

Guidelines for Risk Adjusted Utilization Measures

SUMMARY OF CHANGES TO HEDIS MY 2025

- No changes to these guidelines.

Guidelines

1. **Which services count?** Include all services, whether or not the organization paid for them or expects to pay for them (include denied claims) when applying risk adjustment in the Risk Adjusted Utilization measures. *Do not include* denied services (only include paid services and services expected to be paid) when identifying all other events (e.g., the IHS in the PCR measure or observed events in the other risk adjusted utilization measures).

When confirming that an ED visit does not result in an inpatient or observation stay, all inpatient and observation stays must be considered, regardless of payment status (paid, suspended, pending, denied). For example, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and is not included in the Emergency Department Utilization measure when identifying observed ED visits.

The organization may have:

- Covered the full amount.
- Paid only a portion of the amount (e.g., 80%).
- Paid nothing because the member covered the entire amount to meet a deductible.
- Paid nothing because the service was covered as part of a PMPM payment.
- Denied the service.

Count the service as paid or expected to be paid if:

- The organization paid the full amount **or** a portion of the amount (e.g., 80%).
- The member paid for the service as part of the benefit offering (e.g., to meet a deductible), **or**
- The service was covered under a PMPM payment.

Count the service as denied if:

- The organization denied the service for any reason, unless the member paid for the service as part of the benefit offering (e.g., to meet a deductible), **or**
- The claim for the service was rejected because it was missing information or was invalid for another reason.

2. **Risk adjustment.** Organizations may not use supplemental data sources when applying the risk adjustment methodology.

Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses and diagnoses from additional data sources would affect the validity of the models as they are current implemented in the specification.

3. **Counting transfers.** Unless otherwise specified in the measure, treat transfers *between* institutions as separate admissions. Base transfer reports *within* an institution on the type and level of services provided. Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.

Count only one admission when the transfer takes place within the same service category but to a different level of care; for example, from intensive care to a lesser level of care or from a lesser level of care to intensive care.

4. **Mental health and chemical dependency transfers.** Unless otherwise specified in the measure, count as a separate admission a transfer within the same institution but to a different level of care (e.g., a transfer between inpatient and residential care). Each level must appropriately include discharges and length of stay (count inpatient days under inpatient; count residential days under residential).

5. **Observation stays without an admission and/or discharge date.** For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.

6. **Direct transfers.** A direct transfer is when the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. For example:

- A discharge on June 1, followed by a subsequent admission on June 1, *is a direct transfer*.
- A discharge on June 1, followed by a subsequent admission on June 2, *is a direct transfer*.
- A discharge on June 1, followed by a subsequent admission on June 3, *is not a direct transfer*; these are two distinct stays.
- A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, *is a direct transfer*.

Direct transfers may occur from and between different facilities and/or different service levels. Refer to individual measure specifications for details.

Risk Adjustment Comorbidity Category Determination

- Step 1** Identify all diagnoses for encounters during the classification period for each denominator unit of the measure (i.e., denominator event or member). Include the following when identifying encounters:

- Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service during the classification period.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date during the classification period.

For PCR, exclude the principal discharge diagnosis on the IHS. For the HFS measure, exclude the primary discharge diagnosis on the skilled nursing facility discharge (SND) to the community.

- Step 2** Assign each diagnosis to a comorbid Clinical Condition (CC) category using Table CC—Mapping. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to the *Risk Adjustment Weighting* section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3 Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

Step 4 Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

Example Assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).

- CC-85 does not have a map to the ranking table and becomes HCC-85.
- HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.
- The final comorbidities for this denominator unit are HCC-17 and HCC-85.

Example: Table HCC—Rank

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

Step 5 Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCC conditions.

If there are fully nested combinations, use only the more comprehensive pattern. For example, if the diabetes/CHF combination is nested in the diabetes/CHF/renal combination, count only the diabetes/CHF/renal combination.

If there are overlapping combinations, use both sets of combinations. Based on the combinations, a denominator unit can have none, one or more of these added HCCs.

Example For a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

Example: Table HCC—Comb

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC- Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF