Connecticut Quality Council
2022 Annual Review of the Core Measure Set
May 19, 2022 Meeting
Measure Specifications

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):**

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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).

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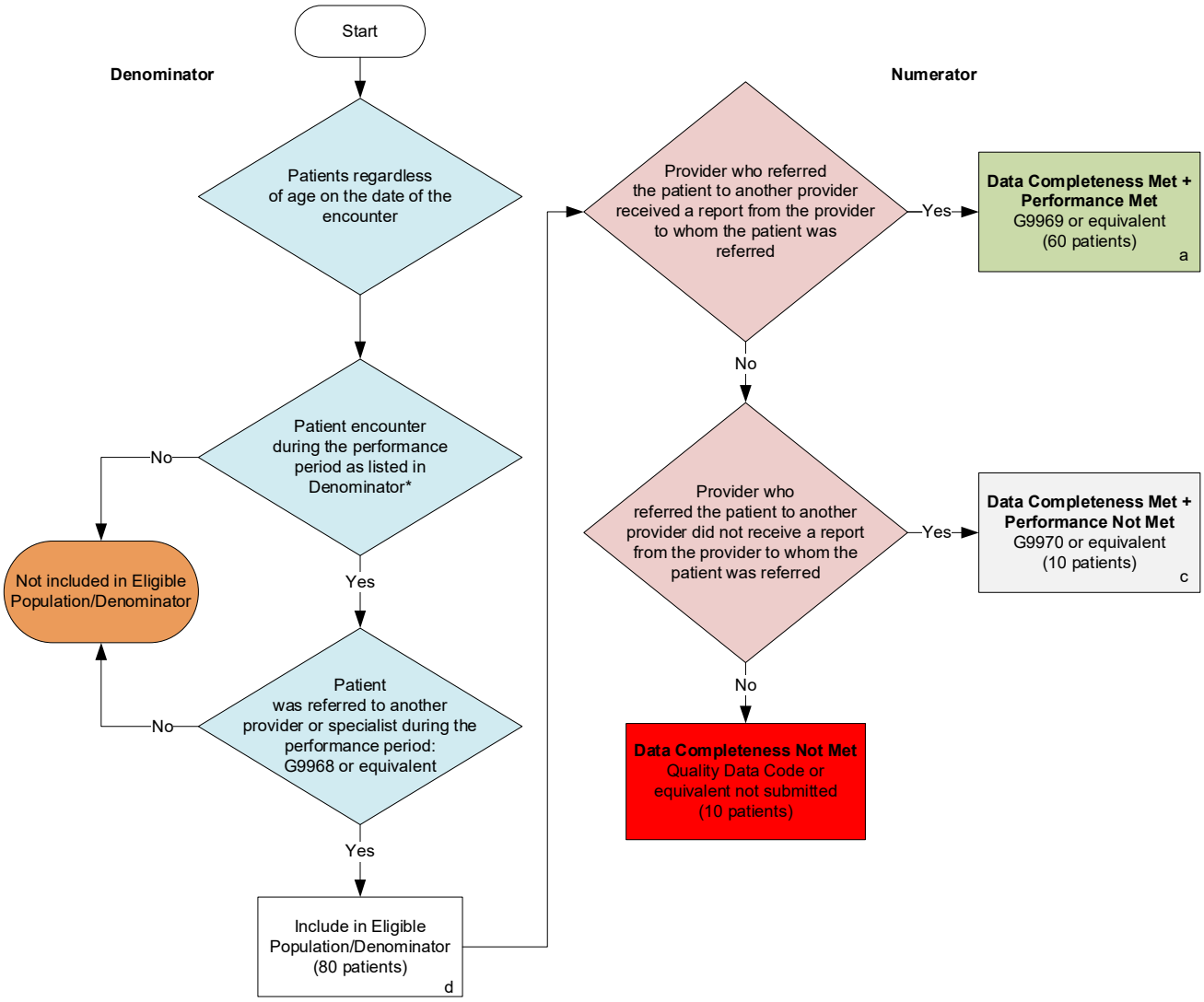
2022 Clinical Quality Measure Flow for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

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

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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.

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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.

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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)

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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)

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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

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)

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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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Transitions of Care (TRC)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added physician assistant as an appropriate provider type to perform a medication reconciliation for the Medication Reconciliation Post-Discharge indicator.
- Clarified in the *Notes* that documentation of "post-op/surgery follow-up" without a reference to "hospitalization," "admission" or "inpatient stay" does not meet criteria for the fifth bullet of the Medication Reconciliation Post-Discharge indicator.
- Revised the Reporting Instructions for the "NumeratorByAdminElig" data element in Table TRC-3: Data Elements for Transitions of Care to "For each Metric and Stratification" to indicate that it is a stratified value.
- Added required exclusions to the Rules for Allowable Adjustments.
- Clarified allowable adjustments to the numerator criteria in the Rules for Allowable Adjustments.

Description

The percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported:

- *Notification of Inpatient Admission*. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- *Receipt of Discharge Information.* Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- *Patient Engagement After Inpatient Discharge*. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- *Medication Reconciliation Post-Discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Definitions

Medication reconciliation	A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
Medication list	A list of medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.

Eligible Population

Product lines Medicare.

Ages 18 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate:

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

Continuous enrollment The date of discharge through 30 days after discharge (31 total days).

Allowable gap None.

Anchor date None.

Benefit Medical.

Event/diagnosis An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges:

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

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Observation visits that precede the inpatient stay Do not adjust the admit date if the discharge is preceded by an observation stay; use the admit date from the acute or nonacute inpatient stay.

Readmission or direct transfer If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay (the admission date must occur during the 31-day period).
3. Identify the discharge date for the stay (the discharge date is the event date).

Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the admission date and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge. To identify acute inpatient discharges:

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 admission date for the stay.
4. Identify the discharge date for the stay.

To identify nonacute inpatient discharges:

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).
3. Identify the admission date for the stay.
4. Identify the discharge date for the stay.

Note: *If a member remains in an acute or nonacute facility through December 1 of the measurement year, a discharge is not included in the measure for this member, but the organization must have a method for identifying the member's status for the remainder of the measurement year, and may not assume the member remained admitted based only on the absence of a discharge before December 1.*

If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.

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.

Numerators

Notification of Inpatient Admission Administrative reporting is not available for this indicator.

Receipt of Discharge Information Administrative reporting is not available for this indicator.

Patient Engagement After Inpatient Discharge Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement:

- An outpatient visit (Outpatient Value Set).
- A telephone visit (Telephone Visits Value Set).
- Transitional care management services (Transitional Care Management Services Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set).

Medication Reconciliation Post-Discharge Medication reconciliation (Medication Reconciliation Encounter Value Set; Medication Reconciliation Intervention Value Set) conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days).

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

The denominator is based on discharges, not on members. Members may appear more than once in the sample.

Organizations may reduce the sample size based only on the prior year's audited, product line-specific rate for the lowest rate of all TRC indicators. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Identifying the medical record

Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting.

Numerators

Notification of Inpatient Admission

Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (3 total days).

Administrative

Administrative reporting is not available for this indicator.

Medical record

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria:

- Communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system.
- Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria.
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan.
- Indication that the member's PCP or ongoing care provider admitted the member to the hospital.
- Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay.

- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission through 2 days after the admission (3 total days); documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.

Note: *When an ED visit results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.*

Receipt of Discharge Information

Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).

Administrative

Administrative reporting is not available for this indicator.

Medical record

Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following:

- The practitioner responsible for the member's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list.
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care post-discharge.

Note: *If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through 2 days after the discharge (3 total days).*

When using a shared EMR system, documentation of a "received date" in the EMR is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 total days) meets criteria.

Patient Engagement After Inpatient Discharge

Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria:

- An outpatient visit, including office visits and home visits.
- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider).

Note: *If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria.*

Medication Reconciliation Post-Discharge

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - *Notification of Inpatient Admission and Notification of Inpatient Discharge:*
    - *Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge.*
    - *Documentation of notification that does not include a time frame or date when the documentation was received.*
  - *Medication Reconciliation Post-Discharge:*
    - *Documentation of "post-op/surgery follow-up" without a reference to "hospitalization," "admission" or "inpatient stay" does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization.*
- *The Medication Reconciliation Post-Discharge numerator assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record.*
- *The denominator is based on the discharge date found in administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.*
  - *If a different discharge date is found in the medical record, and the organization chooses to use that date, the organization must assess all indicators using the updated discharge date, including those that were previously compliant based on administrative data.*
- *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 (i.e., within 30 days after discharge).*
- *Refer to Appendix 3 for the definition of* PCP *and* ongoing care provider*.*
- *A medication reconciliation performed without the member present meets criteria.*

Data Elements for Reporting

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

Table TRC-3: Data Elements for Transitions of Care

Metric	Age	Data Element	Reporting Instructions	A
MedicationReconciliationPostDischarge	18-64	CollectionMethod	For each Metric, repeat per Stratification	✓
PatientEngagementAfterInpatientDischarge	65+	EligiblePopulation*	For each Metric and Stratification	✓
NotificationInpatientAdmission	Total	ExclusionAdminRequired*†	For each Metric and Stratification	✓
ReceiptDischargeInformation		NumeratorByAdminElig†	For each Metric and Stratification	
		CYAR†	Only for Total (Percent)	
		MinReqSampleSize	For each Metric, repeat per Stratification	
		OversampleRate	For each Metric, repeat per Stratification	
		OversampleRecordsNumber	(Count)	
		ExclusionValidDataErrors	For each Metric, repeat per Stratification	
		ExclusionEmployeeOrDep	For each Metric, repeat per Stratification	
		OversampleRecsAdded	For each Metric, repeat per Stratification	
		Denominator	For each Stratification, repeat per Metric	
		NumeratorByAdmin†	For each Metric and Stratification	✓
		NumeratorByMedicalRecords	For each Metric and Stratification	
		NumeratorBySupplemental	For each Metric and Stratification	✓
		Rate	(Percent)	✓

*Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the administrative method.

†These data elements are only reported or calculated for the MedicationReconciliationPostDischarge and PatientEngagementAfterInpatientDischarge Metrics.

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 Transitions of Care

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	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	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 that contain (or map to) codes in the value sets may be used to identify the eligible population for each rate. The value sets and logic may not be changed. ***Note:*** *Organizations may choose alternate measurement-period date ranges.* *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members with documentation of medication reconciliation after each discharge).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
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**
• Notification of Inpatient Admission • Receipt of Discharge Information	No	Allowable adjustments are not permitted for these components of the Transitions of Care measure.

Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
• Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge	No	Value sets and logic may not be changed.