Connecticut Quality Council
Quality Benchmarks
Measure Specifications

This document includes specifications for select health status measures for discussion during the July 15, 2021 Quality Council meeting. It does not include specifications for the surveys referenced in the meeting materials.

For more information on the measures from the Behavioral Risk Factor Surveillance System, visit: https://www.cdc.gov/brfss/data_documentation/index.htm

For more information on the measures obtained from the Agency for Healthcare Research and Quality, visit: https://nhqrnet.ahrq.gov/inhqrdr/Connecticut/dashboard

Patient Experience Measures from the CAHPS® Health Plan Survey

Documents Available for the CAHPS Health Plan Survey 5.0

This document is part of a comprehensive set of instructional materials that address implementing the Health Plan Survey, analyzing the data, and reporting the results. All documents are available on the Agency for Healthcare Research and Quality's Web site. For assistance in accessing these documents, please contact the CAHPS Help Line at 800-492-9261 or cahps1@westat.com.

For descriptions of these documents, refer to: ***What's Available for the CAHPS Health Plan Survey 5.0.***

Questionnaires

- ***CAHPS Health Plan Survey: Overview of the Questionnaires***
- ***Health Plan Survey 5.0*** (Adult and Child, English and Spanish)
  - ***Medicaid Survey 5.0***
  - ***Commercial Survey 5.0***

Supplemental Items

- Supplemental Items for the Health Plan Survey 5.0

Some supplemental items for this survey are intended to be administered together. Learn more about these item sets:

- People with Mobility Impairments
- Children with Chronic Conditions

Survey Administration Guidelines

- ***Preparing a Questionnaire Using the CAHPS Health Plan Survey***
- ***Fielding the CAHPS Health Plan Survey***
- ***Sample Notification Letters and Emails for the CAHPS Health Plan Survey***
- ***Sample Telephone Script for the CAHPS Health Plan Survey***

Reporting Measures and Guidelines

- ***Patient Experience Measures from the CAHPS Health Plan Survey***

Available for all CAHPS surveys

- Analyzing CAHPS Survey Data: Free programs for analyzing the data, guidance on preparing survey results for analysis, and instructions for using the CAHPS Analysis Program.
- Translating Surveys and Other Materials: Guidelines for translating surveys and selecting translators and translation reviewers.

Introduction

This document reviews the types of patient experience measures associated with the CAHPS Health Plan Survey 5.0, lists the survey's composite and rating measures, and offers basic guidance on reporting the survey results to consumers and other audiences.

Types of Measures

The CAHPS Health Plan Survey generates three types of measures for reporting purposes:

- **Rating measures** are based on items that use a scale of 0 to 10 to measure respondents' assessment of their health plan and the quality of care received over a specified period of time. This measure is sometimes referred to as the "global rating" or "overall rating."
- **Composite measures** (also known as reporting composites) combine results for closely related items that have been grouped together. Composite measures are strongly recommended for both public and private reporting because they allow for reports that are comprehensive, yet of reasonable length. Psychometric analyses also indicate that composite measures from the core items in the survey are reliable and valid measures of patients' experiences.[1, 2] To learn about the calculation of scores for composite measures, read about analyzing CAHPS survey data.
- **Single-item measures** are individual survey questions that did not fit into composite measures. Both the core survey as well as the supplemental item sets contain items that can be reported individually. These single-item measures are especially useful in reports for administrators and other internal audiences that use the data to identify specific strengths and weaknesses. When reporting single-item measures, it is important to indicate that the measure reflects performance on just one survey question in contrast to the multiple questions represented by composite measures.

[1] McGee J, Kanouse DE, Sofaer S, Hargraves JL, Hoy E, Kleimann S. Making survey results easy to report to consumers: How reporting needs guided survey design in CAHPS®. *Med Care*. 1999 Mar;37(3 Suppl):MS32-40.

[2] Hargraves JL, Hays RD, Cleary PD. Psychometric properties of the Consumer Assessment of Health Plans Study (CAHPS™) 2.0 adult core survey. *Health Serv Res*. 2003 Dec;38(6 Pt 1):1509-27.

Measures from Core Survey Items

The Health Plan Survey 5.0 produces the following measures:

- Getting needed care (composite of 2 items)
- Getting care quickly (composite of 2 items)
- How well doctors communicate (composite of 4 items in the Adult Survey; composite of 5 items in the Child Survey)
- Health plan customer service (composite of 2 items)
- Enrollees' rating of their health plan (1 item)
- Enrollees' rating of their health care (1 item)
- Enrollees' rating of their personal doctor (1 item)
- Enrollees' rating of their specialist (1 item)

These measures have been shown to be reliable and are recommended for all types of reporting.

Descriptions of these measures and lists of the survey questions included in each measure are provided in **Appendix A** for the Adult Survey and **Appendix B** for the Child Survey.

The measure names, or labels, listed above and in the appendices are recommended for use in both public and private reports. They are the product of expert input as well as extensive testing with consumers

Guidance on Reporting Health Plan Survey Measures

Users of the CAHPS Health Plan Survey may report the results of the survey publicly to inform health care consumers and/or privately to inform administrative and clinical leaders at health plans and support their efforts to improve enrollees' experiences. While the basic content included in these reports may be the same, the specific content should differ because the purposes differ.

In reports intended for consumers, the goal is to provide information that people can use to assess and compare the performance of health plans and identify those that best meet their needs. Survey results are typically reported along with other measures of quality as well as information on costs and provider networks. For that reason, the presentation of CAHPS measures and scores must be concise and easily digestible. The use of composite measures rather than individual items is one way to avoid "information overload" among consumers.

Another strategy is to limit the number of patient experience measures in a report; all measures from the core survey are recommended for consumer reports, but the use of measures from any supplemental items should be carefully considered. Report sponsors have to weigh the trade-off between offering an array of performance scores and overwhelming consumers with more information than they can process.

For guidance on reporting results of the Health Plan Survey to consumers, refer to –

- Reporting Results to Consumers (AHRQ CAHPS Web site)
- TalkingQuality (AHRQ Web site)

A report intended for administrative and clinical leaders and other internal audiences must also be clear and concise, but can and should contain more information in order to support use of the results to identify relative strengths and weaknesses. These reports need to provide trend data (when available) and different kinds of comparators, such as local or State averages and percentiles. They can also provide a greater level of detail, such as results at the item level, results for any supplemental items, and the full range of survey responses (i.e., the percent that gave each possible response). These reports can include measures from supplemental items that did not achieve a high enough level of reliability at the suggested sample sizes to be recommended for public reporting. A high level of reliability is not necessary for a measure to provide useful information for quality improvement. With this information, health plans are equipped to analyze their performance and take steps towards improving their enrollees' experiences.

Learn more about improving enrollees' experiences.

Related resource: The CAHPS Ambulatory Care Improvement Guide

Appendix A: Measures for the Adult Survey

Organizations reporting the results of the CAHPS Health Plan Adult Survey can use the following labels and descriptions of the composite and rating measures in reports for consumers and other audiences.

Please note that the only difference between the Medicaid and commercial versions is the reference period: 6 months for Medicaid enrollees and 12 months for commercial enrollees.

Getting Needed Care

The survey asked enrollees how often it was easy for them to get appointments with specialists and get the care, tests, or treatment they needed through their health plan.

Q9	Easy for respondent to get necessary care, tests, or treatment	**Response Options** • Never • Sometimes • Usually • Always
Q18	Respondent got appointment with specialists as soon as needed	

Getting Care Quickly

The survey asked enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed.

Q4	Respondent got care for illness/injury as soon as needed	**Response Options** • Never • Sometimes • Usually • Always
Q6	Respondent got non-urgent appointment as soon as needed	

How Well Doctors Communicate

The survey asked enrollees how often their personal doctor explained things clearly, listened carefully, showed respect, and spent enough time with them.

Q12	Doctor explained things in a way that was easy to understand	**Response Options** • Never • Sometimes • Usually • Always
Q13	Doctor listened carefully to enrollee	
Q14	Doctor showed respect for what enrollee had to say	
Q15	Doctor spent enough time with enrollee	

Health Plan Customer Service

The survey asked enrollees how often customer service staff were helpful and treated them with courtesy and respect.

Q22	Customer service gave necessary information/help	**Response Options** • Never • Sometimes • Usually • Always
Q23	Customer service was courteous and respectful	

Enrollees' Ratings

The survey asked enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best.

Q8	Rating of all health care	**Response Options** • 0-10
Q16	Rating of personal doctor	
Q20	Rating of specialist	
Q26	Rating of health plan	

Appendix B: Measures for the Child Survey

Organizations reporting the results of the CAHPS Health Plan Child Survey can use the following labels and descriptions of the composite and rating measures in reports for consumers and other audiences.

Please note that the only difference between the Medicaid and commercial versions is the reference period: 6 months for Medicaid enrollees and 12 months for commercial enrollees.

Getting Needed Care

The survey asked enrollees how often it was easy for them to get appointments for their child with specialists and get the care, tests, or treatment the child needed through their health plan.

Q9	Easy for child to get necessary care, tests, or treatment	**Response Options** • Never • Sometimes • Usually • Always
Q21	Respondent got child an appointment with specialists as soon as needed	

Getting Care Quickly

The survey asked enrollees how often their child got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed.

Q4	Child got care for illness/injury as soon as needed	**Response Options** • Never • Sometimes • Usually • Always
Q6	Child got non-urgent appointment as soon as needed	

How Well Doctors Communicate

The survey asked enrollees how often their child's personal doctor explained things clearly both to the parent and to the child, listened carefully, showed respect, and spent enough time with the child.

Q12	Doctor explained things in a way that was easy to understand	**Response Options** • Never • Sometimes • Usually • Always
Q13	Doctor listened carefully to respondent	
Q14	Doctor showed respect for what respondent had to say	
Q16	Doctor explained things in a way that was easy for child to understand	
Q17	Doctor spent enough time with child	

Health Plan Customer Service

The survey asked enrollees how often customer service staff were helpful and treated them with courtesy and respect.

Q25	Customer service gave necessary information/help	**Response Options** • Never • Sometimes • Usually • Always
Q26	Customer service was courteous and respectful	

Enrollees' Ratings

The survey asked enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best.

Q8	Rating of all health care	**Response Options** • 0-10
Q19	Rating of personal doctor	
Q23	Rating of specialist	
Q29	Rating of health plan	

MEASURE PDENT-CH: PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.

Data Collection Method: Administrative (Form CMS-416)

Guidance for Reporting:

- CMS will calculate this measure for states based on data submitted as part of the annual EPSDT report (Form CMS-416). States are not asked, and will not be able to provide data for this measure.
- The denominator for this measure includes only individuals enrolled in a Medicaid program or a CHIP Medicaid expansion program for at least 90 continuous days during the federal fiscal year and eligible for EPSDT services.
- States with a separate CHIP program should report dental data in Section III.G of the CHIP Annual Report Template System (CARTS) report.
- Instructions for the Form CMS-416, including for the dental lines of the report, are available at https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf. The instructions for each dental line specify the provider type(s) relevant to that line. It is important to report only services delivered by the type(s) of providers specified for that line. Line 12b collects information on dental services (not oral health services), and this distinction relates to the type of provider who delivered the service (see Section B. Definitions).
- Report dental services provided to eligible children in all places of service, such as dental offices, federally qualified health centers, and schools.
- Include all paid, unpaid, and denied claims.

The following coding systems are used in this measure: CDT, CPT, and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Unduplicated	An individual may only be counted once.
Dental services	Services provided by or under the supervision of a dentist. Supervision is a spectrum and includes, for example, direct, indirect, general, collaborative or public health supervision as provided in the state's dental practice act. The most common examples of this are dentists themselves, and dental hygienists who are working under the supervision of dentists.
Oral health services	Services provided by any qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist. The most common examples of this are primary care medical providers and dental hygienists or dental therapists who are not working under the supervision of a dentist.

C. ELIGIBLE POPULATION

Age	Individuals ages 1 to 20 as of September 30 of the federal fiscal year.
Continuous enrollment	Eligible for EPSDT services for at least 90 continuous days during the federal fiscal year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The total unduplicated number of individuals ages 1 to 20 who have been continuously enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 days during the federal fiscal year and are eligible to receive EPSDT services.

Numerator

The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 - D1999 or equivalent CPT codes, that is, only those CPT codes that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

The numerator should be inclusive of services reimbursed directly by the state under fee-for-service, managed care, prospective payment, or any other payment arrangements, or through any other health or dental plans that contract with the state to provide services to Medicaid or CHIP Medicaid expansion beneficiaries, based on an unduplicated paid, unpaid, or denied claim.

Exclusions

Do not include in this count the following groups of individuals:

- Medically needy individuals ages 1 to 20 if your state does not provide EPSDT services for the medically needy population
- Individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available
- Undocumented aliens who are eligible only for emergency Medicaid services
- Children in separate state CHIP programs
- Groups of individuals ages 1 to 20 who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services).

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

SUMMARY OF CHANGES TO HEDIS 2020

- Updated the exclusions (step 4) for both rates.
- Clarified in the continuous enrollment criteria of Rate 2 how to handle members who switch between products.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
2. *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Definitions

Intake Period	The 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year.
Negative Medication History	A period of 120 days (4 months) prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation Phase	The 30 days following the IPSD.
C&M Phase	The 300 days following the IPSD (10 months).
New Episode	The member must have a 120-day (4-month) Negative Medication History on or before the IPSD.
Continuous Medication Treatment	The number of medication treatment days during the 10-month follow-up period must be ≥210 days (i.e., 300 treatment days – 90 gap days).
Treatment days (covered days)	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

Eligible Population: Rate 1—Initiation Phase

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines Commercial, Medicaid (report each product line separately).

Ages Six years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.

Continuous enrollment 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Allowable gap None.

Anchor date None.

Benefits Medical and pharmacy.

Event/diagnosis Follow the steps below to identify the eligible population for the Initiation Phase.

Step 1 Identify all children in the specified age range who were dispensed an ADHD medication (ADHD Medications List) during the 12-month Intake Period.

ADHD Medications

Description	Prescription		
CNS stimulants	• Amphetamine-dextroamphetamine • Dexmethylphenidate	• Dextroamphetamine • Lisdexamfetamine	• Methylphenidate • Methamphetamine
Alpha-2 receptor agonists	• Clonidine	• Guanfacine	
Miscellaneous ADHD medications	• Atomoxetine		

Step 2 Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Step 4 Exclude members who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 30 days after the IPSD. Either of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set).
- An acute inpatient discharge with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set). To identify an acute inpatient discharge:

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

Administrative Specification: *Rate 1—Initiation Phase*

Denominator The Rate 1 eligible population.

Numerator An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Value Set).
- A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set).

Note:

- *Do not count a visit on the IPSD as the Initiation Phase visit.*
- *Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).*

Eligible Population: *Rate 2—C&M Phase*

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines Commercial, Medicaid (report each product line separately).

Ages Six years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.

Continuous enrollment Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.

Members who switch product lines or products between the Rate 1 and Rate 2 continuous enrollment periods are only included in Rate 1. However, if an organization reports products combined, then a member who switches between those products (e.g., the products included in the HEDIS reporting entity) is included in both rates. For example, if an organization reports HMO and POS products combined and a member switches from HMO to POS between the

Rate 1 and Rate 2 continuous enrollment period, the member is included in both Rate 1 and Rate 2.

Allowable gap One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date None.

Benefits Medical and pharmacy.

Event/diagnosis Follow the steps below to identify the eligible population for the C&M Phase.

Step 1 Identify all members who meet the eligible population criteria for Rate 1—Initiation Phase.

Step 2 Calculate continuous enrollment. Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.

Step 3 Calculate the continuous medication treatment. Using the members in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSD. The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 90. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

Step 4 Exclude members who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 300 days (10 months) after the IPSD. Either of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set).
- An acute inpatient discharge with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set). To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.

Administrative Specification: *Rate 2—C&M Phase*

Denominator The Rate 2 eligible population.

Numerator Identify all members who meet the following criteria:

- Numerator compliant for *Rate 1—Initiation Phase,* ***and***
- At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD.

Only one of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) or a telehealth visit.

Identify follow-up visits using the code combinations below, then identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) on the claim.

Any of the following code combinations identify follow-up visits:

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Visit Value Set).
- A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set).
- A telephone visit (Telephone Visits Value Set).

Exclusions *(optional)*

Exclude from the denominator for both rates, members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year.

Note

- *For members who have multiple overlapping prescriptions, count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).*
- *Refer to Appendix 3 for the definition of prescribing practitioner.*
- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table ADD-1/2: Data Elements for Follow-Up Care for Children Prescribed ADHD Medication

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*Each of the 2 rates*
Number of optional exclusions	*Each of the 2 rates*
Numerator events by administrative data	*Each of the 2 rates*
Numerator events by supplemental data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS. HEDIS measures may not be adjusted for any NCQA program.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Follow-Up Care for Children Prescribed ADHD Medication

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed. ***Note:*** *This measure uses newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication; modifying the measurement period can affect other dates; however, the order and relationship of the events may not be changed.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	No, if applied	The optional exclusions are not required, but if they are used, only the specified exclusions may be applied and the value sets may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Initiation Phase	No	Value sets and logic may not be changed.
Continuation and Management Phase	Yes, with limits	Value sets and logic may not be changed. Timing of visit determination may be changed.

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Revised the measure description.
- Added a *Note* to the definition of "plan population" to clarify that it should be used as a denominator for the outlier rate.
- Removed "Risk Adjustment Tables" from the Definitions.
- Replaced references to "Table HCC-Surg" with references to the "Surgery Procedure Value Set" in the *Risk Adjustment Determination* section.
- Replaced references to "Table PCR-DischCC" with "Table CC_Mapping" in the *Risk Adjustment Determination* section.
- Updated the *Note* in the *Risk Adjustment Weighting* section for IHS that are discharged or transferred to skilled nursing care.
- Removed references to specific risk weight tables in the *Risk Adjustment Weighting* section.
- Clarified rounding rules in step 8 of the *Risk Adjustment Weighting* section.
- Revised the data element tables to separate the Medicaid and commercial product lines from the Medicare product line.

Description

For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Note: *For commercial and Medicaid, report only members 18–64 years of age.*

Definitions

HIS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 3 (required exclusions) of the numerator.

Plan population

Members who meet all of the following criteria:

- 18 and older as of January 1 of the measurement year.
- Continuously enrolled for at least 395 days, with no more than one gap in enrollment of up to 45 days during the 395-day period, between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Assign members to the product and product line at the start of this defined continuous enrollment period.

Note: *The plan population is only used as a denominator for the Outlier Rate.*

Outlier

Medicaid and Medicare members in the eligible population with four or more index hospital stays between January 1 and December 1 of the measurement year.

Commercial members in the eligible population with three or more index hospital stays between January 1 and December 1 of the measurement year.

Assign members who transition between product lines during the measurement year to the product they were enrolled in on January 1 of the measurement year. If the member is an outlier and has a gap on January 1 of the measurement year, the member is assigned to the product line based on their last enrollment segment prior to January 1.

Nonoutlier

Members in the plan population who are not considered outliers.

Classification period

365 days prior to and including an Index Discharge Date.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Refer to General Guideline 10: Reporting for small denominator limits.

Product line stratification

Commercial, Medicare, Medicaid (report each product line separately).

For only Medicare IHS, report the following SES stratifications and total:

- Non-LIS/DE, Nondisability.
- LIS/DE.
- Disability.
- LIS/DE and Disability.
- Other.
- Unknown.
- Total Medicare.

Note: *The stratifications are mutually exclusive and the sum of all six stratifications is the Total population.*

Ages	*For commercial,* ages 18–64 as of the Index Discharge Date. *For Medicare,* ages 18 and older as of the Index Discharge Date. *For Medicaid,* ages 18–64 as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/diagnosis	An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all acute inpatient or observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.

Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient and observation stay discharges:

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

Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.

The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Guidelines for Risk Adjusted Utilization Measures.*

Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 Exclude hospital stays for the following reasons:

- The member died during the stay.
- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 5 Calculate continuous enrollment.

Step 6 Remove hospital stays for outlier members and report these members as outliers in Table PCR-1/2/3.

Note: *Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier members.*

Step 7 Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.

Risk Adjustment Determination

For each IHS among nonoutlier members, use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age and gender.

Observation Stay Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.

Surgeries Determine if the member underwent surgery during the stay (Surgery Procedure Value Set). Consider an IHS to include a surgery if at least one procedure code is present from any provider between the admission and discharge dates.

Discharge Condition Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table CC_Mapping. For direct transfers, use the primary discharge diagnosis from the last discharge.

Exclude diagnoses that cannot be mapped to Table CC_Mapping.

Comorbidities Refer to the *Risk Adjustment Comorbidity Category Determination* in the *Guidelines for Risk Adjusted Utilization Measures.*

Risk Adjustment Weighting

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, comorbidity, age and gender. Weights are specific to product line (Medicare Under 65, Medicare 65+, commercial, Medicaid). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

Note: *For Medicare product lines, IHS that are discharged or transferred to skilled nursing care should be assigned two sets of risk adjustment weights; the skilled nursing care risk weights for reporting in Table PCR-E-3 and the standard set of risk weights for reporting in Table PCR-C-3 and Table PCR-D-3. For reporting IHS that are discharged or transferred to skilled nursing care, do not assign the skilled nursing care risk weights for the stays when reporting in Table PCR-C-3 and Table PCR-D-3 and do not assign the standard set or risk weights for the stays when reporting in Table PCR-E-3.*

Step 1 For each IHS discharge that is an observation stay, link the observation stay IHS weight.

Step 2 For each IHS with a surgery, link the surgery weight.

Step 3 For each IHS with a discharge CC Category, link the primary discharge weights.

Step 4 For each IHS with a comorbidity HCC Category, link the comorbidity weights.

Step 5 Link the age and gender weights for each IHS.

Step 6 Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, primary discharge diagnosis, comorbidities, age and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS:

$$\text{Estimated Readmission Risk} = \frac{e^{(\sum \text{WeightsForIHS})}}{1+e^{(\sum \text{WeightsForIHS})}}$$

OR

Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)]

Note: *"Exp" refers to the exponential or antilog function.*

Step 7 Calculate the Count of Expected Readmissions for each age and stratification category. The Count of Expected Readmissions is the sum of the Estimated Readmission Risk calculated in step 6 for each IHS in each age and stratification category.

$$Count\ of\ Expected\ Readmissions = \sum (\text{Estimated Readmission Risk})$$

Step 8 Use the formula below and the Estimated Readmission Risk calculated in step 6 to calculate the variance for each IHS.

Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk)

Example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

Note: *When calculating variance at the IHS level, do not round. Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.*

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient and observation admissions:

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

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Guidelines for Risk Adjusted Utilization Measures.*

Step 3 Exclude acute hospitalizations with any of the following criteria on the discharge claim:

- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
- Planned admissions using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set).
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 4 For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Note: *Count each acute hospitalization only once toward the numerator for the last denominator event.*

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

- *Acute inpatient stay 1: May 1–10.*
- *Acute inpatient stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).*
- *Acute inpatient stay 3: May 30–June 5.*

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only toward the last denominator event (Stay 2, May 15–25).

Reporting: Number of Members in Plan Population

Step 1 Determine the member's age as of January 1 of the measurement year.

Step 2 Report the count of members in the plan population for each age group and the overall total. Enter these values in reporting Tables PCR-1/2 and PCR-A-3.

Reporting: Number of Outliers

Step 1 Determine the member's age as of January 1 of the measurement year.

Step 2 Report the count of outlier members for each age group and the overall total. Enter these values in reporting Tables PCR-1/2 and PCR-A-3.

Calculated: Outlier Rate

The number of outlier members divided by the number of members in the plan population, displayed as a permillage (multiplied by 1,000), for each age group and the overall totals calculated by IDSS.

Reporting: Denominator

Count the number of IHS among nonoutlier members for each age group and enter these values into the reporting table under Count of Index Stays.

Reporting: SES Stratification (Medicare only)

Step 1 Determine the member's SES stratifications as of the end of the continuous enrollment period for each Medicare discharge:

- *Non-LIS/DE, Nondisability:* Member is eligible for Medicare due to age only (does not receive LIS, is not DE for Medicaid, does not have disability status).
- *LIS/DE:* Member is eligible for Medicare due to age and receives LIS (includes members eligible for Medicare due to DE), does not have disability status.
- *Disability*: Member is eligible for Medicare due to disability status only.
- *LIS/DE and Disability:* Member is eligible for Medicare, receives LIS and has disability status.
- *Other:* Member has ESRD-only status or is assigned "9—none of the above."
- *Unknown:* Member's SES is unknown.
- *Total Medicare:* Total of all categories.

Step 2 Report Medicare discharges based on the SES stratification assigned for each Medicare index stay in Table PCR-D-3.

Reporting: Skilled Nursing Care Stratification (Medicare only)

Step 1 For Medicare nonoutlier members, determine if the IHS was discharged or transferred to skilled nursing care (Skilled Nursing Stay Value Set).

An index stay is discharged or transferred to skilled nursing care when the discharge date from the acute inpatient or observation stay precedes the admission date for skilled nursing care by one calendar day or less. For example:

- An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 1, is an IHS discharged or transferred to skilled nursing care.
- An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 2, is an IHS discharged or transferred to skilled nursing care.
- An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 3, is not an IHS discharged or transferred to skilled nursing care.

Step 2 Report Medicare discharges for each IHS discharged or transferred to skilled nursing care to an age group in Table PCR-E-3.

Reporting: Numerator

Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and enter these values into the reporting tables under Count of Observed 30-Day Readmissions.

Calculated: Observed Readmission Rate

The Count of Observed 30-Day Readmissions divided by the Count of Index Stays calculated by IDSS.

Reporting: Count of Expected 30-Day Readmissions

Step 1 Calculate the Count of Expected Readmissions among nonoutlier members for each age group and overall total.

Step 2 Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting tables.

Calculated: Expected Readmission Rate

The Count of Expected 30-Day Readmissions divided by the Count of Index Stays calculated by IDSS.

Reporting: Variance

Step 1 Calculate the total (sum) variance for each SES stratification (Medicare only), skilled nursing stratification (Medicare only) and age group.

Step 2 Round to four decimal places using the .5 rule and enter the variance into the reporting tables.

Calculated: O/E Ratio

The Count of Observed 30-Day Readmissions divided by the Count of Expected 30-Day Readmissions calculated by IDSS.

Note

- *Supplemental data may not be used for this measure.*

Table PCR-1/2: Plan Population and Outlier Rate (Medicaid, Commercial, 18-64)

Age	Members in Plan Population	Outlier Members	Outlier Rate
18-44			
45-54			
55-64			
18-64 Total			

Table PCR-A-3: Plan Population and Outlier Rate (Medicare, 18+)

Age	Members in Plan Population	Outlier Members	Outlier Rate
18-44			
45-54			
55-64			
65-74			
75-84			
85+			
18-64 Total			
65+ Total			

Table PCR-B-1/2: Plan All-Cause Readmissions Rates Among Nonoutlier Members by Age (Medicaid, Commercial, 18–64)

Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
18-44							
45-54							
55-64							
18-64 Total							

Table PCR-C-3: Plan All-Cause Readmissions Rates Among Nonoutlier Members by Age (Medicare, 18+)

Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
18-44							
45-54							
55-64							
65-74							
75-84							
85+							
18-64 Total							
65+ Total							

Table PCR-D-3: Plan All-Cause Readmissions Rates Among Nonoutlier Members by SES Stratification (Medicare, 18+)

SES Stratification	Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
Non-LIS/ DE, Non-disability	18-64							
	65+							
LIS/DE	18-64							
	65+							
Disability	18-64							
	65+							
LIS/DE and Disability	18-64							
	65+							
Other	18-64							
	65+							
Unknown	18-64							
	65+							

Table PCR-E-3: Plan All-Cause Readmissions Rates Among Nonoutlier Members Discharged or Transferred to Skilled Nursing Care by Age (Medicare, 18+)

Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
18-44							
45-54							
55-64							
65-74							
75-84							
85+							
18-64 Total							
65+ Total							

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

NQF Endorsement Status	Not Endorsed
NQF ID	9999
Measure Type	Outcome
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	This measure is a re-specified version of the measure, “Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any condition” (NQF 1789), which was developed for patients 65 years and older using Medicare claims. This re-specified measure attributes outcomes to MIPS participating clinician groups and assesses each group’s readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology.
Numerator	The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as a subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. Any readmission is eligible to be counted as an outcome, except those that are considered planned. To align with data years used, the planned readmission algorithm version 4.0 was used to classify readmissions as planned or unplanned
Denominator	Patients eligible for inclusion in the measure have an index admission hospitalization to which the readmission outcome is attributed and includes admissions for patients: Enrolled in Medicare Fee-For-Service (FFS) Part A for the 12 months prior to the date of admission; Aged 65 or over; Discharged alive from a non-federal short-

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

	term acute care hospital; and, Not transferred to another acute care facility.
Denominator Exclusions	1. Patients discharged against medical advice (AMA) are excluded. 2. Admissions for patients to a PPS-exempt cancer hospital are excluded. 3. Admissions primarily for medical treatment of cancer are excluded. 4. Admissions primarily for psychiatric disease are excluded. 5. Admissions for “rehabilitation care; fitting of prostheses and adjustment devices” (CCS 254) are excluded. 6. Admissions where patient cannot be attributed to a clinician group.
Rationale	This risk-adjusted administrative claims measure was proposed to address unplanned readmissions at the physician group level of Medicare aged > 65 patients. This measure is a re-specified version of the hospital-level measure, “Hospital-Wide All-Cause, Unplanned Readmission Measure” (NQF #1789), which has been in the MIPS program since 2017. In the event we did not finalize this measure, we would have maintained the current measure Q458: All-Cause Hospital Readmission. The respecification of this measure promotes a systems-level approach by clinicians and focus on high-risk conditions, such as COPD and heart failure. The measure was evaluated by the MAP and was conditionally supported pending NQF endorsement. While we agreed with the MAP that NQF endorsement of measures is preferred, NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus as required in section 1848(q)(2)(D)(v) of the Act. A riskadjusted readmission rate of 15.3 percent at the physician group level was provided by the measure developer. The readmission rate indicates a substantial need to reduce the expected rate and variation of rates across eligible physician groups. Physician groups have the capability to influence unplanned readmission outcomes by appropriate medication reconciliation at discharge, reduction of infection risk, and ensuring proper outpatient follow-up. As an administrative claims measure, there is no separate reporting burden. To maintain continuity with the existing measure Q458: All-

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

	Cause Hospital Readmission, the case minimum will remain at 200 cases for consistency in implementation. For 2023 payment determination, the performance period will include administrative claims from January 1, 2021 to December 31, 2021. For further information regarding the implementation of this measure, please see section IV.A.3.c.(1)(e)(i) of this final rule.
Evidence	Not Available

Developer/Steward

Steward	Centers for Medicare & Medicaid Services (CMS)
Contact	Not Available
Measure Developer	Not Available
Development Stage	Fully Developed

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Admissions and Readmissions to Hospitals
Healthcare Priority	Promote Effective Communication & Coordination of Care
eCQM Spec Available	No
NQF Endorsement Status	Not Endorsed
NQF ID	9999
Last NQF Update	Not Available
Target Population Age	65+
Target Population Age (High)	Not Available

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

Target Population Age (Low)	65
Reporting Level	Accountable Care Organization
Conditions	Not Available
Subconditions	Not Available
Care Settings	Hospital/Acute Care Facility

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier
qpp quality id	479
ACO	8

Measure Links

Measure Program: Medicare Shared Savings Program

Info As Of	Not Available
Program / Model Notes	
Data Sources	Claims Data
Purposes	Not Available
Quality Domain	Communication and Care Coordination
Reporting Frequency	Not Available

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2021-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about

Milestones

Milestone: Implemented

Effective Date	2012-04-01
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2011-11-02/pdf/2011-27461.pdf

Milestone: Finalized

Effective Date	2011-11-02
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2011-11-02/pdf/2011-27461.pdf