Quality Provider Program 2025 Performance Measures

ADULT AND PEDIATRIC

Select Health

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* Intake and measurement periods are defined as follows for each measure:
- Intake Period: The time period when a new member can be identified for inclusion in the denominator
- Measurement Period: The time period wherein data is evaluated for compliance to measure

Other online resources include:

- Primary Care Program Quick Guide
- Allowable Corrections Guide
- Frequently Asked Questions (by Measure)
- Transitions of Care Best Practices

Adult Quality Measures

Annual Wellness Visits

Description	The percentage of eligible Select Health Medicare™ members who have received their annual wellness visit (AWV)
Denominator	Members who have active Select Health Medicare coverage
Numerator	Members in the denominator who have received an AWV during 2025
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	Enrollment in hospice anytime during the measurement year
Preferred Correction Process*	Centers for Medicare and Medicaid Services (CMS) does not allow for corrections at this time. Best practice is to submit an appropriate billing code with the visit, as follows: • G0438–G0439, or • 99381–99397 **NOTE**: The above can be billed with 99201–99205 or 99212–99215 with modifier 25 (when documentation supports both services according to Select Health policy)* For telehealth codes, refer to the *Select Health Coding and Reimbursement Policy* ***#85: Telehealth and Telemedicine***, which was last revised on **October 1, 2024**.

* Select Health pays for an AWV and a preventive or evaluation and management (E&M) exam on the same date of service (frequently referred to as a comprehensive wellness visit or CWV). Copays apply to an AWV billed with an E&M visit. Additionally, coinsurance may apply for some labs performed as part of the visit. Note that no copay applies when an AWV is billed with a preventive exam.

ABOUT THE BENEFITS OF ANNUAL WELLNESS VISITS

Members value an opportunity to review preventive care, chronic conditions, and functional status issues with their providers.

For providers, a thorough review of a health risk assessment and a member's chronic medical condition(s) helps the primary care provider better coordinate care with secondary providers. In addition, accurate documentation and coding of chronic conditions improves the accuracy of the member's complexity, thereby making comparative outcome data more relevant and actionable.

Cancer Screening: Breast

Description	The percentage of members ages 50 to 74 who had a screening mammogram for breast cancer*
Denominator	Members ages 52 to 74 during 2025**
Numerator	Members in the denominator who had 1 or more mammograms any time between October 2023 and December 2025 Include members recommended for routine breast cancer screening with any of the following criteria: • Administrative Gender of Female (Administrative gender code female) at any time in the member's history • Sex Assigned at Birth (LOINC code LA3-6) at any time in the member's history • Sex Parameter for Clinical Use of Female (Sex Parameter for Clinical Use code Female-typical) during the measurement period
Intake and Measurement Periods	**Intake Period:** January 1, 2024, through December 31, 2025 **Measurement Period**: October 1, 2023, through December 31, 2025
Exclusions	**Members who:** • Enrolled in hospice or palliative care any time during the measurement year • Are age 66 and older and have claim-based proof of both frailty plus either advanced illness on at least 2 different dates of service or were dispensed a dementia medication during the measurement year • Have a history of a bilateral mastectomy or both left and right unilateral mastectomies with 2 different dates of service (may be excluded from the denominator) • Had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during the member's history through the end of the measurement period **Medicare Members** age 66 years and older who have been enrolled in an I-SNP or living in a long-term institution any time during the measurement year
Corrections Allowed	• "Patient had a mammogram." • "Patient is male at birth." • "Patient does not fit age criteria." • "Patient had bilateral mastectomy or two unilateral mastectomies."

* NCQA's intent is to include members who were assigned as female at birth. Only mammography as recommended by the U.S. Preventive Services Task Force (USPSTF) or digital breast tomosynthesis screenings will satisfy this measure.

** Once a member turns 50, this difference between the measure description and the denominator description allows two years to complete the mammogram .

Cancer Screening: Colorectal

Description	The percentage of members ages 45 to 75 who had appropriate screening for colorectal cancer
Denominator	Members ages 46 to 75 during the measurement year*
Numerator	Members in the denominator who had 1 of the following: • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) 1 or more times during 2025 • Flexible sigmoidoscopy 1 or more times from 2021 to 2025 • Colonoscopy 1 or more times from 2016 to 2025 • CT colonography 1 or more times from 2021 to 2025 • Fit DNA or Cologuard test 1 or more times from 2023 to 2025**
Intake and Measurement Periods	**Intake Period**: **January 1** through **December 31** of the measurement year **Measurement Period**: January 1, 2016, through December 31, 2025
Exclusions	**Members who:** • Enrolled in hospice or palliative care any time during the measurement year • Are age 66 and older and have claim-based proof of both frailty plus either advanced illness on at least 2 different dates of service or were dispensed a dementia medication during the measurement year • Have been diagnosed with colorectal cancer or who have had a total colectomy at any time • Died any time during the measurement year **Medicare Members** age 66 years and older who have been enrolled in an I-SNP or living in a long-term institution any time during the measurement year
Corrections Allowed	• "Patient had appropriate screening." • "Patient has a diagnosis of colorectal cancer." • "Patient does not fit age criteria." • "Patient has a diagnosis of total colectomy."

* Once a member turns 45, this difference between the measure description and the denominator description allows 1 year to complete a colon cancer screening.

** Please note:
- FIT and FIT-DNA (stool DNA with FIT test) are different tests.
- Cologuard test is a covered benefit on Select Health Medicare and Commercial plans.

Diabetes Care

Description	The percentage of members ages 18 to 75 with diabetes (type 1 or type 2) who had: • Glycemic status testing in control • Retinal eye exam performed **NOTE:** Each of the measures listed above is evaluated and scored separately.
Denominator	Members ages 18 to 75 who have been identified as having diabetes (type 1 or type 2) through the use of claim/encounter data and pharmacy data
Numerator	Members in the denominator who had one of the following during the current measurement year: • Most recent hemoglobin A1c (HbA1c) or glucose management indicator (GMI) is < 8% • A retinal eye exam performed by an eye care professional* **OR** a negative retinal eye exam performed in 2024
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	**Members who:** • Are enrolled in hospice or palliative care any time during the measurement year • Died any time during the measurement year **NOTE:** Blindness does not remove patient from the retinal eye exam measure. **Medicare members 66 years and older:** • Enrolled in an I-SNP or living in a long-term institution any time during the measurement year • With claim-based proof of frailty and advanced illness during the measurement year or were dispensed a dementia medication during the measurement year
Corrections Allowed	"A1c results are available." "Patient had a diabetic eye exam."

* To be compliant, a retinal exam performed during the measurement year must include the result and evidence that result was read or reviewed by an optomotrist or opthalmologist; for abnormal retinal eye exams, diabetes eye exams must be repeated annually. An eye exam with result documented as "unknown" does not meet criteria.

Diabetes Care: Kidney Health Evaluation

Description	The percentage of members ages 18–85 with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR)
Denominator	Members 18 to 85 who have been identified as having diabetes (type 1 or type 2) through the use of claim/encounter data and pharmacy data
Numerator	Members who received both of the following during the measurement year on the same or different dates of service: • At least 1 eGFR (blood test) • At least 1 uACR* (urine test)
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	**Members who**: • Have had ESRD or dialysis by the end of the measurement year • Enrolled in hospice or palliative care any time during the measurement year • Died any time during the measurement year **Medicare members:** • **(For those 66 years and older)** Enrolled in an I-SNP or living in a long-term institution any time during the measurement year • **(For those 66 to 80 years of age)** With claim-based proof of frailty and advanced illness or were dispensed a dementia medication during the measurement year • **(For those 81 years of age and older by the end of the measurement year)** • With at least 2 indications of frailty during the measurement year on different dates of service
Correction Allowed	"Patient completed an eGFR, urine albumin, and urine creatinine." **NOTE**: All missing KED components can be entered in 1 correction. If submitting both eGFR and uACR results, select the 2-entry option. If only 1 of these components is missing, select the 1-entry option.

* uACR is a quantitative urine albumin and a urine creatinine test with service dates four or less days apart.

Hypertension: Controlling High Blood Pressure

Description	The percentage of members ages 18 to 85 with hypertension (HTN) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg)
Denominator	Members ages 18 to 85 who had at least 2 outpatient, telephone, or virtual check-in visits on different dates of service with a diagnosis of hypertension through the use of claim/ encounter data
Numerator	Members in the denominator whose most recent BP level reading is in control (BP is <140/90 mm Hg)*
Intake/ Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	**Members who:** • Have had a diagnosis that indicates end-stage renal disease (ESRD) or history of kidney transplant any time during the member's history • Have had a procedure that indicates ESRD, such as dialysis, nephrectomy (full or partial), or kidney transplant any time during the member's history • Are enrolled in hospice or palliative care any time during the measurement year • Died any time during the measurement year • Have had a diagnosis of pregnancy any time during the measurement year **Medicare members:** • **(For those 66 years and older)** Enrolled in an I-SNP or living in a long-term institution any time during the measurement year • **(For those 66 to 80 years of age)** With claim-based proof of both frailty plus either advanced illness on at least 2 different dates of service or were dispensed a dementia medication during the measurement year • **(For those 81 year of age and older)** With at least 2 indications of frailty on different dates of service during the intake period to the end of the measurement year
Corrections	• No blood pressure corrections are allowed for this measure. • Blood pressure results must be billed using the CPT Category II codes as indicated below.

Diastolic Blood Pressure	3078F.	Most recent diastolic blood pressure <80 mm Hg
	3079F	Most recent diastolic blood pressure 88–89 mm Hg
	3080F	Most recent diastolic blood pressure ≥90 mm Hg
Systolic Blood Pressure	3074F	Most recent systolic blood pressure <130 mm Hg
	3075F	Most recent systolic blood pressure 130–139 mm Hg
	3077F	Most recent systolic blood pressure ≥140 mm Hg

* Self-reported blood pressure readings can be taken by the member using a digital device.

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

Description	The percentage of emergency department (ED) visits for Select Health members 18 years of age and older with multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit
Denominator	The eligible population for this measure includes Medicare members 18 years old and older with multiple, high-risk chronic conditions who visit an ED on or between January 1 and December 24 of the measurement year. **Note that:** • Included events are those where patients are diagnosed with 2 or more of these conditions (determined by ICD 10 codes in claims data) during the prior or current measurement year.* • Each condition listed below is an eligible chronic condition. **NOTE**: Chronic obstructive pulmonary disease (COPD) and asthma are considered the same chronic condition: — Chronic respiratory conditions (e.g., COPD, asthma, or emphysema) — Depression — Alzheimer's disease and other dementia-related disorders — Heart failure — Stroke and transient ischemic attack — Atrial fibrillation — Acute myocardial infarction — Chronic kidney disease • Diagnoses must be documented on 2 different dates of service. Visits must be for the same eligible chronic condition during the measurement year or the year prior to the measurement year, but prior to the ED visit.
Numerator	Members in the denominator, must have a follow-up service on or within 7 days of the ED visit (8 total days) via: • A case management visit • Monitored electroconvulsive therapy in an outpatient, ambulatory surgical, community mental health, or partial hospitalization setting • Transitional care management services • An outpatient, telephone, or telehealth visit, including those for behavioral health services in a clinic, at home, or at a community mental health center • Complex care management services • An intensive outpatient encounter or partial hospitalization, including observation visits • An e-visit or virtual check-in • Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET) stand-alone visits **NOTE**: FMC is an event-based measure. For each ED visit, there will be a care opportunity that needs to be addressed.
Intake/Measurement Periods	**January 1** through **December 24** of the measurement year

Continued

FMC, Continued

Exclusions	• Patients in hospice or using hospice services any time during the measurement year • Any ED visit resulting in an inpatient admission on the day of, or within 7 days following, the ED visit regardless of the principal diagnosis for admission • ED visits occurring within the same 8-day period (e.g., an ED visit on April 1 is in scope, but subsequent visits occurring April 2–8 are not. If the same patient visits an ED on April 9, this would be a new event requiring follow up).
Allowable Corrections	Unaccounted for follow-up service. Transitional care management, case management, and complex care management visits must include detailed evidence of patient interaction. Documentation of visit must include some or all of the following: • Thorough and diagnosis-appropriate mental health assessment • Review of medication list and medication side effects • Physical exam findings • Compliance with documentation and prescribed treatment • Discharge summary review, verifying understanding of instructions and that all new prescriptions were filled • Questions/concerns the member or caregiver may have **NOTE**: Documentation example, "...contacted patient after ED visit, no questions," will not meet criteria.

* Access the online **FMC Coding Reference** for more information.

Medication Adherence: Cholesterol*

Description	The percentage of Select Health Medicare members ages 18 and older with a prescription for a cholesterol medication (statin drug) who filled their prescription 80% or more of the time they are supposed to be taking the medication**
Denominator	Members ages 18 and older with at least 2 fills of cholesterol medication on 2 separate dates during the measurement year
Numerator	Members in the denominator who filled their prescription 80% or more of the time they are supposed to be taking the medication
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	Enrollment in hospice care, diagnosis of end-stage renal disease (ESRD), or dialysis coverage dates any time during the measurement year
Corrections	The Centers for Medicare and Medicaid Services (CMS) does not allow for corrections at this time.

* The Select Health pharmacy department conducts outreach phone calls to Select Health Medicare members at risk for noncompliance, as identified through pharmacy claims data.

** Statins and statin combination therapies will enter a member into the Medication Adherence: Cholesterol measure. There is no consideration for an off-label use of a cholesterol medication listed within the methodology of this measure. If a cholesterol medication is filled twice in the measurement year, the member will be included in the measure.

Medication Adherence: Diabetes*

Description	The percentage of Select Health Medicare members ages 18 and older with a prescription for non-insulin diabetes medication who filled their prescription 80% or more of the time they are supposed to be taking the medication**
Denominator	Members ages 18 and older with at least 2 fills of non-insulin diabetes medication on 2 separate dates during the measurement year
Numerator	Members in the denominator who filled their prescription 80% or more of the time they are supposed to be taking the medication
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	Enrollment in hospice care, diagnosis of end-stage renal disease (ESRD), or dialysis coverage dates any time during the measurement year One or more prescriptions for insulin
Corrections	The Centers for Medicare and Medicaid Services (CMS) does not allow for corrections at this time.

* The Select Health pharmacy department conducts outreach phone calls to Select Health Medicare members at risk for noncompliance, as identified through pharmacy claims data.

** Non-insulin diabetes and non-insulin diabetes combination therapy will enter a member into the Medication Adherence: Diabetes measure. There is no consideration for an off-label use of a non-insulin diabetes medication within the methodology of this measure. If a diabetes medication is filled twice in the measurement year, the member will be included in the measure.

Medication Adherence: Hypertension*

Description	The percentage of Select Health Medicare members ages 18 and older with a prescription for a blood pressure medication who filled their prescription 80% or more of the time they are supposed to be taking the medication**
Denominator	Members ages 18 and older with at least 2 fills of hypertension medication on 2 separate dates during the measurement year
Numerator	Members in the denominator who filled their prescription 80% or more of the time they are supposed to be taking the medication
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	Enrollment in hospice care, diagnosis of end-stage renal disease (ESRD), or dialysis coverage dates any time during the measurement year One or more prescriptions for sacubitril/valsartan
Corrections	The Centers for Medicare and Medicaid Services (CMS) does not allow for corrections at this time.

* The Select Health pharmacy department conducts outreach phone calls to Select Health Medicare members at risk for noncompliance, as identified through pharmacy claims data.

** ACE inhibitors, ACE inhibitors combination therapy, ARB, and ARB combination therapy will enter a member into the Medication Adherence: Hypertension measure. There is no consideration for an off-label use of a blood pressure medication within the methodology of this measure. If a hypertension medication is filled twice in the measurement year, the member will be included in the measure.

Statin Therapy: Diabetes*

Description	The percentage of Select Health Medicare members ages 40 to 75 with diabetes who were dispensed at least 2 diabetes medication fills and received one statin medication fill during the measurement year**
Denominator	Members ages 40 to 75 with at least 2 diabetes medication fills on unique dates of service during the measurement year
Numerator	Members in the denominator who were dispensed at least 1 statin medication of any intensity in during the measurement year
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	Any of the following diagnoses/criteria at any time during the measurement year: • Hospice enrollment • End-stage renal disease (ESRD) diagnosis or dialysis coverage dates • Rhabdomyloysis and myopathy • Pregnancy, lactation, and fertility • Cirrhosis • Pre-diabetes • Polycystic overy syndrome
Preferred Correction Process	**Do NOT complete a correction submission**. Best practice is to submit an appropriate exclusion code with the visit for the following:*** • "Patient has diagnosis of myositis.": M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9 codes • "Patient has diagnosis of myopathy.": G72.0, G72.89, G72.9 codes • "Patient has diagnosis of rhabdomyolysis.": M62.82 code • "Patient has diagnosis of lactation.": O91.03, O91.13, O91.23, O92.03, O92.13, O92.5, O92.70, O92.79, Z39.1 codes • "Patient has diagnosis of polycystic ovarian syndrome (PCOS).": E28.2 code • "Patient has diagnosis of cirrhosis.": K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69 codes • "Patient has diagnosis of ERSD.": I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 codes • "Patient has diagnosis of pre-diabetes.": R73.03, R73.09 codes

* This measure is based on the Medicare Statin Use in Persons with Diabetes (SUPD) criteria.
** For members who cannot tolerate statin therapy, a trial of as little as 7 days, if appropriate, would count for compliance.
*** Code must be submitted each year for SUPD exclusion.

Pediatric Quality Measures

Immunizations: Adolescence

Description	The percentage of members 13 years of age who have completed the following vaccines by their 13th birthday:* • Meningococcal conjugate: 1 dose (age range 11–13) • Human papillomavirus (HPV): Either the 2-dose or 3-dose series (age range 9–13)** • Tetanus, diphtheria toxoids, and acellular pertussis (Tdap): 1 dose (age range 10–13)
Denominator	Adolescents who turn 13 years of age during the measurement year
Numerator	Adolescents in the denominator who have completed the vaccinations **listed in the "Description" above** by their 13th birthday
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Data Source	Data for this measure comes from Select Health claims, Utah and Nevada state immunization information systems (i.e., USIIS, WebIZ), and corrections made in the QDC tool (for Idaho and Colorado).
Exclusions	Enrollment in hospice at any time during the measurement year **Any 1 of the following**, vaccine-specific contraindications documented prior to the 13th birthday: • **Meningococcal conjugate**: Anaphylaxis due to meningococcal vaccine • **Tdap**: Anaphylaxis or encephalitis due to the tetanus, diphtheria, or pertussis vaccine • **HPV**: Anaphylaxis due to the HPV vaccine
Preferred Correction Process	Enter the immunization into the relevant state immunization information system using valid vaccine codes and avoiding unspecified codes when possible as follows: • **(Utah)** Intermountain Medical Group clinics enter into iCentra; affiliate clinics enter into USIIS. For corrections documentation, use the Immunization History Report from USIIS, which shows vaccination date. • **(Nevada)** Enter missing immunizations into WebIZ, which shows vaccination date, and use it for documenting corrections. • **(Idaho, Colorado)** Because Select Health does not receive data feeds from the state immunization records, use the QDC tool for data correction submissions including the Vaccine History Report. For the Quality Provider Program correction, include 1 of the following required forms of documentation from the medical record: • A vaccine history report indicating the name of the specific antigen and the date of service • A certificate of immunization prepared by an authorized healthcare provider or agency that includes the specific dates and types of immunization administered

* The measure includes all adolescents who fit the criteria.

** To meet the requirement for compliance, the 2-dose series of HPV vaccine must be administered at a minimum of 146 days apart and prior to the member's 13th birthday.

Immunizations: Childhood

Description	The percentage of members who have completed the following by their 2nd birthday: • Diphtheria, tetanus, and acellular pertussis (DTaP): 4 doses • Polio (IPV): 3 doses • Measles, mumps, and rubella (MMR): 1 dose • Haemophilus influenza type B (HiB): 3 doses • Hepatitis B (HepB): 3 doses • Chicken pox (VZV): 1 dose • Pneumococcal conjugate (PCV): 4 doses • Hepatitis A (HepA): 1 dose • Rotavirus (RV) vaccinations*: 2 or 3 doses
Denominator	Children who turn 2 years of age during the measurement year
Numerator	Children in the denominator who have completed the vaccinations **listed in the "Description" above** on or prior to their 2nd birthday
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Data Source	Data for this measure comes from Select Health claims, the Utah Statewide Immunization Information System (USIIS), and corrections entered in the QDC tool.
Exclusions	Enrollment in hospice any time during the measurement year A vaccine-specific contraindications documented prior to the 2nd birthday as follows: • **Any Vaccine**: Severe combined immunodeficiency, immunodeficiency, HIV, lymphoreticular cancer, multiple myeloma, leukemia, or intussusception • **DTaP**: Encephalitis with a vaccine-adverse effect code • **Rotavirus, IPV, HIB, PCV**: Anaphylactic reaction to vaccine • **MMR**: Anaphylactic reaction to the vaccine or history of measles, mumps, or rubella • **VZV**: Anaphylactic reaction to vaccine or history of varicella zoster • **Hepatitis A**: Anaphylactic reaction to vaccine or history of Hep A • **Hepatitis B**: Anaphylactic reaction to common baker's yeast or history of Hep B
Preferred Correction Process	Enter the immunization into USIIS using valid vaccine codes and avoiding unspecified codes when possible.** For the Quality Provider Program correction, include **1 of the following** required forms of documentation from the medical record:** • A vaccine history report indicating the name of the specific antigen and the date of service • A certificate of immunization prepared by an authorized healthcare provider or agency that includes the specific dates and types of immunization administered

* Depending on the brand used

** Intermountain Medical Group clinics should enter into iCentra, while Utah affiliates clinics should enter into USIIS. For Idaho, Nevada, and Colorado clinics, data must be entered into the QDC tool as Select Health does not receive data feeds from those states' immunization records. Each missing date of service must be entered as a separate correction.

Immunizations: Childhood Influenza

Description	The percentage of members who have had 2 influenza vaccinations by their 2nd birthday
Denominator	Children 2 years of age during the measurement year
Numerator	Children in the denominator who have two doses of influenza vaccine, with different dates of service, on or prior to their 2nd birthday*
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Data Source	Data for this measure comes from Select Health claims and the Utah Statewide Immunization Information System (USIIS).
Exclusions	Enrollment in hospice any time during the measurement year One of the following contraindications documented prior to the 2nd birthday: • Immunodeficiency • Human immunodeficiency virus (HIV) • Lymphoreticular cancer, multiple myeloma, or leukemia • Anaphylactic reaction to neomycin
Preferred Correction Process	Enter the immunization into USIIS using valid vaccine codes and avoiding unspecified codes when possible.** For the Quality Provider Program correction, include one of the following required forms of documentation from the medical record:** • A vaccine history report indicating the name of the specific antigen and the date of service • A certificate of immunization prepared by an authorized healthcare provider or agency that includes the specific dates and types of immunization administered

* Vaccinations administered prior to 6 months (180 days) of age do not count.

** Intermountain Medical Group clinics should enter into iCentra, while Utah affiliates clinics should enter into USIIS. For Idaho, Nevada, and Colorado clinics, data must be entered into the QDC tool as Select Health does not receive data feeds from those states' immunization records. Each missing date of service must be entered as a separate correction.

Well-Care Visits: 0 to 15 Months*

Description	The percentage of members who turned age 15 months during the measurement year and had 6 well-care visits with a primary care provider during their first 15 months of life**
Denominator	Children who turned age 15 months during the measurement year
Numerator	Children in the denominator who had at least 6 well-care visits on or before the day the child turned 15 months old. (Note that the date by which the visits must be completed is in the Measure Instructions column on the gaps list.)
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusion	Enrollment in hospice any time during the measurement year Members who died any time during the measurement year
Corrections Allowed	"Patient had at least 6 well-care visits before age 15 months old."***

* This measure is based on the *American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents* (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about **well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/)**

** To count toward the measure, visits must:

- **Occur on or before the member's 15-month birth date**. The 15-month birthday is calculated as the child's 1st birthday plus 90 days.
- **Be at least 14 days apart.** If the newborn and 2-week visit are conducted within 2 weeks of each other, they will count as 1 visit.

*** If a visit was not coded as a well-care visit or if the patient has Selcect Health as a secondary insurance provider, correction for missing visits can be submitted. Note that:

- Uploaded documentation must be labeled or identifiable as well-care or preventive visit.
- Notation of acute or sick care cannot be the primary focus of the visit.
- Multiple visits can be entered on the same submission. Select the correct number of visits on the numerator visit entry in the "Component" dropdown.

Refer to Bright Futures for more information. **(https://www.aap.org/en/practice-management/bright-futures)**

Well-Care Visits: 15 to 30 Months*

Description	The percentage of members who turned age 30 months during the measurement year and had 2 or more well-care visits with a primary care provider between the child's 15-month birthday plus 1 day and the 30-month birthday**
Denominator	Children who turned age 30 months during the measurement year
Numerator	Children in the denominator who had at least 2 well-care visits between the child's 15-month birthday (plus 1 day) and the 30-month birthday*** (Note that the date by which the visits must be completed is in the Measure Instructions column on the gaps-in-care list.
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusion	Enrollment in hospice any time during the measurement year Members who died any time during the measurement year
Corrections Allowed	"Patient had at least 2 well-care visits before age 30 months."****

* This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about **well-child visits** (**https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/**)

** To count toward the measure, visits must:

- Occur between the child's 15-month birthday and the 30-month birthday. Calculate:
  - The 15-month birthday plus 1 day as the first birthday plus 91 days
  - The 30-month birthday as the second birthday plus 18 days
- Be at least 14 days apart.

*** Children 3 years of age during the measurement year may be in both well-care visit measures: 15 to 30 months and 3 to 11 years.

**** If a visit was not coded as a well-care visit or if the patient has Select Health as a secondary insurance provider, correction for missing visits can be submitted. Note that:

- Uploaded documentation must be labeled or identifiable as well-care or preventive visit.
- Notation of acute or sick care cannot be the primary focus of the visit.
- Multiple visits can be entered on the same submission. Select the correct number of visits on the numerator visit entry in the "Component" dropdown.

Refer to Bright Futures for more information. (**https://www.aap.org/en/practice-management/bright-futures**)

Well-Care Visits: 3 to 21 Years*

Description	The percentage of members ages 3 to 21 who had one or more comprehensive well-care visits with a primary care provider or OB/GYN during the measurement year**
Denominator	Children and adolescents ages 3 to 21 during the measurement year***
Numerator	Children and adolescents in the denominator who had at least one well-care visit during the measurement year
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusion	Enrollment in hospice anytime during the measurement year Members who died any time during the measurement year
Corrections Allowed	Patient had at least one well-care visit during the measurement year."****

* This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about **well-child visits** (**https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/**)

** From birth to age 12 years, there is no required time period that must elapse between visits. From ages 12–21 years, visits must be 275 days apart.

*** Children 3 years of age during the measurement year may be in both well-care visit measures: 15 to 30 months and 3 to 21 years.

**** If a visit was not coded as a well-care visit or if the patient has Select Health as a secondary insurance provider, correction for missing visits can be submitted. Note that:

- Uploaded documentation must be labeled or identifiable as well-care or preventive visit.
- Notation of acute or sick care cannot be the primary focus of the visit.

Refer to Bright Futures for more information. (**https://www.aap.org/en/practice-management/bright-futures**)

Screening: Childhood Lead (Medicaid/Children's Health Insurance Program [CHIP] Only)

Description	The percentage of Select Health Community Care members who had at least 1 capillary or venous lead blood test for lead poisoning by their 2nd birthday
Denominator	Children who turn 2 years of age during the measurement year
Numerator	Children who had at least 1 lead capillary or venous blood test on or before their 2nd birthday
Intake and Measurement Periods	**January 1** through **December 31** of the measurement year
Exclusions	Members in hospice or using hospice services any time during the measurement year Members who died any time during the measurement year
Corrections Allowed	"Patient had lead screening."*

* For Quality Provider Program corrections, enter lead blood tests into the QDC Tool. Correction must include uploaded documentation of the test date and test result.

Screening: Maternal Depression

Description	The percentage of babies ages 1 day to 1 year who had a parent/caregiver screened for clinical depression in a primary care setting up to 3 times during their first year of life*
Denominator	The number of of babies ages 1 day to 1 year during the measurement year
Numerator	The number of babies in the denominator who had a parent/caregiver screened for clinical depression in a primary care setting using a standardized screening tool during their first year of life
Intake and Measurement Periods	**Intake period:** Babies ages 1 day to 1 year at any time during the measurement year. Each baby is eligible for 3 separate payments from 1 day to 1 year old. The measure will roll over each year.**
Data Source	Data for this measure comes from Select Health claims.
Exclusions	Deliveries for which members were in hospice or using hospice services any time during the measurement period
Preferred Correction Process	No corrections are allowed for this measure at this time. Best practice is to submit an appropriate billing code with the visit, as follows: *CPT **96161** "Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument."*

* Displayed as 3 distinct measures in the performance summary. **Screenings must**:

- Be 30 days apart to count for gap closure/payment.
- Conducted/billed on the baby's account.
- Conducted at any encounter billed.

** Screenings may be conducted the following year for credit and paid for any missed opportunities (e.g., a baby who was born **July 1, 2024**, would be eligible for any missed screenings up until **July 1, 2025**. If the member completed 2 screenings in 2024, there will be one open opportunity for 2025).

Select Health