Adolescence and Adult Performance Measures

Updated October 2025

Background:

The Health Resource and Services Administration (HRSA) HIV/AIDS Bureau (HAB) maintains an efficient set of performance measures. HAB Performance Measures focus on priority topics unique to HIV care and treatment and do not include ones relevant to the general population. As per the Ryan White HIV/AIDS Program (RWHAP) legislation, HAB Performance Measures are consistent with U.S. Department of Health and Human Services (HHS) HIV Clinical Guidelines.

HRSA HAB prioritizes aligning HIV performance measures across federal programs by including HIV care and treatment measures in Centers for Medicare & Medicaid Services (CMS) quality measures programs. HRSA HAB supports the HIV viral suppression measure in the CMS Medicaid Adult Core Set and four electronic clinical quality measures (eCQMs) in the CMS Merit-based Incentive Payment System (MIPS). HRSA HAB eCQMs are endorsed by the CMS consensus based entity (CBE).

RWHAP recipients can include a combination of HAB Performance Measures and performance measures from other sources in their clinical quality management programs. RWHAP recipients can customize the HAB Performance Measures to reflect the needs of their client populations.

CMS hosts a measures inventory that RWHAP recipients can consult to identify performance measures in addition to HIV care and treatment.

Annually, HRSA HAB reviews the HAB performance measures and makes changes for the following reasons:

- HHS HIV Clinical Guidelines include new or updated information.
- HAB Performance Measure is no longer consistent with professional standards.
- CMS CBE identification number changes or there is no longer an equivalent measure endorsed by the CBE.

About the HAB Adolescent and Adult Performance Measures:

HAB Adolescent and Adult Performance Measures were developed and updated to reflect the HHS HIV Clinical Guidelines. HAB Adult and Adolescent Performance Measures focus on common and essential aspects of HIV primary care for patients aged 13 years and older.

HAB Adolescent and Adult Performance Measures are:

- Cervical Cancer Screening
- Chlamydia Screening
- Gonorrhea Screening
- Hepatitis C Screening
- HIV Risk Counseling
- Oral Health Exam
- Preventive Care and Screening for Clinical Depression and Follow-Up Plan
- Preventive Care and Screening Tobacco Use Smoking Cessation Intervention
- Sexually Transmitted Infection (STI) Testing for People with HIV
- Substance Use Screening

- Syphilis Screening

Summary of Changes to the Adolescent and Adult Performance Measures:

HRSA HAB reviewed previous versions of the Performance Measures and revised the text and references.

Key updates include the following:

- Reviewed and updated as needed HHS HIV Clinical Practice Guidelines citations for all Performance Measures.
- Moved Hepatitis B Screening, Hepatitis B Vaccination, and Pneumococcal Vaccination Performance Measures to the All Ages Group.
- Added Sexually Transmitted Infection (STI) Testing for People with HIV Performance Measure.
- Updated denominator, patient exclusions, and data elements for the following Performance Measures:
    - Chlamydia Screening
    - Gonorrhea Screening
    - Syphilis Screening
- Edited Performance Measures to ensure consistent wording in numerators and denominators.
- Added the MIPS ID to the performance measures.
- Added eCQM identification number.
- Changed National Quality Forum number to the CBE number.

Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: Cervical Cancer Screening

Consensus Based Entity ID: 0032 (not specific to people with HIV)

Merit-based Incentive Payment System ID: No equivalent measure

CMS eCQM ID: CMS124v13 (not specific to people with HIV)

Description: Percentage of female patients with a diagnosis of HIV who were screened for cervical cancer in the last three years.

Numerator: Number of female patients who were screened for cervical cancer in the last three years.

Denominator: Number of female patients with a diagnosis of HIV who:

- Had at least one medical visit in the measurement year; and
- Were at least 21 years old in the measurement year.

Patient Exclusions: Female patients who had a hysterectomy for non-dysplasia/non-malignant indications.

Data Elements:

1. Does the patient have a diagnosis of HIV? (Y/N)
    a. If yes, is the patient female? (Y/N)
        i. If yes, did the patient have at least one medical visit in the measurement year? (Y/N)
            1. If yes, is the patient aged 21 years and older in the measurement year? (Y/N)
                a. If yes, was a cervical cytology (Pap test) performed in the measurement year or the two years prior to the measurement year?

Department of Health & Human Services Clinical Practice Guidelines:

"People aged 21 to 29 years with HIV should have cervical cytology at the time of initial diagnosis with HIV **(**AII). See Figure 1. Screening Algorithm for Cervical Cancer in People With HIV Aged 21 to 29 Years for detailed recommendations. The absolute incidence of ICC (invasive cervical cancer) is exceedingly low among women with HIV under 25 years; therefore, cervical cancer screening is recommended to start at age 21. The rationale for beginning screening at age 21 is to provide a three to five-year window prior to age 25, when the risk of ICC in women with HIV exceeds that of the general population.

“Cervical cancer screening in people with HIV should continue throughout their lifetime (and not, as in the general population, end at 65 years of age)**.** Either cytology only or cytology and HPV co-testing is acceptable for screening**.**

“Women with HIV Aged 30 Years and Older: people with HIV should continue throughout their lifetime (and not, as in the general population, end at 65 years of age). Either cytology only or

cytology and HPV co-testing is acceptable for screening (*BIII*). See Figure 2. Screening Algorithm for Cervical Cancer in People With HIV Aged 30 Years and Older (PDF) for detailed recommendations. Current guidelines from both the ACS and USPSTF allow use of HPV co-testing with cytology. A negative HPV test predicts prolonged low risk of cancer. Cytology/HPV co-testing can allow a prolonged cervical cancer screening interval in women with HIV who are older than 29 years and have normal cervical cytology with concurrent negative HPV testing.

"For people aged more than 65 years, it is recommended to continue cervical cancer screening because people with HIV are at higher risk for cervical cancer (*BIII*). However, clinicians should consider other factors, such as the life expectancy of the patient and the risk for developing cervical cancer at this age."[1]

Figure 1. Screening Algorithm for Cervical Cancer in People with HIV Aged 21 to 29 Years for detailed recommendations

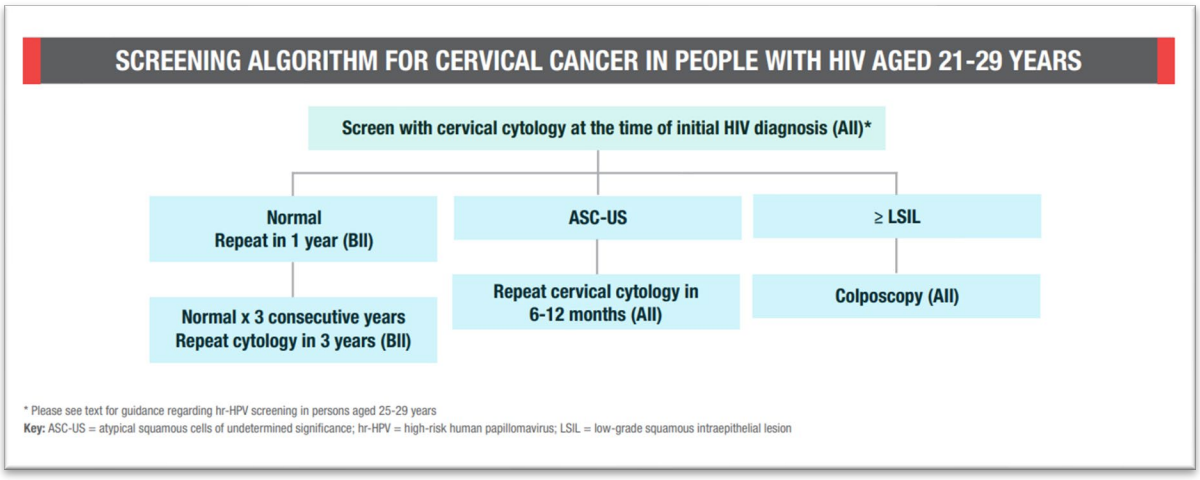
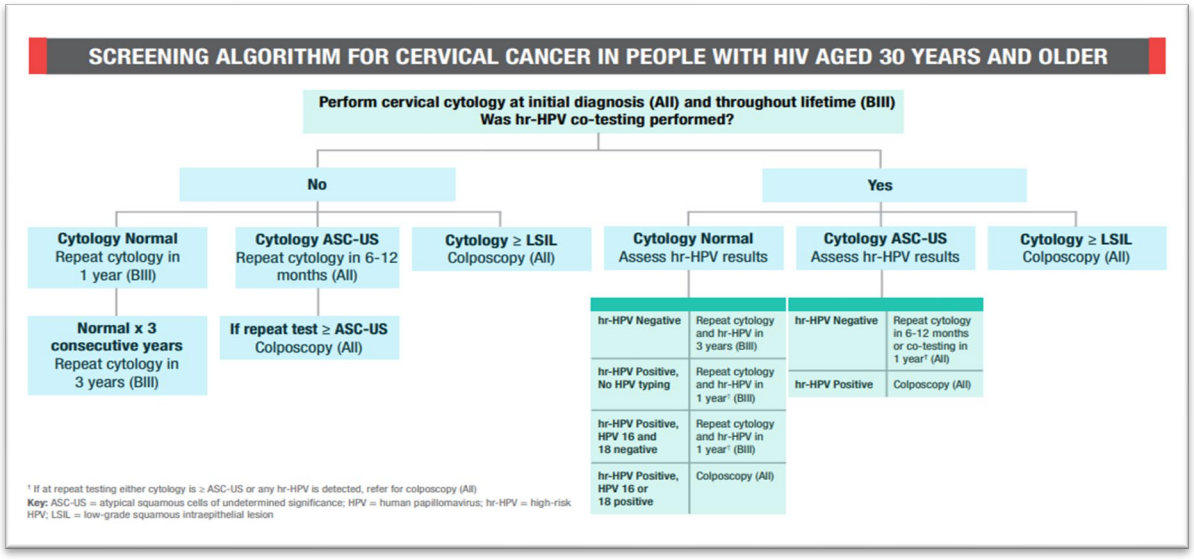


Figure 2. Screening Algorithm for Cervical Cancer in People with HIV Aged 30 Years and Older



Use in Other Federal Programs

A similar or exact measure is in Healthy People 2030.

References and Notes

[1] Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents With HIV. National Institutes of Health, HIV Medicine Association, and Infectious Diseases Society of America. Department of Health and Human Services. Available online. Accessed October 2025. Q-6 through Q-7.

Date Last Reviewed: October 2025

Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: Chlamydia Screening

Consensus Based Entity ID: 0033 (not specific to people with HIV)

Merit-based Incentive Payment System ID: 128 (not specific to people with HIV)

CMS eCQM ID: CMS153v13 (not specific to people with HIV)

Description: Percentage of patients 13 years and older with a diagnosis of HIV who had a chlamydia test during the measurement year.

Numerator: Number of patients who had a chlamydia test during the measurement year.

Denominator: Number of patients 13 years and older with a diagnosis of HIV who had at least one medical visit during the measurement year.

Data Elements:

1. Is the patient 13 years and older? (Y/N)
    a. Does the patient have a diagnosis of HIV? (Y/N)
        i. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)
            1. If yes, did the patient have a chlamydia test during the measurement year? (Y/N)

Department of Health and Human Services Clinical Practice Guidelines:

“Rectal and pharyngeal testing by NAAT for gonorrhea and chlamydia is recognized as an important sexual health consideration for [men who have sex with men] MSM… Pharyngeal infections with gonorrhea or chlamydia might be a principal source of urethral infections… Approximately 70% of gonococcal and chlamydial infections might be missed if urogenital-only testing is performed among [men who have sex with men] MSM because most pharyngeal and rectal infections are asymptomatic. Self-collected swabs have been reported to be an acceptable means of collection for pharyngeal and rectal specimens, which can enhance patient comfort and reduce clinical workloads.

"At the initial HIV care visit, providers should screen all sexually active persons for syphilis, gonorrhea, and chlamydia, and perform screening for these infections at least annually during the course of HIV care. Specific testing includes syphilis serology and nucleic acid amplification test (NAAT) for *N. gonorrhoeae* and *C. trachomatis* at the anatomic site of exposure… More frequent screening for syphilis, gonorrhea, and chlamydia (e.g., every three or six months) should be tailored to individual risk behavior and the local prevalence of specific STIs.

“For women, *C. trachomatis* urogenital infection can be diagnosed by vaginal or cervical swabs or first-void urine. For men, *C. trachomatis* urethral infection can be diagnosed by testing first-void urine or a urethral swab. NAATs are the most sensitive tests for these specimens and are the recommended test for detecting *C. trachomatis* infection. NAATs that are FDA cleared for use with vaginal swab specimens can be collected by a clinician or patient in a clinical setting. Patient-collected vaginal swab specimens are equivalent in sensitivity and specificity to those collected by a clinician using NAATs, and this screening strategy is highly acceptable among women.

"Recent studies have demonstrated that among men, NAAT performance on self-collected meatal swabs is comparable to patient-collected urine or provider-collected urethral swabs. Patient collection of a meatal swab for *C. trachomatis* testing might be a reasonable approach for men who are either unable to provide urine or prefer to collect their own meatal swab over providing urine.

"Rectal and oropharyngeal *C. trachomatis* infection among persons engaging in receptive anal or oral intercourse can be diagnosed by testing at the anatomic exposure site… Data indicate that NAAT performance on self-collected rectal swabs is comparable to clinician-collected rectal swabs, and this specimen collection strategy for rectal *C. trachomatis* screening is highly acceptable among men. Self-collected rectal swabs are a reasonable alternative to clinician-collected rectal swabs for *C. trachomatis* screening by NAAT, especially when clinicians are not available or when self-collection is preferred over clinician collection. Annual screening for rectal *C. trachomatis* infection should be performed among men who report sexual activity at the rectal site. Extragenital chlamydial testing at the rectal site can be considered for females on the basis of reported sexual behaviors and exposure through shared clinical decision-making by the patient and the provider. The majority of persons with *C. trachomatis* detected at oropharyngeal sites do not have oropharyngeal symptoms."[1]

Use in Other Federal Programs:

- A similar measure is in the CMS Merit-based Incentive Payment System.
- A similar or exact measure is in Healthy People 2030.

References and Notes:

[1] Workowski, KA, Bachmann, LH, Chan, PA, Johnston CM, Muzny, CA, Park, I, Reno, H, Zenilman, JA, & Bolan, GA. "Sexually Transmitted Infections Treatment Guidelines, 2021" (PDF). MMWR Recomm Rep 2021; 70(No. RR-4): 16, 26, 66. Available online. Accessed October 2025.

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Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: Gonorrhea Screening

Consensus Based Entity ID: no equivalent measure

Merit-based Incentive Payment System ID: no equivalent measure

CMS eCQM ID: no equivalent measure

Description: Percentage of patients 13 years and older with a diagnosis of HIV who had a gonorrhea test during the measurement year.

Numerator: Number of patients who had a gonorrhea test during the measurement year.

Denominator: Number of patients 13 years and older with a diagnosis of HIV who had at least one medical visit during the measurement year.

Data Elements:

1. Is the patient 13 years and older? (Y/N)
    a. If yes, does the patient have a diagnosis of HIV? (Y/N)
        i. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)
            1. If yes, did the patient have a gonorrhea test during the measurement year? (Y/N)

Department of Health and Human Services Clinical Practice Guidelines:

“Rectal and pharyngeal testing by NAAT for gonorrhea and chlamydia is recognized as an important sexual health consideration for [men who have sex with men] MSM… Pharyngeal infections with gonorrhea or chlamydia might be a principal source of urethral infections… Approximately 70% of gonococcal and chlamydial infections might be missed if urogenital-only testing is performed among [men who have sex with men] MSM because most pharyngeal and rectal infections are asymptomatic. Self-collected swabs have been reported to be an acceptable means of collection for pharyngeal and rectal specimens, which can enhance patient comfort and reduce clinical workloads.

"At the initial HIV care visit, providers should screen all sexually active persons for syphilis, gonorrhea, and chlamydia, and perform screening for these infections at least annually during the course of HIV care. Specific testing includes syphilis serology and nucleic acid amplification test (NAAT) for *N. gonorrhoeae* and *C. trachomatis* at the anatomic site of exposure… More frequent screening for syphilis, gonorrhea, and chlamydia (e.g., every three or six months) should be tailored to individual risk behavior and the local prevalence of specific STIs.

“For urogenital infections, optimal specimen types for gonorrhea screening using NAATs include first-void urine for men and vaginal swab specimens for women. Patient-collected samples can be used in place of provider-collected samples in clinical settings when testing by NAAT for urine (men and women), vaginal swabs, rectal swabs, and oropharyngeal swabs after patient instructions have been provided. Patient-collected specimens are reasonable alternatives to provider-collected swabs for gonorrhea screening by NAAT.”[1]

Use in Other Federal Programs:

- A similar measure is in the CMS Merit-based Incentive Payment System.
- A similar or exact measure is in Healthy People 2030.

References and Notes:

[1] Workowski, KA, Bachmann, LH, Chan, PA, Johnston CM, Muzny, CA, Park, I, Reno, H, Zenilman, JA, & Bolan, GA. "Sexually Transmitted Infections Treatment Guidelines, 2021" (PDF). MMWR Recomm Rep 2021; 70(No. RR-4): 16, 17, 26, 71-72. Available online. Accessed October 2025.

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Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: Hepatitis C Screening

Consensus Based Entity ID: No equivalent measure

Merit-based Incentive Payment System ID: 387 and 400 (not specific to people with HIV)

CMS eCQM ID: No equivalent measure

Description: Percentage of patients 13 years and older with a diagnosis of HIV who had a hepatitis C test at least once since the diagnosis of HIV.

Numerator: Number of patients who had a hepatitis C test at least once since diagnosis of HIV or have hepatitis C status in the medical record.

Denominator: Number of patients 13 years and older with a diagnosis of HIV who had at least one medical visit during the measurement year.

Patient Exclusions: None

Data Elements:

1. Is the patient 13 years and older? (Y/N)
    a. If yes, does the patient have a diagnosis of HIV? (Y/N)
        1. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)
            1. If yes, did the patient have a hepatitis C test at least once since being diagnosed with HIV or have hepatitis C status in the medical record? (Y/N)

Note:

The Department of Health and Humans Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV and Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents With HIV and the HIV Medicine Association of the Infectious Diseases Society of America Primary Care Guidance for Persons with HIV recommend annual hepatitis C testing for people at risk for hepatitis C infection. RWHAP recipients should review the compositions of their patients and determine if they should adapt this performance measures to annual hepatitis C testing. RWHAP recipients can also:

- Develop a plan to assess patients' hepatitis C risk and provide hepatitis C testing to patients without a hepatitis C test result or hepatitis C status in their medical record.
- Identify patients with a positive hepatitis C antibody testing to determine if they have a hepatitis C RNA test result in their medical record.

Department of Health and Human Services Clinical Practice Guidelines:

"On entry into HIV care, all patients should undergo routine hepatitis C (HCV) screening (AII). Initial testing for HCV should be performed using a U.S. Food and Drug Administration (FDA)-approved immunoassay licensed for detection of antibody to HCV (anti-HCV) in blood. For at-risk HCV seronegative individuals, specifically [men who have sex with men] MSM or persons who inject drugs, HCV antibody testing, using an FDA-approved immunoassay, is recommended

annually or as indicated by clinical presentation, risk activities, or exposure (AII). Concordantly, both the American Association for the Study of Liver Diseases (AASLD)/Infectious Diseases Society of America (IDSA) HCV guidance and CDC PrEP guidelines also recommend HCV serologic testing at baseline and every 12 months for [men who have sex with men] MSM … and people who inject drugs. Nucleic acid testing for HCV RNA is recommended in settings where acute infection is suspected or in persons with known prior infection cleared spontaneously or after treatment (AIII)."[1]

Use in Other Federal Programs:

A similar or exact measure is in Healthy People 2030.

References and Notes:

[1] Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents With HIV. National Institutes of Health, HIV Medicine Association, and Infectious Diseases Society of America. Department of Health and Human Services. Available online. Accessed October 2025. M-3.

Date Last Reviewed: October 2025

Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: HIV Risk Counseling

Consensus Based Entity ID: No equivalent measure

Merit-based Incentive Payment System ID: No equivalent measure

CMS eCQM ID: No equivalent measure

Description: Percentage of patients 13 years and older with a diagnosis of HIV who received HIV risk counseling[1] during the measurement year.

Numerator: Number of patients who received HIV risk counseling during the measurement year.

Denominator: Number of patients 13 years and older with a diagnosis of HIV who had at least one medical visit during the measurement year.

Patient Exclusions: None

Data Elements:

1. Is the patient 13 years and older? (Y/N)
    a. If yes, does the patient have a diagnosis of HIV? (Y/N)
        1. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)
            1. If yes, did the patient receive HIV risk counseling during the measurement year? (Y/N)

Department of Health and Human Services Clinical Practice Guidelines:

“Providers who manage people with HIV need to be aware of the data supporting treatment as prevention ([Treatment as Prevention] TasP, its implications, and how to operationalize this prevention strategy in clinical practice. For people with HIV who intend to rely on TasP to prevent sexual transmission, providers should make an individualized assessment that considers the person’s risk tolerance, personal health, history of maintaining viral suppression on treatment, and access to health care services and ART, as well as other factors that may affect their ability to maintain a high level of adherence to ART.”[2]

"Screen persons with HIV at initial and later encounters (at least yearly or more frequently as needed) for these risk factors:

- Behavioral characteristics that affect their risk of exposing others to HIV (e.g., [condomless] sex, sharing drug-injection equipment)
- Biologic or biomedical characteristics that affect their level of infectiousness, (e.g., use of and adherence to antiretroviral treatment (ART), viral load level, sexually transmitted disease [STD] diagnoses, pregnancy)
- Characteristics of partners that affect the partner’s risk of acquiring HIV or STD, when information available (e.g., use of preexposure prophylaxis [PrEP] or nonoccupational postexposure prophylaxis [nPEP])

"Use information collected during risk screening to identify risk-reduction messages and interventions that address the person's risk of exposing others to HIV, level of infectiousness, and partners' risks of acquiring HIV.

"Offer risk-reduction information and interventions that are tailored to risks of the person with HIV (and of partners they refer) specifically:

- Information about:
  - Behavioral interventions that can reduce the risk of exposing others to HIV (e.g., brief or intensive risk-reduction strategies that encourage safer sex and substance use treatment)
  - Biomedical interventions that can reduce viral load or HIV shedding (e.g., HIV medical care, ART use, STD services, special reproductive and pregnancy services)
  - Strategies for partners [without HIV] to reduce their risk of acquiring HIV (e.g., partner notification, PrEP, nPEP)[3]

"Behavioral risk-reduction interventions include various services provided in clinical settings and nonclinical settings that have been shown to promote safer behaviors and reduce the risk of exposing others to HIV." [3]

Use in Other Federal Programs:

This measure is not used in other federal programs.

References and Notes:

[1] "Risk screening is the collection of information to determine a person's risk of transmitting HIV to others….risk screening is defined as a brief evaluation of behavioral factors that may affect the risk of exposing others to HIV (e.g., [condomless] sex or sharing drug-injection equipment) and biomedical or biologic factors that influence HIV viral load, viral shedding, and infectiousness (e.g., antiretroviral treatment [ART] use, ART adherence, sexually transmitted disease [STD], and pregnancy). Risk screening† is used to identify behavioral or biomedical risk-reduction interventions suited to a specific individual.

[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available online. Accessed October 2025. F-2.

[3] Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. *Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014*. http://stacks.cdc.gov/view/cdc/26062. 102-103. Accessed October 2025.

Date Last Reviewed: October 2025

Performance Measure: Oral Health Exam

Consensus Based Entity ID: No equivalent measure

Merit-based Incentive Payment System ID: No equivalent measure

CMS eCQM ID: No equivalent measure

Description: Percentage of patients 13 years and older with a diagnosis of HIV who received at least two oral health exams by a dentist during the measurement year.

Numerator: Number of patients who had at least two oral health exams by a dentist based on patient self-report or other documentation during the measurement year.

Denominator: Number of patients 13 years and older with a diagnosis of HIV who had at least one medical visit during the measurement year.

Patient Exclusions: None

Data Elements:

1. Is the patient 13 years and older? (Y/N)
    a. If yes, does the patient have a diagnosis of HIV? (Y/N)
        i. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)
            1. If yes, did the patient receive at least two oral health exams by a dentist during the measurement year? (Y/N)

Department of Health and Human Services Clinical Practice Guidelines:

The Department of Health and Human Services Clinical Practice Guidelines do not provide information about oral care. The Department of Health and Human Service Clinical Guidelines state care should be initiated as recommended in the HIV Medicine Association of the Infectious Diseases Society of America's Primary Care Guidance for Persons with HIV[1].

The HIV Medicine Association of the Infectious Diseases Society of America's Primary Care Guidance for Persons with HIV state the following about oral exams.

> "People with HIV have frequent oral health complications, especially if the CD4 cell count is low. Any identified oral health complication should be addressed immediately. In addition, every patient should have regular oral health exams. Given the risks for oral complications, a biannual oral health examination for people with HIV is reasonable."[1]

Use in Oher Federal Programs:

This measure is not used in other federal programs.

References and Notes:

[1] Michael Horberg, Melanie Thompson, Allison Agwu, Jonathan Colasanti, Marwan Haddad, Mamta Jain, Grace McComsey, Asa Radix, Natella Rakhmanina, William R Short, Tulika Singh, Hansel Tookes, on behalf of the HIV Medicine Association, Primary Care Guidance for Providers of Care for Persons With Human Immunodeficiency Virus: 2024 Update by the HIV

Adolescence and Adult Performance Measures

Updated October 2025

Medicine Association of the Infectious Diseases Society of America, Clinical Infectious Diseases, 2024;, ciae479, https://doi.org/10.1093/cid/ciae479

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Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: Preventive Care and Screening for Clinical Depression and Follow-Up Plan

Consensus Based Entity ID: No equivalent measure

Merit-based Incentive Payment System ID: 134 (Not specific to people with HIV)

CMS eCQM ID: CMS2v14 (Not specific to people with HIV)

Description: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter. [1,2]

Numerator: Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Denominator: All patients aged 12 years and older at the beginning of the performance period with at least one qualifying encounter during the performance period.

Patient Exclusions:

1. Documentation stating the patient has had a diagnosis of bipolar disorder.
2. Patient refuses to participate in or complete the depression screening.
3. Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status).

Data Elements:

1. Is the patient 12 years or older? (Y/N)
    a. If yes, did the patient have a depression screening during measurement period? (Y/N)
        i. If yes, did the depression screening result in a diagnosis of depression? (Y/N)
            1. If yes, was an intervention documented? (Y/N)

*You can find performance measure details at CMS2v14 and 134.

Department of Health and Human Services Clinical Practice Guidelines:

"People with HIV often must cope with many social, psychiatric, and medical issues that are best addressed through a patient-centered, multidisciplinary approach. The baseline evaluation should include consideration of the patient's readiness for ART, including an assessment of substance use (including tobacco use), social support, mental health, medical comorbidities, economic factors (e.g., unstable housing, food instability), medical insurance status and adequacy of coverage, and other factors that are known to impair adherence to ART and increase the risk of HIV transmission. Once evaluated, these factors should be managed accordingly."[3]

Use in Other Federal Programs:

- This measure is in the CMS Merit-based Incentive Payment System.
- A similar or exact measures is in Healthy People 2030.

References and Notes:

[1] Centers for Medicare & Medicaid Services developed and maintains this measure.

[2] The following information is from the CMS MIPS clinical quality measure description. Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized.

Examples of standardized depression screening tools include but are not limited to:

- Adolescent Screening Tools (12-17 years): Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2
- Adult Screening Tools (18 years and older): Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety- Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD)
- Perinatal Screening Tools: Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

Follow-Up Plan – Documented follow-up for a positive depression screening *must* include one or more of the following:

- Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Examples of a follow-up plan include but are not limited to:

- Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychiatric nurse practitioner, psychologist, clinical social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for

treatment of depression
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options

[3] Panel on Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available online. Accessed October 2025. B-2.

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Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: Preventive Care and Screening Tobacco Use Smoking Cessation Intervention

Consensus Based Entity ID: 0028

Merit-based Incentive Payment System ID: 226 (Not specific to people with HIV)

CMS eCQM ID: CMS138v14 (Not specific to people with HIV)

Description: Percentage of patients aged 12 years and older who were screened for tobacco use one or more times within the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user.[1,2]

Numerator: This measure is calculated with three performance rates. For example, use numerator one and denominator one to calculate a performance rate.

1. Patients who were screened for tobacco use at least once during the measurement period.
2. Patients who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period.
3. Patients who were screened for tobacco use at least once during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user.

Denominator:

1. All patients aged 12 years and older seen for at least two visits or at least one preventive visit during the measurement period.
2. All patients aged 12 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use during the measurement period and identified as a tobacco user.
3. All patients aged 12 years and older seen for at least two visits or at least one preventive visit during the measurement period.

Patient Exclusions: Patients who are in hospice care for any part of the measurement period.

Data Elements:

Denominator and Numerator 1:

1. Is patient 12 years or older? (Y/N)
    a. If yes, did the patient have at least two visits or at least one preventive visit during the measurement period (Y/N)
        i. If yes, was the patient screened for tobacco use at least once during the measurement period? (Y/N)

Denominator and Numerator 2:

1. Is patient 12 years or older? (Y/N)

a. If yes, did the patient have at least two visits or at least one preventive visit during the measurement period (Y/N)
    i. If yes, was the patient screened for tobacco use at least once during the measurement period? (Y/N)
        1. If yes, was the patient identified as a tobacco user? (Y/N)
            1. If yes, did the patient received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period? (Y/N)

Denominator and Numerator 3:

1. Is patient 12 years or older? (Y/N)
    a. If yes, did the patient have at least two visits or at least one preventive visit during the measurement period (Y/N)
        i. If yes, was the patient identified as a tobacco user? (Y/N)
            1. If yes, was the patient screened for tobacco use at least once during the measurement period AND did the patient received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period? (Y/N)

*You can find performance measure details at CMS138v14 and 226.

Department of Health and Human Services Clinical Practice Guidelines:

"People with HIV and SUDs should be offered evidence-based pharmacotherapy (e.g., opioid agonist therapy, tobacco cessation treatment, alcohol use disorder treatment) as part of comprehensive HIV care in clinical settings.

"To maximize the survival benefits of ART, clinicians should consider using evidence-based behavioral and pharmacological cessation strategies when treating people with HIV who smoke tobacco (see the tools and recommendations provided by the CDC and the U.S. Preventive Services Task Force and recent review). These include (but are not limited to) advising the individual to quit smoking, using the five A's, employing motivational interviewing, and referring them to a tobacco quit line. Pharmacotherapies for smoking cessation (nicotine replacement therapy, bupropion, and varenicline) have few clinically significant interactions with ARV drugs and can lead to enormous reductions in morbidity and mortality if the person is able to stop smoking."[3]

U.S. Preventative Service Task Force:

"The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to nonpregnant adults who use tobacco. Grade A.

"The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco. Grade A.

" The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant persons. (I statement) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of e-cigarettes for tobacco cessation in adults, including pregnant persons. The USPSTF recommends that clinicians direct patients who use tobacco to other tobacco cessation interventions with proven effectiveness and established safety. (I statement)."[4]

Use in Other Federal Programs:

This measure is in the CMS Merit-based Incentive Payment System.

References and Notes:

[1] Tobacco Use includes any tobacco product.

[2] National Committee for Quality Assurance is the measure developer and steward.

[3] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV. Department of Health and Human Services. Available at https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new. Accessed October 2025. J-64, J-76.

[4] US Preventive Services Task Force. Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons: US Preventive Services Task Force Recommendation Statement. *JAMA.* 2021;325(3):265–279. doi:10.1001/jama.2020.25019. Accessed October 2025.

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Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: Sexually Transmitted Infection Testing for People with HIV

Consensus Based Entity ID: 3755e

Merit-based Incentive Payment System ID: 205

CMS eCQM ID: CMS1188v2

Description: Percentage of patients aged 13 years and older with a diagnosis of HIV who had syphilis, gonorrhea, and chlamydia tests during the measurement year.

Numerator: Patients who has chlamydia, gonorrhea, and syphilis tests during the measurement year.

Denominator: All patients aged 13 years and older at the start of the measurement period with an eligible encounter during the measurement period with a diagnosis of HIV during the measurement year.

Patient Exclusions: None

Data Elements:

1. Is the patient 13 years or older? (Y/N)
    a. If yes, does the patient have a diagnosis of HIV? (Y/N)
        i. If yes, did the patient have an eligible encounter in the measurement period with a diagnosis of HIV before the end of the measurement year? (Y/N)
            1. If yes, did the patient have chlamydia, gonorrhea, and syphilis tests during the measurement year? (Y/N)

Department of Health and Human Services Clinical Practice Guidelines:

"At the initial HIV care visit, providers should screen all sexually active persons for syphilis, gonorrhea, and chlamydia, and perform screening for these infections at least annually during the course of HIV care. Specific testing includes syphilis serology and nucleic acid amplification test (NAAT) for *N. gonorrhoeae* and *C. trachomatis* at the anatomic site of exposure…. More frequent screening for syphilis, gonorrhea, and chlamydia (e.g., every 3 or 6 months) should be tailored to individual risk behavior and the local prevalence of specific STIs.

“Rectal and pharyngeal testing by NAAT for gonorrhea and chlamydia is recognized as an important sexual health consideration for [men who have sex with men] MSM…. Pharyngeal infections with gonorrhea or chlamydia might be a principal source of urethral infections…. Approximately 70% of gonococcal and chlamydial infections might be missed if urogenital-only testing is performed among [men who have sex with men] MSM because most pharyngeal and rectal infections are asymptomatic. Self-collected swabs have been reported to be an acceptable means of collection for pharyngeal and rectal specimens, which can enhance patient comfort and reduce clinical workloads.

“For women, *C. trachomatis* urogenital infection can be diagnosed by vaginal or cervical swabs or first-void urine. For men, *C. trachomatis* urethral infection can be diagnosed by testing first-void urine or a urethral swab. NAATs are the most sensitive tests for these specimens and are the

recommended test for detecting *C. trachomatis* infection. NAATs that are FDA cleared for use with vaginal swab specimens can be collected by a clinician or patient in a clinical setting. Patient-collected vaginal swab specimens are equivalent in sensitivity and specificity to those collected by a clinician using NAATs, and this screening strategy is highly acceptable among women.

"Recent studies have demonstrated that among men, NAAT performance on self-collected meatal swabs is comparable to patient-collected urine or provider-collected urethral swabs. Patient collection of a meatal swab for *C. trachomatis* testing might be a reasonable approach for men who are either unable to provide urine or prefer to collect their own meatal swab over providing urine.

"Rectal and oropharyngeal *C. trachomatis* infection among persons engaging in receptive anal or oral intercourse can be diagnosed by testing at the anatomic exposure site…. Data indicate that NAAT performance on self-collected rectal swabs is comparable to clinician-collected rectal swabs, and this specimen collection strategy for rectal *C. trachomatis* screening is highly acceptable among men. Self-collected rectal swabs are a reasonable alternative to clinician-collected rectal swabs for *C. trachomatis* screening by NAAT, especially when clinicians are not available or when self-collection is preferred over clinician collection. Annual screening for rectal *C. trachomatis* infection should be performed among men who report sexual activity at the rectal site. Extragenital chlamydial testing at the rectal site can be considered for females on the basis of reported sexual behaviors and exposure through shared clinical decision-making by the patient and the provider. The majority of persons with *C. trachomatis* detected at oropharyngeal sites do not have oropharyngeal symptoms."[1]

Use in Other Federal Programs:

- This measure is in the CMS Merit-based Incentive Payment System.
- This measure is linked to an exact or similar indicator(s) within Healthy People 2030.

References and Notes:

[1] Workowski, KA, Bachmann, LH, Chan, PA, Johnston CM, Muzny, CA, Park, I, Reno, H, Zenilman, JA, & Bolan, GA. "Sexually Transmitted Infections Treatment Guidelines, 2021" (PDF). MMWR Recomm Rep 2021; 70(No. RR-4): 16, 26, 66. Available online. Accessed October 2025.

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Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: Substance Use Screening

Consensus Based Entity ID: No equivalent measure

Merit-based Incentive Payment System ID: No equivalent measure

CMS eCQM ID: No equivalent measure

Description: Percentage of new patients 13 years and older with a diagnosis of HIV who have been screened for substance use during the measurement year.

Numerator: Number of patients who were screened for substance use during the measurement year.

Denominator: Number of patients aged 13 years with a diagnosis of HIV who had at least one medical visit during the measurement year.

Patient Exclusions: None

Data Elements:

1. Is the patient 13 years and older? (Y/N)
    a. If yes, does the patient have a diagnosis of HIV? (Y/N)
        i. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)
            1. If yes, was the patient screened for substance use during the measurement year? (Y/N)

Department of Health and Human Services Clinical Practice Guidelines:

"Substance use disorders (SUDs) are prevalent among people with HIV and contribute to poor health outcomes; therefore, screening for SUDs should be a routine part of clinical care (AII).

"People with HIV and SUDs should be screened for additional mental health disorders (AII)."[1]

Use in Other Federal Programs:

This measure is linked to an exact or similar indicator(s) within Healthy People 2030.

References and Notes:

[1] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available online. Accessed October 2025. J-64.

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Adolescence and Adult Performance Measures

Updated October 2025

Performance Measure: Syphilis Testing

Consensus Based Entity ID: No equivalent measure

Merit-based Incentive Payment System ID: No equivalent measure

CMS eCQM ID: No equivalent measure

Description: Percentage of patients 13 years and older with a diagnosis of HIV who had a syphilis test during the measurement year.

Numerator: Number of patients who had a syphilis test during the measurement year.

Denominator: Number of patients 13 years and older with a diagnosis of HIV who had at least one medical visit during the measurement year.

Patient Exclusions: None

Data Elements:

1. Is the patient 13 years and older? (Y/N)
    a. Does the patient have a diagnosis of HIV? (Y/N)
        i. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)
            1. If yes, did the patient receive a syphilis test during the measurement year?

Department of Health and Human Services Clinical Practice Guidelines:

"Routine serologic screening for syphilis is recommended at least annually for all people with HIV who are sexually active, with more frequent screening (every three to six months) for those who have multiple or anonymous partners."[1]

"At the initial HIV care visit, providers should screen all sexually active persons for syphilis, gonorrhea, and chlamydia, and perform screening for these infections at least annually during the course of HIV care… More frequent screening for syphilis, gonorrhea, and chlamydia (e.g., every three or six months) should be tailored to individual risk and the local prevalence of specific STIs. Certain STIs can be asymptomatic; their diagnosis might prompt referral for partner services, might identify sexual and needle-sharing partners who can benefit from early diagnosis and treatment of HIV, and might prompt reengagement in care or HIV prevention services (e.g., PEP or PrEP)."[2]

Use in Other Federal Programs:

This measure is linked to an exact or similar indicator(s) within Healthy People 2030.

References and Notes:

[1] Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents With HIV. National Institutes of Health, HIV Medicine Association,

and Infectious Diseases Society of America. Department of Health and Human Services. Available online. Accessed October 2025. AA-5.

[2] Workowski, KA, Bachmann, LH, Chan, PA, Johnston CM, Muzny, CA, Park, I, Reno, H, Zenilman, JA, & Bolan, GA. "Sexually Transmitted Infections Treatment Guidelines, 2021" (PDF). MMWR Recomm Rep 2021; 70(No. RR-4): 26. Available online. Accessed October 2025.

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