrative reporting, LOINC code 97506-0 (glucose management indicator) is used to identify GMI values.

FYI: The intent of KHS' focus as directed by DHCS, is to capture whether the result of the ***most recent*** glycemic status assessment (HbA1c or GMI performed during the measurement year) is >9.0% (uncontrolled), missing, or was not done during the measurement year, as documented through laboratory data or medical record review.
*Please note, in this *inverted* measure, a lower rate indicates better performance for this indicator (i.e., low rates of Glycemic Status >9.0% indicate better care).

Ways To Improve MCAS Rates:

- Check for gaps in care at every office visit.
- Refer members to KHS' Health Education Diabetes Management Program by contacting the Health Education Department at 661-832-1590.
- Use appropriate billing codes, including CPT II quality tracking codes, which reduce the number of medical records your practice will need to provide KHS during MCAS audit season.
- Outreach to members with gaps in care or who miss appointments with letters, emails, reminder calls, and/or text messages.

Reproductive Health Domain Measures

Chlamydia Screening (CHL)

Measure Description:

The percentage of members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year.

Two methods identify sexually active women: pharmacy data (prescription contraceptives) and claim/encounter data (diagnoses or procedures indicating sexual activity, including pregnancy testing).

Required Exclusions:

Please note: If the member has a pregnancy test during the measurement year and a prescription for isotretinoin on the date of the pregnancy test through 6 days after the pregnancy test, then the member is removed from the Eligible population. For example, if a member takes a pregnancy test on 9/1, the prescription can be dated from 9/1 - 9/7 for the member to be excluded from the measure.

Exclude members who meet either of the following criteria:

- Sex assigned at birth of male, any time in the member's history.
- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Ways To Improve MCAS Rates:

- Use appropriate billing codes.
- Check for gaps in care at every office visit.
- Perform annual chlamydia screening for all members 16 to 24 years of age assigned female at birth and who identify as being sexually active.
- Offer chlamydia screening urine test.
- Consider standing orders for STI screening.
- Place chlamydia swab in Pap test kits.
- Incorporate sexual history into the History and Physical.

Timeliness of Prenatal Care (PPC-Prenatal)

Measure Description:

The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date *or* within 42 days of enrollment in the organization.

The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.

The prenatal care visit can be with ***any*** of the following:

- OB/GYN, *or*

PCP (must have a diagnosis of pregnancy to meet compliance), *or*

- Other prenatal care practitioners who deliver prenatal care services under the direction of an OB/GYN certified or accredited provider such as:
    - Certified nurse midwife, *or*
    - Nurse practitioner, *or*
    - Physician assistant.

Required Exclusions:

Exclude members who meet ***any*** of the following criteria:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Medical Record Documentation:

****Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.***

Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence as seen below:

- Documentation indicating the member is pregnant or references the pregnancy such as *one* of the following:
    - Documentation in a standardized prenatal flow sheet.
    - Documentation of last monthly period, EDD/EGA.
    - A positive pregnancy test result.
    - Documentation of gravidity and parity.
    - Documentation of complete obstetrical history.
    - Documentation of prenatal risk assessment and counseling/education.

- OR - A basic physical obstetrical examination that includes *one* of the following:
    - Auscultation for fetal heart tone.
    - Pelvic exam with obstetric observations.
    - Measurement of fundus height (a standardized prenatal flow sheet may be used).
- OR - Evidence that a prenatal care procedure was performed such as *one* of the following:
    - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing)
    - TORCH antibody panel alone.
    - Rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing.
    - Ultrasound of a pregnant uterus.

Ways To Improve MCAS Rates:

- Use appropriate billing codes, including use of CPT II quality tracking codes to reduce the number of medical records your practice will need to provide KHS during MCAS audit season.
- Educate members on KHS' Baby Steps Program – members can find details on the prenatal portion of the program in the Member Portal, or on our main website here: Baby Steps program | Kern Family Health Care.
- You can also find the Prenatal Reward Form here: prenatal-reward-form_2023.pdf (cloudinary.com)
- Have a direct referral process to OB/GYN in place.
- Educate staff to prioritize prenatal visits and schedule them within the first trimester.

Postpartum Care (PPC-Post)

Measure Description:

The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting.

The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.

The postpartum visit can be with ***any*** of the following:

- OB/GYN, *or*
- PCP, *or*
- Other prenatal care practitioners who deliver prenatal care services under the direction of an OB/GYN certified or accredited provider such as:
    - Certified nurse midwife, *or*
    - Nurse practitioner, *or*
    - Physician assistant.

Required Exclusions:

Exclude women who meet ***any*** of the following criteria:

- Delivery of non-live birth.
- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Medical Record Documentation:

****Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure and must be combined with an office visit with an appropriate practitioner in order to count for this measure.***

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and ***one*** of the following:

- Pelvic exam or Pap test. *A colposcopy alone is not compliant.*
- Evaluation of weight, BP, breasts/notation of "breastfeeding", and abdomen.
- Notation of postpartum care, including but not limited to:
    - Notation of "postpartum care", "PP care", "PP check", "6-week check".
    - Preprinted "Postpartum Care" form in which information was documented during the visit.
- Perineal or cesarean incision/wound check.

- Screening for any *one* of the following:
    - Depression,
    - Anxiety,
    - Tobacco use,
    - Substance use disorder,
    - Preexisting mental health disorders.
- Glucose screening for members with gestational diabetes.
- Documentation of any *one* of the following topics:
    - Infant care or breastfeeding.
    - Resumption of intercourse, birth spacing, or family planning.
    - Sleep/fatigue.
    - Resumption of physical activity.
    - Attainment of healthy weight.

Ways To Improve MCAS Rates:

- Use appropriate billing codes, including use of CPT II quality tracking codes to reduce the number of medical records your practice will need to provide KHS during MCAS audit season.
- Educate members on KHS' Baby Steps Program – members can find details on the postpartum portion of the program in the Member Portal, or on our main website here: Baby Steps program | Kern Family Health Care.
- Schedule cesarean section postop visits before members are discharged from hospital.
- For members undergoing a scheduled cesarean section, pre-schedule their post-op follow-up within the specified timeframe.
- Educate staff to prioritize postpartum visits and schedule them on or between 7 and 84 days after delivery.

Cancer Prevention Domain

Measures

Breast Cancer Screening (BCS-E)

Measure Description:

The percentage of members 40–74 years of age who were recommended for routine breast cancer screening ***and*** had a mammogram to screen for breast cancer.

*Please note this measure as being captured by ECDS methodology only. Refer to the ECDS section at the beginning of this guide for more information.

Measurement Period: January 1 – December 31

Clinical Recommendation Statement:

The U.S. Preventive Services Task Force recommends screening women 50–74 years of age for breast cancer every 2 years. (B recommendation)

The Fenway Institute recommends that for patients assigned female at birth who have not undergone chest reconstruction (including those who have had breast reduction), breast/chest screening recommendations are the same as for cisgender women of a similar age and medical history.

The University of California San Francisco Center of Excellence for Transgender Health recommends that transgender men who have not undergone bilateral mastectomy, or who have only undergone breast reduction, undergo screening according to current guidelines for non-transgender women.

The World Professional Association for Transgender Health recommends health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement period.
- Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy:
  - Bilateral mastectomy
  - Unilateral mastectomy with a bilateral modifier (CPT Modifier code 50) (same procedure).
  - Unilateral mastectomy found in clinical data with a bilateral qualifier value (SNOMED CT Modifier code 51440002) (same procedure).

- Any combination of codes from the lists below that indicate a mastectomy on both the left and right side on the same date of service or on different dates of service.
  - Left Mastectomy:
    - Unilateral mastectomy with a left-side modifier (CPT Modifier code LT) (same procedure).
    - Unilateral mastectomy found in clinical data with a left-side qualifier value (SNOMED CT Modifier code 7771000) (same procedure).
    - Absence of the left breast. Do not include laboratory claims (claims with POS code 81).
    - Left unilateral mastectomy.
  - Right Mastectomy:
    - Unilateral mastectomy with a right-side modifier (CPT Modifier code RT) (same procedure).
    - Unilateral mastectomy found in clinical data with a right-side qualifier value (SNOMED CT Modifier code 24028007) (same procedure).
    - Absence of the right breast. Do not include laboratory claims (claims with POS code 81).
    - Right unilateral mastectomy.
- Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.
- Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded.
- Members receiving palliative care any time during the measurement period.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS code 81).

Ways To Improve MCAS Rates:

- Use appropriate billing codes.
- Biopsies, breast ultrasounds, and MRIs do not count as appropriate primary breast cancer screening methods.
- Check for gaps in care at every office visit.
- Request results of mammograms ordered by other providers such as OB/GYNs and ensure the results are placed into the member's medical record.
- Outreach to members with gaps in care or who miss appointments with letters, emails, reminder calls, and/or text messages.

Cervical Cancer Screening (CCS-E)

Measure Description:

The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria:

- Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

*Please note the large change this measure as being captured by ECDS methodology only. Refer to the ECDS section at the beginning of this guide for more information.

Measurement Period: January 1 – December 31

Clinical Recommendation Statement:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21–29 years. This recommendation statement applies to all asymptomatic individuals with a cervix.

The USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone or every 5 years with hrHPV testing in combination with cytology (cotesting) in women aged 30–65 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (A recommendation)

The USPSTF recommends against screening for cervical cancer in women younger than 21 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (D recommendation)

The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. This recommendation statement applies to all asymptomatic individuals with a cervix. (D recommendation)

The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix, and do not have a history of a high-grade precancerous lesion or cervical cancer.

The American Cancer Society recommends that individuals with a cervix initiate cervical cancer screening at age 25 years and undergo primary HPV testing every 5 years through age 65 years (preferred). If primary HPV testing is not available, individuals aged 25–65 years should be screened with cotesting (HPV testing in combination with cytology) every 5 years, or cytology alone every 3

years (acceptable). The recommendations apply to all asymptomatic individuals with a cervix, regardless of their sexual history or HPV vaccination status, including those who have undergone supracervical hysterectomy and transgender men who retain their cervix. (Strong Recommendation)

The Fenway Institute recommends that transgender and gender diverse patients who have a cervix have regular cervical pap tests, as per the published guidelines for cisgender women.

The University of California San Francisco Center of Excellence for Transgender Health recommends that cervical cancer screening for transgender men, including intervals of screening and age to begin and end screening, follows recommendations for non-transgender women as endorsed by the American Cancer Society, the American Society of Colposcopy and Cervical Pathology, the American Society of Clinical Pathologists, the U.S. Preventive Services Task Force and the World Health Organization.

The World Professional Association for Transgender Health recommends that health care professionals offer cervical cancer screening to transgender and gender diverse people who currently have or previously had a cervix, following local guidelines for cisgender women.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.
- Members who die any time during the measurement period.
- Hysterectomy with no residual cervix any time during the member's history through December 31 of the measurement year.
- Cervical agenesis or acquired absence of cervix any time during the member's history through the end of the measurement period. Do not include laboratory claims (claims with POS code 81).
- Members receiving palliative care any time during the measurement period.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS code 81).
  Members with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time during the patient's history.

Ways To Improve MCAS Rates:

- Check for gaps in care at every office visit. Avoid missed opportunities by completing PAP tests during annual well-care visits.
- Request results of PAP tests performed by other providers such as OB/GYNs and ensure the results are placed into the member's medical record.
- Biopsies are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

- Outreach to members with gaps in care or who miss appointments with letters, emails, reminder calls, and/or text messages.