Connecticut Quality Council
2022 Annual Review of the Core Measure Set
April 21, 2022 Meeting
Measure Specifications

Supplemental Items for the CAHPS® Clinician & Group Survey 3.0

Topic: People with Mobility Impairments
Population Version: Adult
Language: English

Users of the CAHPS® Clinician & Group Survey are free to incorporate supplemental items in order to meet the needs of their organizations, local markets, and/or audiences. Some items cover events that occur with low frequency in the general population. You should include them only if your sample design is likely to yield a sufficient number of responses to those questions for statistical analysis and reporting.

Learn more about CAHPS supplemental items.

C-IM1.	In the last 6 months, when you visited this provider's office, how often were you examined on the examination table? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After core question 20
C-IM2.	In the last 6 months, when you visited this provider's office, how often did someone weigh you? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After C-IM1
C-IM3.	In the last 6 months, when you visited this provider's office, did you try to use the restroom? 1☐ Yes 2☐ No→ **If No, go to C-IM5**	After C-IM2
C-IM4.	In the last 6 months, how often was it easy to move around the restroom at this provider's office? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After C-IM3 Note: Use with C-IM3
C-IM5.	In the last 6 months, how often did pain limit your ability to do the things you needed to do? 1☐ Never→ **If Never, go to C-IM7** 2☐ Sometimes 3☐ Usually 4☐ Always	After C-IM4
C-IM6.	In the last 6 months, did this provider ask about the impact of pain on your life? 1☐ Yes 2☐ No	After C-IM5 Note: Use with C-IM5

C-IM7.	In the last 6 months, how often did fatigue limit your ability to do the things you needed to do? 1☐ Never→ **If Never, go to core question 21** 2☐ Sometimes 3☐ Usually 4☐ Always	After C-IM6
C-IM8.	In the last 6 months, did this provider ask about the impact of fatigue on your life? 1☐ Yes 2☐ No	After C-IM7 Note: Use with C-IM7
C-IM9.	A quarter mile is about 5 city blocks or 0.4 kilometers. In the last 6 months, were you able to walk that far? 1☐ Yes 2☐ No→ **If No, go to core question 25**	After core question 24
C-IM10.	In the last 6 months, did you have difficulty or need assistance walking that far? 1☐ Yes 2☐ No	After C-IM9 Note: Use with C-IM9

Supplemental Items for the CAHPS® Health Plan Survey 5.0

Topic: People with Mobility Impairments
Population Version: Adult
Language: English

Users of the CAHPS® Health Plan Survey are free to incorporate supplemental items in order to meet the needs of their organizations, local markets, and/or audiences. Some items cover events that occur with low frequency in the general population. You should include them only if your sample design is likely to yield a sufficient number of responses to those questions for statistical analysis and reporting.

Learn more about CAHPS supplemental items.

P-IM1.	In the last 12 months, did you visit your personal doctor for care? 1☐ Yes 2☐ No→ **If No, go to core question 17**	After core question 16 Note: Use P-IM1 if using P-IM2-IM9
P-IM2.	In the last 12 months, when you visited your personal doctor's office, how often were you examined on the examination table? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After P-IM1 Note: Use with P-IM1
P-IM3.	In the last 12 months, when you visited your personal doctor's office, how often did someone weigh you? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After P-IM2 Note: Use with P-IM1
P-IM4.	In the last 12 months, when you visited your personal doctor's office, did you try to use the restroom? 1☐ Yes 2☐ No→ **If No, go to P-IM6**	After P-IM3 Note: Use with P-IM1
P-IM5.	In the last 12 months, how often was it easy to move around the restroom at your personal doctor's office? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After P-IM4 Note: Use with P-IM4
P-IM6.	In the last 12 months, how often did pain limit your ability to do the things you needed to do? 1☐ Never→ **If Never, go to P-IM8** 2☐ Sometimes 3☐ Usually 4☐ Always	After P-IM5 Note: Use with P-IM1

P-IM7.	In the last 12 months, did your personal doctor ask about the impact of pain on your life? [1] ☐ Yes [2] ☐ No	After P-IM6 Note: Use with P-IM6
P-IM8.	In the last 12 months, how often did fatigue limit your ability to do the things you needed to do? [1] ☐ Never→ **If Never, go to core question 17** [2] ☐ Sometimes [3] ☐ Usually [4] ☐ Always	After P-IM7 Note: Use with P-IM1
P-IM9.	In the last 12 months, did your personal doctor ask about the impact of fatigue on your life? [1] ☐ Yes [2] ☐ No	After P-IM8 Note: Use with P-IM8
P-IM10.	In the last 12 months, did you need physical or occupational therapy? [1] ☐ Yes [2] ☐ No→ **If No, go to P-IM12**	After core question 26
P-IM11.	In the last 12 months, how often was it easy to get this kind of therapy? [1] ☐ Never [2] ☐ Sometimes [3] ☐ Usually [4] ☐ Always	After P-IM10 Note: Use with P-IM10
P-IM12.	In the last 12 months, did you need speech therapy? [1] ☐ Yes [2] ☐ No→ **If No, go to P-IM14**	After P-IM11
P-IM13.	In the last 12 months, how often was it easy to get speech therapy? [1] ☐ Never [2] ☐ Sometimes [3] ☐ Usually [4] ☐ Always	After P-IM12 Note: Use with P-IM12

P-IM14. Mobility equipment includes things like a wheelchair, scooter, walker, or cane. In the last 12 months, have you used any mobility equipment? 1☐ Yes 2☐ No→ **If No, go to core question 27**	After P-IM13
P-IM15. In the last 12 months, did you try to get your mobility equipment repaired? 1☐ Yes 2☐ No→ **If No, go to P-IM17**	After P-IM14 Note: Use with P-IM14
P-IM16. In the last 12 months, how often was it easy to get your mobility equipment repaired? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After P-IM15 Note: Use with P-IM15
P-IM17. In the last 12 months, did you try to get or replace any mobility equipment? 1☐ Yes 2☐ No→ **If No, go to core question 27**	After P-IM16 Note: Use with P-IM14
P-IM18. In the last 12 months, how often was it easy to get or replace the mobility equipment that you needed? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After P-IM15 Note: Use with P-IM17
P-IM19. A quarter mile is about 5 city blocks or 0.4 kilometers. In the last 12 months, were you able to walk that far? 1☐ Yes 2☐ No→ **If No, go to core question 33**	After core question 32
P-IM20. In the last 12 months, did you have difficulty or need assistance walking that far? 1☐ Yes 2☐ No	After P-IM19 Note: Use with P-IM19

Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Transfer of Health Information and Interoperability

2022 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients with a referral during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure for the patients for whom a referral was made during the performance period based on the services provided and the measure-specific denominator coding. The provider who refers the patient to another provider is the provider who should be held accountable for the performance of this measure. All MIPS eligible professionals or eligible clinicians reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, all MIPS eligible professionals or eligible clinicians who refer patients towards the end of the performance period (i.e., November - December), should request that providers to whom they referred their patients share their consult reports as soon as possible in order for those patients to be counted in the measure numerator during the performance period. When providers to whom patients are referred communicate the consult report as soon as possible with the referring providers, it ensures that the communication loop is closed in a timely manner and that the data is included in the submission to CMS.

NOTE: *Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
Number of patients, regardless of age, who had a visit during the measurement period and were referred by one provider to another provider

> ***DENOMINATOR NOTE*:** *If there are multiple referrals for a patient during the performance period, use the first referral.*
>
> **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*
>
> **Denominator Criteria (Eligible Cases):**

Patients regardless of age on the date of the encounter

AND

Patient encounter during the performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*

AND

Patient was referred to another provider or specialist during the performance period: G9968

NUMERATOR:

Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred

Definitions:

Referral – A request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient's condition. This term encompasses "referral" and consultation as defined by Centers for Medicare & Medicaid Services.

Report – A written document prepared by the eligible clinician (and staff) to whom the patient was referred and that accounts for his or her findings, provides summary of care information about findings, diagnostics, assessments and/or plans of care, and is provided to the referring eligible clinician.

NUMERATOR NOTE: *The consultant report that will successfully close the referral loop should be related to the first referral for a patient during the measurement period. If there are multiple consultant reports received by the referring provider which pertain to a particular referral, use the first consultant report to satisfy the measure.*

The provider to whom the patient was referred is responsible for sending the consultant report that will fulfill the communication. Note: this is not the same provider who would report on the measure.

Numerator Options:

Performance Met:	Provider who referred the patient to another provider received a report from the provider to whom the patient was referred **(G9969)**
OR	
Performance Not Met:	Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred **(G9970)**

RATIONALE:

Problems in the outpatient referral and consultation process have been documented, including lack of timeliness of information and inadequate provision of information between the specialist and the requesting physician (Gandhi et al., 2000; Forrest et al., 2000; Stille et al., 2005). In a study of physician satisfaction with the outpatient referral process, Gandhi et al. (2000) found that 68% of specialists reported receiving no information from the primary care provider prior to referral visits, and 25% of primary care providers had still not received any information from specialists 4 weeks after referral visits. In another study of 963 referrals (Forrest et al., 2000), pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialists in only 51% of the time.

In a 2006 report to Congress, the Medicare Payment Advisory Commission (MedPAC) found that care coordination programs improved quality of care for patients, reduced hospitalizations, and improved adherence to evidence-based care guidelines, especially among patients with diabetes and CHD. Associations with cost-savings were less clear; this was attributed to how well the intervention group was chosen and defined, as well as the intervention put in place. Additionally, cost-savings were usually calculated in the short-term, while some argue that the greatest cost-savings accrue over time (MedPAC, 2006).

Improved mechanisms for information exchange could facilitate communication between providers, whether for time-limited referrals or consultations, on-going co-management, or during care transitions. For example, a study by Branger, van't Hooft, van der Wouden, Moorman & van Bemmel (1999) found that an electronic communication network that linked the computer-based patient records of physicians who had shared care of patients with diabetes significantly increased frequency of communications between physicians and availability of important clinical data. There was a 3-fold increase in the likelihood that the specialist provided written communication of results if the primary care physician scheduled appointments and sent patient information to the specialist (Forrest et al., 2000).

Care coordination is a focal point in the current health care reform and our nation's ambulatory health information technology (HIT) framework. The National Priorities Partnership (2008) recently highlighted care coordination as one of the most critical areas for development of quality measurement and improvement.

CLINICAL RECOMMENDATION STATEMENTS:
None

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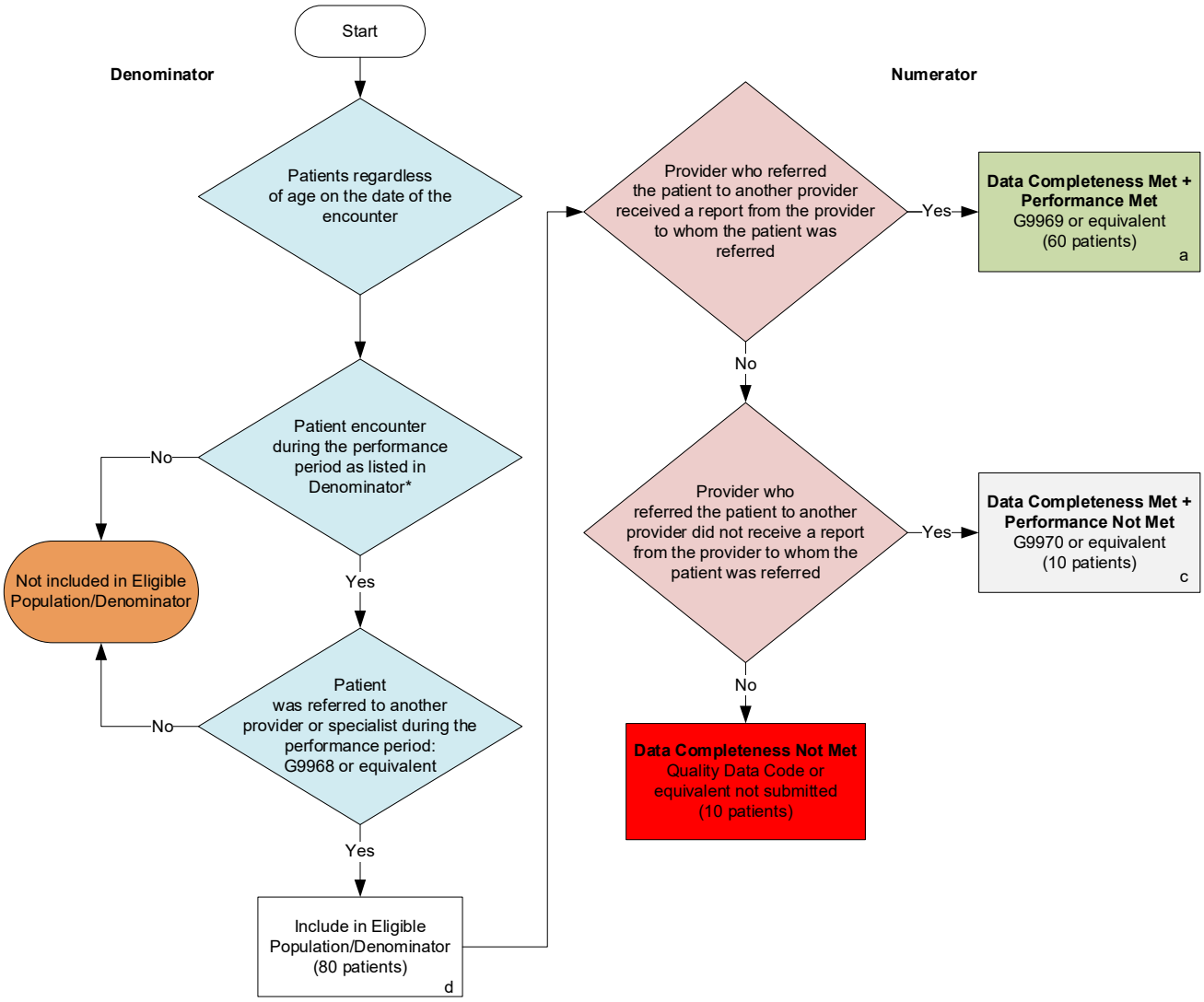
These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.

2022 Clinical Quality Measure Flow for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a=60 patients) + Performance Not Met (c=10 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a=60 patients) = 60 patients = **85.71%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

v6

2022 Clinical Quality Measure Flow Narrative for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. *Patients regardless of age on the date of the encounter*
3. Check *Patient encounter during the performance period as listed in Denominator*:*
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Patient was referred to another provider or specialist during the performance period.*
4. Check *Patient was referred to another provider or specialist during the performance period*:
    a. If *Patient was referred to another provider or specialist during the performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient was referred to another provider or specialist during the performance period* equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
6. Start Numerator
7. Check *Provider who referred the patient to another provider received a report from the provider to whom the patient was referred*:
    a. If *Provider who referred the patient to another provider received a report from the provider to whom the patient was referred* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 60 patients in the Sample Calculation.
    b. If *Provider who referred the patient to another provider received a report from the provider to whom the patient was referred* equals No, proceed to check *Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred.*
8. Check *Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred:*
    a. If *Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred* equals Yes, include in *Data Completeness Met and Performance Not Met.*
        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 10 patients in the Sample Calculation.

b. If *Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred* equals No, proceed to *Data Completeness Not Met.*

9. Check *Data Completeness Not Met:*

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 60 patients) plus Performance Not Met (c equals 10 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 60 patients) divided by Data Completeness Numerator (70 patients). All equals 60 patients divided by 70 patients. All equals 85.71 percent.

* See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

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

SUMMARY OF CHANGES FOR HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Eligible Population

Product lines Medicare.

Ages 18 years and older as of the ED visit. Report two age stratifications and a total rate:

- 18–64 years.
- 65 years and older.
- Total.

Continuous enrollment 365 days prior to the ED visit through 7 days after the ED visit.

Allowable gap No more than one gap in enrollment of up to 45 days during the 365 days prior to the ED visit and no gap during the 7 days following the ED visit.

Anchor date None.

Benefits Medical.

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

Step 1 An ED visit (ED Value Set) on or between January 1 and December 24 of the measurement year where the member was 18 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all ED visits between January 1 and December 24 of the measurement year.

Step 2: Exclusions Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting:

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

These events are excluded from the measure because admission to an acute or nonacute setting may prevent an outpatient follow-up visit from taking place.

Step 3: Eligible chronic condition diagnoses

Identify ED visits where the member had a chronic condition prior to the ED visit.

The following are eligible chronic condition diagnoses. Each bullet indicates an eligible chronic condition (for example, COPD and asthma are considered the same chronic condition):

- COPD and asthma (COPD Diagnosis Value Set; Asthma Diagnosis Value Set; Unspecified Bronchitis Value Set).
- Alzheimer's disease and related disorders (Dementia Value Set; Frontotemporal Dementia Value Set).
- Chronic kidney disease (Chronic Kidney Disease Value Set).
- Depression (Major Depression Value Set; Dysthymic Disorder Value Set).
- Heart failure (Chronic Heart Failure Value Set; Heart Failure Diagnosis Value Set).
- Acute myocardial infarction (MI Value Set).
- Atrial fibrillation (Atrial Fibrillation Value Set).
- Stroke and transient ischemic attack (Stroke Value Set).
  - Exclude any visit with a principal diagnosis of encounter for other specified aftercare (Stroke Exclusion Value Set).
  - Exclude any visit with any diagnosis of concussion with loss of consciousness or fracture of vault of skull, initial encounter (Other Stroke Exclusions Value Set).

Using the eligible chronic condition diagnoses above, identify members who had any of the following during the measurement year or the year prior to the measurement year, **but prior to the ED visit** (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an eligible chronic condition. Visit type need not be the same for the two visits, but the visits must be for the same eligible chronic condition*.* To identity a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with an eligible chronic condition.
- At least one acute inpatient discharge with an eligible chronic condition on the discharge claim. 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.

For each ED visit, identify the total number of chronic conditions the member had prior to the ED visit.

Step 4: Identifying members with multiple chronic conditions Identify ED visits where the member had **two or more** different chronic conditions prior to the ED visit, that meet the criteria included in step 3. These are eligible ED visits.

Step 5: Multiple visits in 8-day period If a member has more than one ED visit in an 8-day period, include only the first eligible ED visit. For example, if a member has an eligible ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 8. Then, if applicable, include the next eligible ED visit that occurs on or after January 9. Identify visits chronologically, including only one visit per 8-day period.

Required exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator

7-Day Follow-Up A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. The following meet criteria for follow-up:

- An outpatient visit (Outpatient Value Set).
- A telephone visit (Telephone Visits Value Set).
- Transitional care management services (Transitional Care Management Services Value Set).
- Case management visits (Case Management Encounter Value Set).
- Complex Care Management Services (Complex Care Management Services Value Set).
- An outpatient or telehealth behavioral health visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set).
- An outpatient or telehealth behavioral health visit (BH Outpatient 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).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set).
- An observation visit (Observation Value Set).
- A substance use disorder service (Substance Use Disorder Services Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits 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 required period for the rate (within 7 days after the ED visit).*

Data Elements for Reporting

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

Table FMC-3: Data Elements for Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions

Metric	Age	Data Element	Reporting Instructions
FollowUp7Day	16-64	EligiblePopulation	For each Stratification
	65+	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

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.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions

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"). Expanding 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	Organizations are not required to use a benefit; 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 value sets may be used to identify visits with a diagnosis. The value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with multiple high-risk chronic conditions, who had a follow-up visit within 7 days).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	These exclusions are part of the eligible population criteria.
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
7-Day Follow-Up	No	Value sets and logic may not be changed.

Appendix B: Social Risk Factor Screening Measures

This appendix contains the current specifications for screening measures used in Massachusetts, North Carolina, and Rhode Island.

Massachusetts

Measure Name: Health-Related Social Needs Screening
Steward: Massachusetts EOHHS
NQF #: -

Description

The Health-Related Social Needs Screening (HRSN) is conducted to identify members who would benefit from receiving community services to address health-related social needs that include but are not limited to housing stabilization services, housing search and placement, utility assistance, transportation, and food insecurity.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	ACO-attributed members 0 to 64 years of age as of December 31st of the measurement year
Continuous enrollment	The measurement year
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year
Anchor date	December 31st of the measurement year
Lookback period	12 months
Event/diagnosis	None
Exclusions	Members in hospice (Hospice Value Set)

Specifications

The percentage of ACO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.

Data Source	Clinical data
Data Collection Method	Sample
Denominator	A systematic sample drawn from the eligible population
Numerator	ACO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.
Unit of Measurement	Individual
Setting of the Screen	Clinical and nonclinical settings

Documentation requirements	To satisfy the measure requirements a member must have received one Health-Related Social Needs Screening during the measurement year. Results from an HRSN screening tool must be present in the member's health record in the measurement year and be readily accessible to the primary care provider. The screen may be completed by any member of the ACO care team. The screening may be completed over the phone, electronically, in-person, by mail, or by any other means approved by EOHHS. The numerator is met if the member's health record (as defined above) contains a completed Health-Related Social Needs screening tool which includes: a. All four (4) core domains, and b. At least 1 supplemental domain The following information must be reported to EOHHS for the purpose of measure performance calculation: Was an HRSN screening completed (including 4 core domains and 1 supplemental domain) (Y/N) Name of Screening Tool Source of Information (Mail, Phone, Email, In-person, Other) Was a need identified for each of the following domains? (Y/N/Unclear)
Approved Screening Tools	EOHHS must approve the screening tool. The screening may be completed over the phone, electronically, in-person, by mail, or by any other means approved by EOHHS.
Required Domains	**Core Domains:** The following domains must be completed and *results must be reported to EOHHS* in order to satisfy the measure: 1. Food 2. Housing 3. Transportation 4. Utility **Supplemental Domains:** At least one of the following domains must be completed: 5. Employment, training, or education 6. Experience of Violence 7. Social Supports

Oral Evaluation, Dental Services (OED)

SUMMARY OF CHANGES TO HEDIS MY 2023

- First-year measure.

Description

The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Eligible Population

Product line	Medicaid.
Ages	Under 21 years as of December 31 of the measurement year. Report four age stratifications and a total rate: • 0–2 years • 3–5 years. • 6–14 years. • 15–20 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	180 days during the measurement year.
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	None.
Required exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator	The eligible population.
Numerator[1]	A comprehensive or periodic oral evaluation with a dental provider during the measurement year (Oral Evaluation Value Set ***with*** NUCC Provider Taxonomy Value Set).

[1] The NCQA Value Set Directory includes Current Dental Terminology (CDT) codes, © 2022 American Dental Association. All rights reserved.
Use of the CDT codes by NCQA, including inclusion in HEDIS, is contingent on NCQA and the ADA/DQA entering into an appropriate license agreement.

Data Elements for Reporting

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

Table OED-1: Data Elements for Oral Evaluation, Dental Services

Metric	Age Stratification	Data Element	Reporting Instructions
OralEvaluationDentalServices	0-2	Benefit	Metadata
	3-5	EligiblePopulation	For each Stratification
	6-14	ExclusionAdminRequired	For each Stratification
	15-20	NumeratorByAdmin	For each Stratification
	Total	Rate	(Percent)

PERSON-CENTERED PRIMARY CARE MEASURE

v 2.1-ENG

HOW WOULD YOU ASSESS YOUR PRIMARY CARE EXPERIENCE?	
My practice makes it easy for me to get care.	Definitely Mostly Somewhat Not at all
My practice is able to provide most of my care.	Definitely Mostly Somewhat Not at all
In caring for me, my doctor considers all factors that affect my health.	Definitely Mostly Somewhat Not at all
My practice coordinates the care I get from multiple places.	Definitely Mostly Somewhat Not at all
My doctor or practice knows me as a person.	Definitely Mostly Somewhat Not at all
My doctor and I have been through a lot together.	Definitely Mostly Somewhat Not at all
My doctor or practice stands up for me.	Definitely Mostly Somewhat Not at all
The care I get takes into account knowledge of my family.	Definitely Mostly Somewhat Not at all
The care I get in this practice is informed by knowledge of my community.	Definitely Mostly Somewhat Not at all
Over time, my practice helps me to stay healthy.	Definitely Mostly Somewhat Not at all
Over time, my practice helps me to meet my goals.	Definitely Mostly Somewhat Not at all

Appendix B: SDOH Screening Measure Specifications

Social Determinants of Health (SDOH) Screening
Steward: Rhode Island Executive Office of Health and Human Services
As of February 14, 2022

SUMMARY OF CHANGES FOR 2022 (PERFORMANCE YEAR 5)

- Updated to add one SNOMED code to the list of code list to identify patients in hospice.

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[89]

The percentage of attributed patients who were screened for Social Determinants of Health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

Eligible Population

Note: *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Allowable gap	No break in coverage lasting more than 30 days.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Benefit	Medical

Event/diagnosis	• The patient has been seen by an AE/ACO-affiliated primary care clinician anytime within the last 12 months
	• For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel.
	• Follow the below to determine a primary care visit:
	  ○ The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496
	  ○ The following are the eligible telephone visit, e-visit or virtual check-in codes for determining a primary care

[89] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 3/18/19.

	visit: ▪ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following POS codes: 02 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following modifiers: 95, GT
Exclusions	• Patients in hospice care (see Code List below) • Refused to participate

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[90]

Electronic Data Specifications

The percentage of attributed patients who were screened for Social Determinants of Health using an EOHHS-approved screening tool, where the primary care practice has documentation of the completion of the screening, the date of the screen, and the results.

Denominator	The eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement

[90] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.

	year and for whom results are in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria. AEs can, but not required to, use ICD-10 Z codes to track performance for this measure electronically. An example of two Z codes in use by at least one AE is provided below: • Z04 o Definition: Encounter for examination and observation for other reasons o Meaning: SDOH screening completed • Z53 o Definition: Persons encountering health services for specific procedure and treatment, not carried out o Meaning: SDOH screening offered, but patient refused/declined to complete screen
Unit of measurement	Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record.
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer or a community partner. The screening results must a) be embedded in the EHR, b) be accessible in the EHR as a PDF of the screening results, or c) be accessible from within the EHR without requiring the primary care clinician to leave the EHR to access another electronic location to search for the patient's record and locate and view the screening results. An integrated EHR interface with Unite Us that allows providers to view a patient's screening results meets the documentation requirements. Results for at least one question per required domain must be included for a screen to be considered numerator complaint.
Approved screening tools	For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure.

Required domains	1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance. Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Code List

The following codes should be utilized to identify patients in hospice care:

Code System	Code
UBREV	0115
UBREV	0125
UBREV	0135
UBREV	0145
UBREV	0155
UBREV	0235
UBREV	0650
UBREV	0651
UBREV	0652
UBREV	0655
UBREV	0656
UBREV	0657
UBREV	0658
UBREV	0659
SNOMED CT US EDITION	170935008
SNOMED CT US EDITION	170936009
SNOMED CT US EDITION	183919006
SNOMED CT US EDITION	183920000
SNOMED CT US EDITION	183921001
SNOMED CT US EDITION	305336008
SNOMED CT US EDITION	305911006
SNOMED CT US EDITION	385763009
SNOMED CT US EDITION	385765002

Code System	Code
CPT	99377
CPT	99378
HCPCS	G0182
HCPCS	G9473
HCPCS	G9474
HCPCS	G9475
HCPCS	G9476
HCPCS	G9477
HCPCS	G9478
HCPCS	G9479
HCPCS	Q5003
HCPCS	Q5004
HCPCS	Q5005
HCPCS	Q5006
HCPCS	Q5007
HCPCS	Q5008
HCPCS	Q5010
HCPCS	S9126
HCPCS	T2042
HCPCS	T2043
HCPCS	T2044
HCPCS	T2045
HCPCS	T2046

Proposed New Measure for HEDIS®[1] Measurement Year (MY) 2023: Social Need Screening and Intervention (SNS-E)

NCQA seeks comments on a proposed new measure for inclusion in HEDIS MY 2023.

Social Need Screening and Intervention: The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported:

- *Food screening*: The percentage of members who were screened for unmet food needs.
- *Food intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet food needs.
- *Housing screening*: The percentage of members who were screened for unmet housing needs.
- *Housing intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet housing needs.
- *Transportation screening*: The percentage of members who were screened for unmet transportation needs.
- *Transportation intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet transportation needs.

The measure excludes individuals who are enrolled in hospice or in Institutional Special Needs Plans (I-SNP), or who reside in long-term care institutions (LTI). It is stratified by age (≤17, 18–64, 65+). Screening instruments and intervention codes included in the measure have been identified as appropriate for each domain by The Gravity Project consensus process, a multi-stakeholder, public collective initiative aimed at developing standardized terminology for documentation and exchange of data on social determinants of health (SDOH).

NCQA developed this measure as part of an organization wide effort to advance health equity and hold health plans accountable for assessing and addressing the food, housing and transportation needs of their patient populations. These social needs have been identified as high priority and actionable by a multitude of health system entities, including health plans, providers and other key stakeholders, yet most health care quality measures continue to focus on *clinical* processes and outcomes—there are currently no national health plan measures that assess and address a patient's social needs. NCQA sees this as a critical quality measurement gap to fill.

Disparities in morbidity and mortality across social needs have been well documented over the last few decades, as leading health organizations increasingly elevate health equity as a priority.[2,3] Organizations such as the Centers for Disease Control and Prevention and the World Health Organization, and policy initiatives like Healthy People 2030, have indicated the need to pursue health equity in the face of widening disparities between subgroups in the United States.[4,5] Additionally, there is wide acknowledgment that social factors such as access to food, housing, transportation and social supports contribute significantly to health

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] Baciu, A., Y. Negussie, A. Geller, J.N. Weinstein. 2017. *The State of Health Disparities in the United States.* National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK425844/
[3] Penman-Aguilar, A., M. Talih, D. Huang, R. Moonesinghe, K. Bouye, & G. Beckles. 2016. "Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity." *Journal of Public Health Management and Practice*, *22*, S33. https://doi.org/10.1097/PHH.0000000000000373
[4] CDC. 2019. *Attaining Health Equity—Healthy Communities Program*. https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm
[5] Pendo, E., L.I. Iezzoni. 2020. *The Role of Law and Policy in Achieving Healthy People's Disability and Health Goals around Access to Health Care, Activities Promoting Health and Wellness, Independent Living and Participation, and Collecting Data in the United States.* Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://www.healthypeople.gov/sites/default/files/LHP_Disability-Health-Policy_2020.03.12_508_0.pdf

outcomes. In fact, 30%–55% of health outcomes are attributed to SDOH.[6] The proposed measure would encourage health plans to identify specific needs and connect members with the resources necessary to overcome social barriers to their wellness.

Testing confirmed a large performance gap in terms of documenting results of screening for social needs. In Medicare, screening performance rates were highest for food (12.6%), followed by transportation (3.5%) and then housing (3.3%). Intervention performance rates were high compared to screening, with highest rates for food (75.1%) followed by transportation (68.5%) and housing (24.3%). Denominator sizes were small (<30) for some intervention indicators, particularly housing and transportation, suggesting that some plans may struggle to meet the minimum denominator size for reporting the intervention indicators.

NCQA seeks general feedback on the measure and specific feedback on the following:

1. *Phasing in the intervention indicators*. Should NCQA implement the measure with the intervention indicators or introduce the intervention component at a later time, given the current small denominators (which may be a barrier to reporting for some plans)?
2. *Follow-up time frame.* If the intervention indicators are retained in the measure, should NCQA shorten the follow-up time frame from 30 days (e.g., 1 week,2 weeks)?
3. *Exclusion of members in I-SNPs and LTIs*. Should NCQA exclude members who receive these services?
4. *Screening instruments specified*. Current measure specifications require a limited set of standardized, social needs screening instruments: the Accountable Health Communities Health-Related Social Needs screening tool, the PRAPARE, We Care, WellRx and the Hunger Vital Sign. Is this list appropriate? Should NCQA include additional tools in the measure?

NCQA expert panel members strongly support the proposed measure and believe it is an important step toward holding health plans accountable for addressing the social needs of their members.

Supporting documents include the draft measure specification and evidence workup.

NCQA acknowledges the contributions of the Health Equity Expert and Care Coordination Work Groups, and the Geriatric and Technical Measurement Advisory Panels.

[6] World Health Organization (WHO). (n.d.). *Social Determinants of Health*. https://www.who.int/westernpacific/health-topics/social-determinants-of-health

Measure title	Social Need Screening and Intervention	**Measure ID**	SNS-E
Description	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported: • *Food screening*: The percentage of members who were screened for unmet food needs. • *Food intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet food needs. • *Housing screening*: The percentage of members who were screened for unmet housing needs. • *Housing intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet housing needs. • *Transportation screening*: The percentage of members who were screened for unmet transportation needs. • *Transportation intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet transportation needs.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice			

	Unadjusted Uncertified Measures: A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on unadjusted HEDIS specifications, may not be called a "Health Plan HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as **"Uncertified, Unaudited Health Plan HEDIS Rates."** Adjusted Uncertified Measures: A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called an "Adjusted HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as **"Adjusted, Uncertified, Unaudited HEDIS Rates."** Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications. The American Medical Association holds a copyright to the CPT® codes contained in the measure specifications. The American Hospital Association holds a copyright to the Uniform Billing Codes ("UB") contained in the measure specifications. The UB Codes in the HEDIS specifications are included with the permission of the AHA. All uses of the UB Codes may require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@aha.org. Some measure specifications contain coding from LOINC® (http://loinc.org). The LOINC table, LOINC codes, LOINC panels and form file, LOINC linguistic variants file, LOINC/RSNA Radiology Playbook, and LOINC/IEEE Medical Device Code Mapping Table are copyright © 1995–2021 Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee and are available at no cost under the license at http://loinc.org/terms-of-use. "SNOMED" and "SNOMED CT" are registered trademarks of the International Health Terminology Standards Development Organisation (IHTSDO). "HL7" is the registered trademark of Health Level Seven International. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording or any information storage and retrieval system, without the written permission of NCQA. © 2022 by the National Committee for Quality Assurance 1100 13th Street, NW, Third Floor Washington, DC 20005 All rights reserved. NCQA Customer Support: 888-275-7585 NCQA Fax: 202-955-3599 NCQA Website: www.ncqa.org Submit policy clarification support questions via My NCQA (http://my.ncqa.org).
Clinical recommendation statement	**American Academy of Family Physicians:** The AAFP urges health insurers and payors to provide appropriate payment to support health care practices to identify, monitor, assess and address SDoH. **American Academy of Pediatrics:** The AAP recommends surveillance for risk factors related to social determinants of health during all patient encounters.

	American Diabetes Association: Assess food insecurity, housing insecurity/homelessness, financial barriers, and social capital/social community support and apply that information to treatment decisions. **A** Refer patients to local community resources when available. **B**
Citations	American Academy of Pediatrics. (2015). *Promoting Food Security for All Children.* https://pediatrics.aappublications.org/content/136/5/e1431. American Academy of Pediatrics. (2016). *Poverty and Child Health in the United States.* https://pediatrics.aappublications.org/content/137/4/e20160339#sec-12 American Academy of Pediatrics. (2013). *Policy Statement. Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity.* https://pediatrics.aappublications.org/content/131/6/1206 American Diabetes Association (2021). *Improving Care and Promoting Health in Populations: Standards of Medical Care in Diabetes—2021*. Diabetes Care, 44(Supplement 1), S7–S14. https://doi.org/10.2337/dc21-S001
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Product line: – Commercial. – Medicaid. – Medicare. • Age: – ≤17 years. – 18–64 years. – 65 and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 17* for identification of hospice members using the monthly

<table>
<tr><td></td><td>membership detail data files are not included in the measure calculation logic and need to be programmed manually.

Reporting:
The total is the sum of the age stratifications.

Product line stratifications are not included in the measure calculation logic and need to be programmed manually.</td></tr>
<tr><td colspan="2">Definitions</td></tr>
<tr><td>Participation</td><td>The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.</td></tr>
<tr><td>Participation period</td><td>The measurement period.</td></tr>
<tr><td>Food screening instrument</td><td>Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Instruments</th><th>Screening Item</th><th>Positive Finding</th></tr>
<tr><td rowspan="2">Accountable Health-Communities Health Related Social Needs Screening Tool (AHC HRSN)</td><td>Within the past 12 months, you worried that your food would run out before you got money to buy more.</td><td>Often true
Sometimes true</td></tr>
<tr><td>Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.</td><td>Often true
Sometimes true</td></tr>
<tr><td>Comprehensive Universal Behavior Screen (CUBS)</td><td>Tell us about your household and how you purchase food</td><td>I can meet basic food needs, but require occasional assistance
My household is on food stamps
I have no food or means to prepare it. I rely to a significant degree on other sources of free or low-cost food</td></tr>
<tr><td>Hunger Vital Sign (HVS)</td><td>Food insecurity risk</td><td>At risk</td></tr>
<tr><td>Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE)</td><td>Have you or any family members you live with been unable to get any of the following when it was</td><td>Food</td></tr>
</table></td></tr>
</table>

		really needed in past 1 year?	
	U.S. Food Security Survey (Household, Adult, Child, 6-item)	Food security status	Low food security Very low food security
	We Care	Do you always have enough food for your family?	No
	WellRX	In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?	Yes

Housing screening instrument

Eligible screening instruments with thresholds for positive findings include:

Instruments	Screening Item	Positive Finding(s)
Accountable Health-Communities Health Relates Social Needs Screening Tool (AHC HRSN)	What is your living situation today?	I have a place to live today, but I am worried about losing it in the future I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
	Think about the place you live. Do you have problems with any of the following?	Pests, such as bugs, ants, or mice Oven or stove not working Mold Smoke detectors missing or not working Lead paint or pipes Water leaks Lack of heat
Comprehensive Universal Behavior Screen (CUBS)	Tell us about your housing	I'm in stable housing that is safe but only marginally adequate I'm in transitional, temporary or substandard housing; and/or current

			rent/mortgage is unaffordable (over 30% of income) I'm homeless or threatened with eviction
	Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE)	What is your housing situation today?	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park
		Are you worried about losing your housing?	Yes
	We Care	Do you think you are at risk of becoming homeless?	Yes
	WellRx	Are you homeless? Or worried that you might be in the future?	Yes
Transportation screening instrument	Eligible transportation screening instruments with thresholds for positive findings include:		

Instruments	Screening Item	Positive Finding(s)
Accountable Health-Communities Health Relates Social Needs Survey (AHC HRSN)	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes
Comprehensive Universal Behavior Screen (CUBS)	Access to transportation/mobility status	My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured My transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.

<table>
<tr><td></td><td>
<table>
<tr><td></td><td></td><td>I have no access to transportation, public or private; may have car that is inoperable</td></tr>
<tr><td>Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE)</td><td>Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living</td><td>Yes, it has kept me from medical appointments or from getting my medications
Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need</td></tr>
<tr><td>PROMIS</td><td>Current level of confidence I can use public transportation</td><td>I am not at all confident
I am a little confident
I am somewhat confident</td></tr>
<tr><td>WellRx</td><td>Do you have trouble finding or paying for transportation?</td><td>Yes</td></tr>
</table>
</td></tr>
<tr><td>Interventions</td><td>An intervention on, or up to 30 days after, the date of the first positive screening.</td></tr>
<tr><td>Initial population</td><td>Members enrolled at the start of the measurement period who also meet criteria for participation.</td></tr>
<tr><td>Exclusions</td><td>Members in hospice or using hospice services during the measurement period.
Members who meet either of the following:
Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The initial population, minus exclusions.
Denominator 2
All members in numerator 1 with a positive food screen finding between January 1 and December 1 of the measurement period.
Denominator 3
Equal to denominator 1.
Denominator 4
All members in numerator 3 with a positive housing screen finding between January 1 and December 1 of the measurement period.</td></tr>
</table>

	Denominator 5 Equal to denominator 1. **Denominator 6** All members in numerator 5 with a positive transportation screen finding between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1** Members in denominator 1 with a documented result for food screening performed between January 1 and December 1 of the Measurement Period. **Numerator 2** Members in denominator 2 receiving a food intervention on or up to 30 days after the date of the first positive food screen (31 days total). **Numerator 3** Members in denominator 3 with a documented result for housing screening performed between January 1 and December 1 of the Measurement Period. **Numerator 4** Members in denominator 4 receiving a housing intervention on or up to 30 days after the date of the first positive housing screen (31 days total). **Numerator 5** Members in denominator 5 with a documented result for transportation screening performed between January 1 and December 1 of the Measurement Period. **Numerator 6** Members in denominator 6 receiving a transportation intervention on or up to 30 days after the date of the first positive transportation screen (31 days total).
Data criteria (element level)	
Value Sets: • **SNIE_HEDIS_MY2023-1.0.0** – Food Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2262) – Housing Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2263) – Transportation Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2264) • **NCQA_Hospice-1.0.0** – Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761) – Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)	

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table SNS-E-: Metadata Elements for Social Need Screening and Intervention

Metric	Age	Data Element	Reporting Instructions
FoodScreening	0-17	InitialPopulation	For each Metric and Stratification
FoodIntervention	18-64	ExclusionsByEHR	For each Metric and Stratification
HousingScreening	65+	ExclusionsByCaseManagement	For each Metric and Stratification
HousingIntervention	Total	ExclusionsByHIERegistry	For each Metric and Stratification
TransportationScreening		ExclusionsByAdmin	For each Metric and Stratification
TransportationIntervention		Exclusions	(Sum over SSoRs)
		Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Definitions:

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 Member population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

Examples of 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), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older):** Patient Health Questionnaire (PHQ-9 or PHQ-2), 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 Screening, and PRIME MD-PHQ2

Substance Use Assessment in Primary Care

Methodology: IEHP-Defined Quality Measure

Measure Description: The percentage of members 18 years and older who were screened for substance use during the measurement year (2020).

CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE:			
Service	**Code Type**	**Code**	**Code Description**
Substance Use Assessment in Primary Care	CPT	99408	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services 15 to 30 Minutes
Substance Use Assessment in Primary Care	CPT	99409	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services Greater than 30 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0396	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention 15 to 30 Minutes

CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE:			
Service	**Code Type**	**Code**	**Code Description**
Substance Use Assessment in Primary Care	HCPCS	G0397	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention Greater than 30 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0442	Annual Alcohol Misuse Screening 15 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Substance Use Assessment in Primary Care	HCPCS	H0049	Alcohol and/or Drug Assessment
Substance Use Assessment in Primary Care	HCPCS	H0050	Alcohol and/or Drug Service Brief Intervention Per 15 Minutes

Denominator: All Members aged 18 years and older during the measurement year (2020). Member counted only once in the denominator.

Numerator: Members who were screened for substance use at least once during the measurement year (2020).

Population: Women

Breast Cancer Screening (BCS)

Methodology: HEDIS®

Measure Description: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year (2018) and December 31 of the measurement year (2020).

- The eligible population in the measure meets all of the following criteria:
    1. Women 52-74 years as of December 31 of the measurement year (2020).
    2. Continuous enrollment from October 1 two years prior to the measurement year (2018) through December 31 of the measurement year (2020) with no more than one gap in enrollment of up to 45 days for each calendar year of continuous enrollment. No gaps in enrollment are allowed from October 1 two years prior to the measurement year (2018) through December 31 two years prior to the measurement year (2018).

Measure Title: Timely Follow-up After Acute Exacerbations of Chronic Conditions

Measure Steward: IMPAQ International

Description of Measure: The percentage of issuer-product-level acute events requiring either an emergency department (ED) visit or hospitalization for one of the following 6 chronic conditions: hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes mellitus (Type I or Type II), where follow-up was received within the timeframe recommended by clinical practice guidelines in a non-emergency outpatient setting

Unit of Analysis: Issuer-by-product

Numerator Statement: The numerator is the sum of the issuer-product-level denominator events (Emergency Room [ED], observation hospital stay or inpatient hospital stay) for acute exacerbation of hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes where follow-up was received within the timeframe recommended by clinical practice guidelines, as detailed below:

- Hypertension: Within 7 days of the date of discharge
- Asthma: Within 14 days of the date of discharge
- HF: Within 14 days of the date of discharge
- CAD: Within 14 days of the date of discharge
- COPD: Within 30 days of the date of discharge
- Diabetes: Within 30 days of the date of discharge

Numerator Details:
This measure is defined at the issuer-by-product level, meaning that results are aggregated for each qualified insurance issuer and for each product. For clarity, a product is a discrete package of health insurance coverage benefits that issuers offer in the context of a particular network type, such as health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), point of service (POS), or indemnity. Issuers are broadly defined as health insurance providers who participate in the Federally-facilitated Marketplaces and health insurance contracts offered in the Medicare Advantage market.

Timely follow-up is defined as a claim for the same patient after the discharge date of the acute event that is a non-emergency outpatient visit and has a CPT or HCPCS code indicating a visit that constitutes appropriate follow-up, as defined by clinical guidelines and clinical coding experts. The follow-up visit may be a general office visit or telehealth and take place in certain chronic care or transitional care management settings. The follow-up visit must occur within the condition-specific timeframe to be considered timely and for the conditions of the numerator/measure to be met. For a list of individual codes, please see the data dictionary attached in S.2b.

The follow-up visit timeframes for each of the 6 chronic conditions are based on evidence-based clinical practice guidelines (CPGs) as laid out in the evidence form.

Denominator Statement: The denominator is the sum of the issuer-product-level acute exacerbations that require either an ED visit, observation stay, or inpatient stay (i.e., acute events) for any of the 6 conditions listed above (hypertension, asthma, HF, CAD, COPD, or diabetes).

Denominator Details:

Acute events are defined as either an ED visit, observation stay, or inpatient stay. If a patient is discharged and another claim begins for the same condition on the same day or the following day, the claims are considered to be part of one continuous acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. The final claim of the acute event must be a discharge to community.

An acute event is assigned to [condition] if:

1. The primary diagnosis is a sufficient code for [condition].
OR
2. The primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].

    a. In cases where the event has two or more conditions with a related code as the primary diagnosis and a sufficient code in additional diagnosis positions, **assign the event to the condition with a sufficient code appearing in the "highest" (closest to primary) diagnosis position**.

If the visits that make up an acute event are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event. For a list of individual codes, please see the data dictionary attached in S.2b.

Denominator Exclusions:

The measure excludes events with:

1. Subsequent acute events that occur two days after the prior discharge, but still during the follow-up interval of the prior event for the same reason. To prevent double-counting, only the first acute event will be included in the denominator.
2. Acute events after which the patient does not have continuous enrollment for 30 days in the same product.
3. Acute events where the discharge status of the last claim is not "to community" ("Left against medical advice" is not a discharge to community.)

4. Acute events for which the calendar year ends before the follow-up window ends (e.g., acute asthma events ending fewer than 14 days before December 31)
5. Acute events where the patient enters a skilled nursing facility (SNF), non-acute care, or hospice care within the follow-up interval

Measure Scoring:

1) Denominator events are identified by hospitalization, observation, and ED events with appropriate codes (i.e., codes identifying an acute exacerbation of 1 of the 6 included chronic conditions).

2) Exclusions are applied to the population from step 1) to produce the eligible patient population for the measure (i.e., the count of all qualifying events).

3) For each qualifying event, it is determined whether or not claims included a subsequent code that satisfies the follow-up requirement for that particular qualifying event (e.g., a diabetes event received follow-up within the appropriate timeframe for diabetes, from an appropriate provider). Each event for which the follow-up requirement was satisfied is counted as 'one' in the numerator. Each event for which the follow-up requirement was not satisfied is counted as a 'zero' in the numerator.

4) The percentage score is calculated as the numerator divided by the denominator.

Measure Scoring Logic

Following NQF's guideline, we employ **Opportunity-Based Weighting** to calculate the follow-up measure. (1) This means that each condition is weighted by the sum of acute exacerbations that require either an ED visit or an observation or inpatient stay for all the six conditions that occur, as reflected in the logic below.

[NUM(ASM) + NUM(CAD) + NUM(HF) + NUM (COPD) + NUM(DIAB) + NUM(HTN)] / [DENOM(ASM) + DENOM(CAD) + DENOM(HF) + DENOM (COPD) + DENOM(DIAB) + DENOM(HTN)]

***Please note that, while the development team designed the measure to aggregate each condition score in the manner described above into a single overall score, programs may choose to also calculate individual scores for each chronic condition when implementing the measure. Individual measure scores would simply be calculated by dividing the condition-specific numerator by the condition specific denominator, as in the example for heart failure below:

NUM(HF) / DENOM(HF)

Topical Fluoride for Children (TFC)

SUMMARY OF CHANGES TO HEDIS MY 2023

- First-year measure.

Description

The percentage of members 1–20 years of age who received at least two topical fluoride applications during the measurement year.

Eligible Population

Product line	Medicaid.
Ages	1–20 years as of December 31 of the measurement year. Report four age stratifications and a total rate. • 1–2 years. • 3–5 years. • 6–14 years. • 15–20 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 31 days during the measurement year. 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 (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Dental or medical.
Event/diagnosis	None.
Required exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator[1] Two or more fluoride applications (Topical Application of Fluoride Value Set) during the measurement year on different dates of service.

Data Elements for Reporting

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

Table TFC-1: Data Elements for Topical Fluoride for Children

Metric	Age Stratification	Data Element	Reporting Instructions
TopicalFluorideforChildren	1-2	Benefit	Metadata
	3-5	EligiblePopulation	For each Stratification
	6-14	ExclusionAdminRequired	For each Stratification
	15-20	NumeratorByAdmin	For each Stratification
	Total	Rate	(Percent)

[1]The NCQA Value Set Directory includes Current Dental Terminology (CDT) codes, © 2022 American Dental Association. All rights reserved.
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