Connecticut Quality Council
Annual Review
Candidate Measure Specifications
January 10, 2025

H. Achievement of External Standards for Health Equity

OVERVIEW

Measure Name	Achievement of External Standards for Health Equity
Steward	MassHealth (Relying on standards established by the National Committee for Quality Assurance (NCQA), Health Policy Commission (HPC), The Joint Commission (TJC))
NQF Number	N/A
Data Source	Supplemental
Performance Status: PY2	Pay-for-Reporting

POPULATION HEALTH IMPACT

To be successful in addressing persistent and longstanding health disparities, healthcare organizations must adopt structures and systems that systemically and comprehensively prioritize health equity as a fundamental component of high-quality care. These goals include collaboration and partnership with other sectors that influence the health of individuals, adoption and implementation of a culture of equity, and the creation of structures that support a culture of equity. External health equity certification independently and objectively assesses attainment of these and other relevant health equity goals to ensure that healthcare organizations are providing a comprehensively high standard of equitable care.

MEASURE SUMMARY

This measure assesses ACO progress towards and/or achievement of external standards related to health equity established by NCQA, HPC, and The Joint Commission.

NCQA's Health Equity Accreditation Standards are intended to serve as a foundation for Health Plans and ACOs to address health care disparities. These Health Equity Standards build on the equity-focused Health Plan Accreditation standards to recognize organizations that go above and beyond to provide high quality and equitable care. HPC's ACO Certification Program, or ACO Learning, Equity, and Patient-Centeredness (LEAP), is a program designed

to accelerate care delivery transformation in Massachusetts and promote a high quality, efficient health system. The Joint Commission's Health Care Equity Certification recognizes acute hospitals that go above and beyond to high quality and equitable care. Together, these three certification programs provide a comprehensive and objective assessment of the necessary health equity systems and structures across the entire health system.

This measure incentivizes ACOs to demonstrate achievement of the following:

1. Health Plans and PCACOs: Progress towards/achievement of the NCQA Health Equity Accreditation
2. All ACOs: Achievement/maintenance of the HPC ACO Certification (ACO LEAP) for the 2024-2025 and 2026-2027 cycles.
3. ACO's partnered-Hospitals (per the Joint Accountability partnerships formed in the HQEIP): Progress towards/achievement of TJC's Health Care Equity Certification Program

ACOs must demonstrate that all three requirements listed above are met to earn full credit for this measure. Alternatively, for ACPPs, if both the Health Plan and ACO Partner achieve NCQA Health Equity Accreditation, the ACPP will receive full credit for this measure.

DEFINITIONS

Health Plan	For the purpose of this measure, the Health Plan is defined as the MassHealth Contractor, or Managed Care Organization, for the Accountable Care Partnership Plan (ACPP) contract.
ACO Partner	The ACO Partner is defined as the ACO entity the Contractor or Health Plan has an arrangement with for the ACPP contract.

ADMINISTRATIVE SPECIFICATIONS

By December 31, 2024, complete and timely submission of the **"External Standards for Health Equity Report"** that includes, at a minimum:

1. NCQA Health Equity Accreditation Report (either 1a or 1b must be included):
    a. Documentation of achievement of NCQA Health Equity Accreditation (at the Health Plan and/or PCACO level); or
    b. Progress Report related to achievement of NCQA Health Equity Accreditation (at the Health Plan and/or PCACO level), including:

i. List of NCQA Health Equity Standards achieved to date (may be from the Health Plan or ACOs (or ACO Partner, as applicable) own assessment of standards achieved)
ii. List of NCQA Health Equity Standards in progress (may be from the Health Plan or ACOs (or ACO Partner, as applicable) own assessment of standards in progress)
iii. Description of any efforts undertaken in PY2 (CY2024) to make progress towards achieving NCQA Health Equity Accreditation
iv. Description of any anticipated efforts, resources, etc. needed to achieve Accreditation by the end of PY3.

2. Documentation of achievement of the HPC ACO Certification (ACO LEAP)
3. TJC Health Care Equity Certification Report
    a. List of Partnered Hospitals (per HQEIP Joint Accountability partnership attestations to MassHealth) and each hospital's status in meeting HQEIP "Achievement of External Standards for Health Equity" Performance Requirements for PY2

Alternatively, ACPPs may submit both of the following in place of the "External Standards for Health Equity Report":

1. Documentation of achievement of NCQA Health Equity Accreditation for the Health Plan
2. Documentation of achievement of NCQA Health Equity Accreditation for the ACO Partner

ADDITIONAL MEASURE INFORMATION

ACOs without partnered-Hospitals or in-network Hospitals are exempt from the third component of this measure, the requirement that the ACO's Partnered-Hospital achieves TJC Health Care Equity Certification.

PY2 PERFORMANCE REQUIREMENTS AND ASSESSMENT

Performance Requirements	**By December 31, 2024**, the ACO must submit either: 1) An "External Standards for Health Equity Report" or, for ACPPs only, documentation of achievement of NCQA Health Equity Accreditation for both the Health Plan and ACO Partner in a form and format to be further specified by MassHealth;

Performance Assessment	• The ACO will earn 100% of the points attributed to this measure if it submits a timely, complete, and responsive "External Standards for Health Equity Report" or, for ACPPs only, documentation of achievement of NCQA Health Equity Accreditation for both the Health Plan and ACO Partner to MassHealth by December 31, 2024. • The ACO will earn 0% of the points attributed to the measure if the "External Standards for Health Equity Report" or, for ACPPs only, documentation of achievement of NCQA Health Equity Accreditation for both the Health Plan and ACO Partner submission is not timely, complete, and responsive.

PERFORMANCE REQUIREMENTS AND ASSESSMENT FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3

Measure #7: Asthma Action Plan

Asthma

Measure Description

Percentage of patients aged 5 years and older with a diagnosis of asthma who received a written asthma action plan at one or more visits during the measurement period

Measure Components

Numerator Statement	Patients who received a written asthma action plan* at one or more visits during the measurement period *The written asthma action plan can be symptom-based or peak-flow based and must include: 1. Instructions regarding daily management and use of asthma control medications **AND** 2. Instructions for recognizing and handling worsening asthma, including self-adjustment of medications in response to acute symptoms or changes in Peak Expiratory Flow (PEF) measures. See NHLBI/NAEPP Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma for sample asthma action plans
Denominator Statement	All patients aged 5 years and older with a diagnosis of asthma
Denominator Exclusion(s)	None
Denominator Exception(s)	None
Supporting Guideline	The following evidence statements are quoted verbatim from the referenced clinical guidelines. NHLBI/NAEPP Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma[4] The Expert Panel recommends: Provide all patients with a written asthma action plan that includes two aspects: (1) daily management and (2) how to recognize and handle worsening asthma. Provide to all patients a written asthma action plan based on signs and symptoms and/or PEF; written action plans are particularly recommended for patients who have moderate or severe persistent asthma, a history of severe exacerbations, or poorly controlled asthma (Evidence B). Every patient who has asthma should be taught to recognize symptom patterns that indicate inadequate asthma control (Evidence A) Either symptom and/or PEF monitoring should be used as a means to determine the need for intervention, including additional medication, in the context of a written asthma action plan.

Measure Importance

Relationship to desired outcome	Self-management is an important aspect of daily and emergency asthma care. The goal of asthma self-management asthma control and the prevention of asthma exacerbations. Written asthma action plans provide instruction on the appropriate use of medications and identifying and avoiding exposure to asthma triggers. There is evidence that provision of a written action plan significantly increases patient adherence to treatment and asthma control and physicians' recommendations for management and medical follow-up.[17]
Opportunity for Improvement	National guidelines for treatment of asthma include recommendations for providing written asthma action plans. However, the use of asthma action plans may be limited in clinical practice. One study found that 74% of patients with controlled asthma and 65% of patients with uncontrolled asthma reported never received an asthma action plan.[18] A 2009 Asthma Insight and Management survey found that half of physicians prepared a written action plan for all or most of their patients. A lower percentage (32%) of patients reported ever having received a written asthma action plan from their physician.[7]
Exception Justification	This measure has no exceptions.
Harmonization with Existing Measures	There are no existing performance measures at the individual provider or system levels that address provision of a written asthma action plan.

Measure Designation

Measure purpose	Quality Improvement Accountability
Type of measure	Process
Care setting	Ambulatory Care: Clinician Office Clinic
Data source	Registry Electronic Health Record System

Asthma Control: Minimal Important Difference Improvement – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

DESCRIPTION:
Percentage of patients aged 12 years and older whose asthma is not well-controlled as indicated by the Asthma Control Test, Asthma Control Questionnaire, or Asthma Therapy Assessment Questionnaire and who demonstrated a minimal important difference improvement upon a subsequent office visit during the 12-month reporting period.

INSTRUCTIONS:
This outcomes measure e is to be reported a **minimum of once per reporting period** for all patients with a diagnosis of asthma who demonstrate a score ≤ 19 on the Asthma Control Test (ACT), ≥ 1.5 on the Asthma Control Questionnaire (ACQ) or ≥1 on the Asthma Therapy Assessment Questionnaire (ATAQ) and who had at least one follow-up ACT, ACQ, or ATAQ within the 12-month reporting period. In order to meet this measure, the patient must demonstrate a minimal importance difference (MID) improvement between their asthma control score from the initial visit and a subsequent score taken during the 12-month reporting period using the same patient-completed questionnaire. An increase in score by greater than or equal to 3 points on the ACT, decrease in score by greater than or equal to .5 points on the ACQ or a decrease in score by greater than or equal to 1 point on the ATAQ will indicate a minimal importance difference improvement and a higher measure performance. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific coding.

Data Source:
ICD-10-CM diagnosis codes, CPT codes, patient demographics and medical record data are used to identify patients who are included in the measure's denominator. Medical record data and the listed numerator options are used to report the numerator of the measure.

DENOMINATOR:
All patients aged 12 years or older whose asthma is not well-controlled and who had at least one follow-up ACT, ACQ, or ATAQ within the 12-month reporting period.

Definition:
For the purposes of this measure, asthma that is not well-controlled will be defined by a score of ≤ 19 on the ACT, ≥ 1.5 on the ACQ or ≥1 on the ATAQ.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 12 years on date of encounter
AND
Diagnosis for asthma (ICD-10-CM): J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
AND
At least two patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Asthma was not well-controlled based on score of ≤ 19 on the ACT or ≥ 1.5 on the ACQ or ≥1 on the ATAQ at one visit
AND
At least one subsequent patient encounter during the reporting period with completion of the same asthma assessment patient-completed questionnaire (ACT, ACQ or ATAQ)
AND NOT
Diagnosis for COPD (ICD-10-CM): J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9

NUMERATOR:
Patients who demonstrate a minimal important difference (MID) improvement using one of the following three asthma assessment patient-completed questionnaires:

- Change in the Asthma Control Test (ACT) by ≥ 3 points
- Change in Asthma Control Questionnaire (ACQ) by ≥ 0.5 points
- Change in Asthma Therapy Assessment Questionnaire (ATAQ) by ≥ 1 point

Numerator Options:

Performance Met: MID improvement demonstrated, increase in score by ≥ 3 points on the ACT

OR

Performance Met: MID improvement demonstrated, decrease in score by ≥ 0.5 points on the ACQ

OR

Performance Met: MID improvement demonstrated, decrease in score by ≥ 1 point on the ATAQ

OR

Medical Performance Exclusion: Medical reason(s) for patient not demonstrating MID improvement (eg, respiratory infection within 4 weeks of follow-up visit)

OR

Patient Performance Exclusion: Patient reasons for not demonstrating MID improvement (eg, patients with poor adherence to controller therapy as determined by self-report or pharmacy records (per cent of days covered < 50 %))

OR

Performance Not Met: MID improvement **NOT** demonstrated, reason not otherwise specified

RATIONALE:
Current asthma guidelines recommend assessing an asthma patient's level of control and emphasize that the goal of asthma therapy is to achieve control. Several validated asthma questionnaires can be used to assess control. In order to assess clinical improvement or worsening of asthma control in an individual or population overtime, the minimal important difference (MID) [also referred to as the minimal clinically important difference or MCID] can be used. The MID is defined as the smallest difference in score on the instrument that represents a clinically significant change (Schatz 2009).

Lack of asthma control impairs quality of life and is a risk factor for subsequent exacerbations. When control is not achieved, escalation of therapy is warranted to attain and maintain control.

Schatz M, Kosinski M, Yarlas AS, Hanlon J, Watson ME, Jhingran P. The minimally important difference of the Asthma Control Test. J Allergy Clin Immunol 2009;124(4):719-723 e1, Epub 2009/09/22.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

Once treatment is started, the results of the measures of impairment and risk are used to monitor asthma control rather than severity. Monitoring the level of asthma control is used to adjust medication as needed.

National Asthma Education and Prevention Program Guidelines Implementation Panel Report for: Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma, 2008. Bethesda, MD: National Heart, Lung, and Blood Institute, US Dept of Health and Human Services; 2008.

Four instruments have established cutoff values for uncontrolled versus controlled asthma: ACQ score of 1.5 or greater, ACT score of 19 or less, ATAQ score of 1 or greater, and Childhood Asthma Control Test [cACT] score of 19 or less (US study).

Two asthma control composite score instruments (ACQ and ACT) have been designated as core measures for the NIH-initiated clinical research in adults because of (1) the importance of asthma control as a goal of therapy; (2) extensive validation data for these instruments, using the widest range of criterion and construct measures and including demonstration of responsiveness to therapy and an MCID; and (3) low patient burden and risk.

Cloutier MM, Schatz M, Castro M, Clark N, Kelly HW, Mangione-Smith R, et al. Asthma outcomes: composite scores of asthma control. J Allergy Clin Immunol. 2012;129(3) Suppl:S24–S33. doi: 10.1016/j.jaci.2011.12.980

The Asthma Control: Minimal Important Difference Improvement measure was developed by the American Academy of Allergy Asthma and Immunology (AAAAI). The measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The CPT® contained in the measure specification is copyright 2004-2014 American Medical Association.

Measure Type: Outcome

Blood Pressure Control for Patients With Hypertension (BPC-E)

SUMMARY OF CHANGES TO HEDIS MY 2025

- This is a first-year measure.

Description	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.
Measurement period	January 1–December 31.
Clinical recommendation statement	The American Academy of Family Physicians (AAFP) strongly recommends clinicians treat adults who have hypertension to a standard blood pressure target (<140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality. The Joint National Committee recommends that pharmacologic treatment be initiated in the general population <60 years, to lower systolic BP ≥140 mm Hg (and treat to a goal of systolic BP <140 mm Hg) and to lower diastolic BP ≥90 mm Hg (and treat to a goal of diastolic BP <90 mm Hg). The American College of Cardiology (ACC) and American Heart Association (AHA) recommend a target BP of less than 130/80 mm Hg for adults with confirmed hypertension and known cardiovascular disease (CVD) or 10-year atherosclerotic CVD event risk of 10% or higher. In addition, they have determined that a reasonable target BP for adults with confirmed hypertension, without additional markers of increased CVD risk, is less than 130/80 mm Hg.
Citations	Coles, S., L. Fisher, K. Lin, C. Lyon, A. Vosooney, and M. Bird. "Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP." November 14, 2022. James, P.A., S. Oparil, B.L. Carter, W.C. Cushman, C. Dennison-Himmelfarb, J. Handler, D.T. Lackland, et al. "2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)." *JAMA* 311, no. 5 (February 5, 2014): 507–20. https://doi.org/10.1001/jama.2013.284427 Whelton, P.K., R.M. Carey, W.S. Aronow, D.E. Casey, K.J. Collins, C. Dennison Himmelfarb, S.M. DePalma, et al. "2017 ACC/AHA/AAPA/ABC/ACPM/AGS/ APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines." *Hypertension 71,* no. 6 (June 2018): e13–115. https://doi.org/10.1161/HYP.0000000000000065

Characteristics	
Scoring	Proportion.
Type	Outcome.
Stratification	• <140/90 mm Hg. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Race (for each product line): ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity (for each product line): ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Allocation:** The member was enrolled with a medical benefit during the measurement period. No more than one gap in enrollment of up to 45 days during the measurement period. 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 continuously enrolled). The member must be enrolled on the last day of the measurement period. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.

Definitions	
Participation	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.
Participation period	The measurement period.
Initial population	Members who are 18-85 years old as of the last day of the measurement period who meet either of the following criteria: • At least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period. • At least one outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) and at least one dispensed antihypertensive medication (Antihypertensive Medications List) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period.
Exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS code 81). • Members with a nonacute inpatient admission during the measurement period. To identify nonacute inpatient admissions: – Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). – Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. – Identify the admission date for the stay. • Members with a diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Kidney Transplant Value Set), any time during the member's history on or prior to the last day of the measurement period. Do not include laboratory claims (claims with POS code 81).

	• Members with a procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set) any time during the member's history on or prior to the last day of the measurement period. • Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement period. Do not include laboratory claims (claims with POS code 81). • Medicare members 66 years of age and older as of the last day of the measurement period 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. • Members 66–80 years of age as of the last day of the measurement period (all product lines) with frailty ***and*** advanced illness. Members must meet ***both*** frailty and advanced illness criteria to be excluded: 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81). 2. **Advanced Illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). – Dispensed dementia medication (Dementia Medications List). • Members 81 years of age and older as of the last day of the measurement period (all product lines) with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population, minus exclusions.
Numerator	The systolic and diastolic BP values <140/90 (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) from the most recent day a BP was recorded during the measurement period, on or after the date of the second hypertension event. Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or ED visit (ED Value Set; POS code 23). If there are multiple BPs on the same date of service, use the last BP reading on that date as the representative BP.

	The member is numerator compliant if the representative BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement period or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance: • Systolic Compliant: Systolic Less Than 140 Value Set. • Systolic Not Compliant: CPT-CAT-II code 3077F. • Diastolic Compliant: Diastolic Less Than 90 Value Set. • Diastolic Not Compliant: CPT-CAT-II code 3080F.

Data Elements for Reporting

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

Table BPC-E-A-1/2/3: Data Elements for Blood Pressure Control for Patients With Hypertension

Metric	Data Element	Reporting Instructions
BPUnder140Over90	InitialPopulation	Report once
	ExclusionsByEHR	Report once
	ExclusionsByCaseManagement	Report once
	ExclusionsByHIERegistry	Report once
	ExclusionsByAdmin	Report once
	Exclusions	(Sum over SSoRs)
	Denominator	Report once
	NumeratorByEHR	Report once
	NumeratorByCaseManagement	Report once
	NumeratorByHIERegistry	Report once
	NumeratorByAdmin	Report once
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Table BPC-E-B-1/2/3: Data Elements for Blood Pressure Control for Patients With Hypertension: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
BPUnder140Over90	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification
	Asian	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Denominator	For each Stratification
	NativeHawaiianOrOtherPacificIslander	Numerator	For each Stratification
	White	Rate	(Percent)
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table BPC-E-C-1/2/3: Data Elements for Blood Pressure Control for Patients With Hypertension: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
BPUnder140Over90	HispanicOrLatino	InitialPopulation	For each Stratification
	NotHispanicOrLatino	Exclusions	For each Stratification
	AskedButNoAnswer	Denominator	For each Stratification
	Unknown	Numerator	For each Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

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

Rules for Allowable Adjustments of Blood Pressure Control for Patients With Hypertension

NONCLINICAL COMPONENTS		
Initial Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Using product line criteria is not required. Including any product line, combining product lines or not including product line criteria is allowed.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (ages 18–85 years). The denominator age may not be expanded.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Other	Yes	Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Initial Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions: Hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness	Yes	The hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Exclusions: ESRD and pregnancy	No	The ESRD and pregnancy exclusions must be applied. The value sets and logic may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
BP <140/90 mm Hg.	No	Value sets and logic may not be changed.

Care Coordination Quality Measure for Primary Care (CCQM-PC)

Your Care Coordination Experience

Survey Instructions

Answer each question by marking the box to the left of your answer. You are sometimes told to skip over some questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

[1] ☐ Yes
[2] ☒ No → **If No, go to #1**

Introduction

This survey asks questions about your experience with care coordination. Care coordination refers to health care that is provided in a planned way that meets the needs and preferences of the patient. When care is coordinated well, the patient and his or her doctors, nurses, other health care providers, family, and other caregivers all know who is responsible for different parts of the patient's care, and they communicate with each other so that everyone has the information they need.

Your answers to this survey will help us learn more about people's experiences with care coordination.

Definitions

Below are several definitions of terms that are used throughout the survey. Some of these definitions are relevant to specific sections of the survey and are also included at the beginning of that section.

Your primary care provider: The doctor or other provider who cares for most of your usual health care needs and who you normally see when you need care for a new illness or injury, to maintain or control a health issue, or to prevent health problems so you can stay healthy.

Other primary care professionals in this office: doctors, nurse practitioners, physician assistants, nurses, and others who work in the same office or group as your primary care provider and also help people get better, maintain their health, and prevent problems to stay healthy.

Primary care office: A group of primary care professionals and the staff who work with them in an office. The primary care professionals and other staff in the office all work for the same organization or business that shares a common goal of caring for the health needs of patients and keeping patients healthy. A primary care office is designed to be the first place patients go to get their health needs met.

Other health care professionals: Specific or specialized care from doctors, nurse practitioners, physician assistants, nurses, and others who work outside of your primary care practice.

Health care team: this includes your primary care provider, other primary care professionals, and other health care professionals who care for you. It also includes people who are not primary care professionals; for example, the people in your life such as yourself, family members, or friends that help you get the care you need to feel better or stay healthy.

Care plan: Sometimes, in order to coordinate care, the patient and/or family creates a care plan, together with one or more health care providers. It can be created for people with any health condition. The care plan covers the patient's needs and goals for health care and identifies any gaps in care coordination. The plan may set goals for the patient and the patient's providers. Ideally, it anticipates routine needs and tracks current progress toward a patient's goals. This plan is often called a care plan or a plan of action.

Seeking care in the last 12 months

1. In the last 12 months, how many times did you visit your primary care provider's office to get care for yourself from your primary care provider or other primary care professionals?

1 ☐ None
2 ☐ 1
3 ☐ 2
4 ☐ 3
5 ☐ 4
6 ☐ 5 to 9
7 ☐ 10 or more times

2. In the last 12 months, apart from scheduling appointments, how many times did you contact your primary care provider or other primary care professionals in this office about your health—for example, by email or phone call?

1 ☐ None
2 ☐ 1
3 ☐ 2
4 ☐ 3
5 ☐ 4
6 ☐ 5 to 9
7 ☐ 10 or more times

3. In the last 12 months, including your primary care provider, how many different primary care professionals at your primary care provider's office have you seen for a health reason?

1 ☐ 1
2 ☐ 2
3 ☐ 3 or more
4 ☐ I did not get care from this primary care provider's office in the last 12 months.

4. In the last 12 months, how many health care professionals outside of your primary care provider's office have you seen for a health reason?

1 ☐ None
2 ☐ 1
3 ☐ 2
4 ☐ 3 or more

Knowing Who Does What

Care coordination: this refers to health care that is provided in a planned way that meets the needs and preferences of the patient. When care is coordinated well, the patient and his or her doctors, nurses, other health care providers, family, and other caregivers all know who is responsible for different parts of the patient's care, and they communicate with each other so that everyone has the information they need.

Health care team: this includes your primary care provider, other primary care professionals, and other health care professionals who care for you. It also includes people who are not primary care professionals—for example, the people in your life such as yourself, family members, or friends that help you get the care you need to feel better or stay healthy.

5. In the last 12 months, how often did you know what aspects of your care you were responsible for?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

6. In the last 12 months, if you had health problems, how often did your primary care provider or other primary care professionals in this office talk with you about what to do if your condition got worse or came back?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health problem in the last 12 months.

7. In the last 12 months, if you saw more than one health care professional for your health care needs, how often did you know which one to get in touch with when you needed medical care?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not see more than one health care professional for my health care needs in the last 12 months.

Communicating with your health care providers

8. In the last 12 months, if you called your primary care provider's office with a medical question during regular office hours, how often did you get an answer that same day?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not call my primary care provider's office with a medical question during regular office hours in the last 12 months.

9. In the last 12 months, if you called your primary care provider's office **after regular office hours,** how often did you get the help or advice you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not call my primary care provider's office after regular office hours in the last 12 months.

10. In the last 12 months, if you emailed your primary care provider's office with a question, how often did you get an answer as soon as you needed it?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not email my primary care provider's office with a question in the last 12 months.

11. In the last 12 months, how often did the primary care professionals in your primary care provider's office make it easy for you to discuss your care in your preferred language?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

12. In the last 12 months, if you needed to talk to your primary care provider or another primary care professional in this office, how often did you get to talk to the primary care professional who knows you best?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not need to talk to my primary care provider or another primary care professional in this office in the last 12 months.

13. In the last 12 months, how often did your primary care provider or other primary care professionals in this office explain things in a way that was easy to understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

14. In the last 12 months, how often did your primary care provider or other primary care professionals in this office listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

15. In the last 12 months, how often did your primary care provider or other primary care professionals in this office encourage you to ask all the questions you had?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

16. In the last 12 months, how often did your primary care provider or other primary care professional in this office ask you if you understood all of the information he or she gave you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

17. In the last 12 months, how often have you felt comfortable asking questions of your primary care provider or other primary care professionals you saw in this office?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Sharing health information

Care plan: Sometimes, in order to coordinate care, the patient and/or family creates a care plan, together with one or more health care providers. It can be created for people with any health condition. The care plan covers the patient's needs and goals for health care and identifies any gaps in care coordination. The plan may set goals for the patient and the patient's providers. Ideally, it anticipates routine needs and tracks current progress toward a patient's goals. This plan is often called a **care plan** or a **plan of action**.

18. In the last 12 months, how often did your primary care provider or other primary care professionals in this office know about your past health problems or past treatments?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

19. In the last 12 months, if you saw a health care professional outside of your primary care provider's office, how often did your primary care provider know about any tests or results from these visits?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not see a health care professional outside of my primary care provider's office in the last 12 months.

20. In the last 12 months, how often has it seemed like your primary care provider's office keeps health information about you complete and up-to-date?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

21. In the last 12 months, if you asked someone at your primary care provider's office for your medical records, how often did you get them as soon as you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not ask my primary care provider's office for my medical records in the last 12 months.

Develop and execute a plan of action for your care: *Assessing your needs and goals*

22. In the last 12 months, if you had a health insurance plan, how often did your primary care provider or other primary care professionals in this office talk with you about what is and is not covered by your insurance plan?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have health insurance in the last 12 months.

23. In the last 12 months, how often did your primary care provider or other primary care professionals in this office talk to you about any support you might need to take care of your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

24. In the last 12 months, how often did your primary care provider or other primary care professionals at this office ask about your goals for taking care of your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

25. In the last 12 months, how often has your primary care provider or other primary care professional at this office helped you in setting goals for taking care of your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Develop and execute a plan of action for your care: *Collaboration on the design of care*

26. In the last 12 months, how often did your primary care provider or other primary care professionals at this office consider your preferences for where you wanted to receive your care?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

27. Choices for your treatment or health care can include choices about tests and screenings, preventive health care (e.g., flu shot), medicine, surgery, or other treatment.

In the last 12 months, how often did your primary care provider or other primary care professionals in this office tell you there was more than one choice for your health care or treatment?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

28. In the last 12 months, if you talked about different options for your health care or treatment with your primary care provider or other primary care professionals in this office, how often did they talk with you about the reasons for choosing an option?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not talk to my primary care provider or other primary care professionals in this office about different options for my health care or treatment.

29. In the last 12 months, if you talked about different options for your health care or treatment with your primary care provider or other primary care professionals in this office, how often did they talk about the reasons for **not** choosing an option?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not talk to my primary care provider or other primary care professional in this office about different options for my health care or treatment.

Develop and execute a plan of action for your care: *Creating a health care plan of action*

Care plan: Sometimes, in order to coordinate care, the patient and/or family creates a care plan, together with one or more health care providers. It can be created for people with any health condition. The care plan covers the patient's needs and goals for health care and identifies any gaps in care coordination. The plan may set goals for the patient and the patient's providers. Ideally, it anticipates routine needs and tracks current progress toward a patient's goals. This plan is often called a **care plan** or a **plan of action**.

30. In the last 12 months, how often did your primary care provider or other primary care professionals in this office help you create a plan of action that you use every day to help you take care of your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

31. In the last 12 months, if you and a primary care professional in this office had a plan of action to take care of your health, how often did the plan **include different ways to communicate with your primary care practice**?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health care plan of action with primary care professionals in this office in the last 12 months.

32. In the last 12 months, if you and a primary care professional in this office had a plan of action to take care of your health, how often did the plan **include specific outcomes that would tell you when you met your goals**? Outcomes can include functional goals, such as being able to walk a flight of stairs without losing your breath, or target rates—for example, a blood pressure reading below 120/80 mmHg?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health care plan of action with primary care professionals in this office in the last 12 months.

33. In the last 12 months, if you and a primary care professional in this office had a plan of action to take care of your health, how often did the **plan include what to do if there is a problem or a change in your health**?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health care plan of action with primary care professionals in this office in the last 12 months.

34. During stressful times, some people find it harder to take care of their health. In the last 12 months, how often did your primary care provider or other primary care professionals in this office help you to plan ahead so that you could take care of your health even during difficult or stressful times?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Develop and execute a plan of action for your care: *Following up, identifying problems, and making adjustments*

35. In the last 12 months, if you had a health problem, how often did your primary care provider or other primary care professional in this office follow up on a health problem you had, either at the next visit or by phone?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have a health problem in the last 12 months.

36. In the last 12 months, how often did your primary care provider or other primary care professionals in this office ask you how your health or treatment affected your daily life?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

37. In the last 12 months, if you had treatment, how often did your primary care provider or other primary care professionals in this office follow up with you to find out what was working well with your treatment?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have treatment in the last 12 months.

38. In the last 12 months, how often did your primary care provider or other primary care professionals in this office discuss with you whether you were getting the health care you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Connecting you to other sources of care

39. In the last 12 months, if you needed a referral from your primary care provider to see another health care professional, how often did you get one as soon as you needed it?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not need a referral to another health care professional in the last 12 months.

40. In the last 12 months, if you needed to visit another health care professional outside of your primary care provider's office, how often did someone in your primary care provider's office help you make the appointment?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not need to visit a health care professional outside of my primary care provider's office in the last 12 months.
6 ☐ When I needed to visit a health care professional outside of my primary care provider's office in the last 12 months, I did not seek help from anyone in my primary care provider's office.

41. In the last 12 months, how often did your primary care provider or other primary care professionals in this office give you information about available community-based services to support your health such as support groups, classes, counselors, community recreation programs, or faith-based activities?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

42. In the last 12 months, if your primary care provider or another primary care professional in this office told you about resources available in the community that could help you take care of yourself or your family, how often did someone in your primary care provider's office follow up with you about your use of these resources?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ Community-based services were not recommended to me in the last 12 months.

43. In the last 12 months, if you had health problems, how often did your primary care provider or other primary care professionals in this office help you connect with other people with similar health problems?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have health problems in the last 12 months.

Helping you take care of yourself

44. In the last 12 months, if you had an illness or injury, how often did your primary care provider or other primary care professionals in this office ask whether you had enough services to help you take care of this illness or injury at home?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not have an illness or injury in the last 12 months.

45. In the last 12 months, if you needed help at home to manage your health, how often did someone in your primary care provider's office arrange services for you at home to help manage your health condition?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I did not need help at home to manage my health in the last 12 months.

46. In the last 12 months, how often did you feel like the activities that primary care professionals in this office recommended for your care took into account the responsibilities you have at work or home?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

47. In the last 12 months, how often did a primary care professional in this office give you health information such as booklets or videos about what you can do for your health?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

About You

48. In general, how would you rate your overall **physical** health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

49. In general, how would you rate your overall **mental or emotional** health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

50. In the last 12 months, did you get health care 3 or more times for the same condition or problem?

1 ☐ Yes
2 ☐ No → **If No, go to #52**

51. Is this a condition or problem that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

1 ☐ Yes
2 ☐ No

52. Do you now need or take medicine prescribed by a doctor? Do **not** include birth control.

1 ☐ Yes
2 ☐ No → **If No, go to #54**

53. Is this medicine to treat a condition that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

1 ☐ Yes
2 ☐ No

54. In the last 12 months, did you have to stay in the hospital for at least one night?

1 ☐ Yes
2 ☐ No

55. In the last 12 months, were you admitted to or discharged from a nursing home or rehabilitation facility?

1 ☐ Yes
2 ☐ No

56. In the last 12 months, did you have health insurance?

1 ☐ Yes
2 ☐ No

57. What is your age?

1 ☐ 18 to 24 years
2 ☐ 25 to 34
3 ☐ 35 to 44
4 ☐ 45 to 54
5 ☐ 55 to 64
6 ☐ 65 to 74
7 ☐ 75 or older

58. Are you male or female?

1 ☐ Male
2 ☐ Female

59. What is the highest grade or level of school that you have completed?

1 ☐ 8th grade or less
2 ☐ Some high school, but did not graduate
3 ☐ High school graduate or GED
4 ☐ Some college or 2-year degree
5 ☐ 4-year college graduate
6 ☐ More than 4-year college degree

60. Are you Hispanic, Latino/a, or Spanish origin?

1 ☐ Yes, Hispanic, Latino/a, or Spanish origin
2 ☐ No, not of Hispanic, Latino/a, or Spanish origin

61. What is your race? *Mark one or more.*

1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
4 ☐ Asian Indian
5 ☐ Chinese
6 ☐ Filipino
7 ☐ Japanese
8 ☐ Korean
9 ☐ Vietnamese
10 ☐ Other Asian
11 ☐ Native Hawaiian
12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander

62. What is your preferred language?

1 ☐ English
2 ☐ Other
Please specify:
_____

63. How well do you speak English?

1 ☐ Very well
2 ☐ Well
3 ☐ Not well
4 ☐ Not at all

64. Did someone help you complete this survey?

1 ☐ Yes → **If Yes, go to #65**
2 ☐ No → **If No, go to #66**

65. How did that person help you? Mark one or more.

1 ☐ Read the questions to me
2 ☐ Wrote down the answers I gave
3 ☐ Answered the questions for me
4 ☐ Translated the questions into my language
5 ☐ Helped in some other way

66. Have you ever received professional treatment for any of the following conditions? Professional treatment refers to any treatment supervised by a health professional.

	YES, I have received professional treatment for this condition	**NO, I have NOT received professional treatment for this condition**
Arthritis?	☐	☐
Chronic back/neck pain?	☐	☐
Any other chronic pain?	☐	☐
High blood pressure or hypertension?	☐	☐
Congestive heart failure?	☐	☐
Coronary artery disease?	☐	☐
High blood cholesterol or hyperlipidemia?	☐	☐
Asthma?	☐	☐
Chronic Obstructive Pulmonary Disease (COPD)?	☐	☐
Diabetes?	☐	☐
Osteoporosis?	☐	☐
Skin cancer?	☐	☐
Any other kind of cancer?	☐	☐
Anxiety disorder?	☐	☐
Depression?	☐	☐
Any other emotional problem?	☐	☐
Substance problems (drugs or alcohol)?	☐	☐
Stroke	☐	☐
Chronic Kidney Disease	☐	☐
Hepatitis	☐	☐

Thank You
Please return the completed survey in the postage-paid envelope.

Suggested Citation: Agency for Healthcare Research and Quality. Care Coordination Measure for Primary Care Survey. Prepared under Contract No. HHS290-2010-00005I. AHRQ Publication No. 16-0042-1-EF. Rockville (MD): Agency for Healthcare Research and Quality; 2016.
http://www.ahrq.gov/carecoordination

This project was funded under contract number HHS290-2010-00005I from the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. The opinions expressed in this document are those of the authors and do not reflect the official position of AHRQ or the U.S. Department of Health and Human Services.

AHRQ Pub. No. 16-0042-1-EF
July 2016

www.ahrq.gov

Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

2024 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 clinician receives a report from the clinician to whom the patient was referred.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for the first referral for all patients during the measurement 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 measurement period based on the services provided and the measure-specific denominator coding. The clinician who refers the patient to another clinician is the clinician who should be held accountable for the performance of this measure. All MIPS 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, however, only first referrals made between January 1 - October 31 (the measurement period) will count towards the denominator to allow adequate time for the referring clinician to collect the consult report by the end of the performance period. When clinicians to whom patients are referred communicate the consult report as soon as possible with the referring clinicians, 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 (including but not limited to encounters coded with GQ, GT, 95, POS 02, POS 10) 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 an encounter during the performance period and were referred by one clinician to another clinician on or before October 31

> ***DENOMINATOR NOTE*****:** *If there are multiple referrals for a patient during the measurement 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 clinician or specialist during the measurement period: G9968

NUMERATOR:

Number of patients with a referral on or before October 31, for which the referring clinician received a report from the clinician to whom the patient was referred

Definitions:

Referral – A request from one clinician to another clinician 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 clinician which pertain to a particular referral, use the first consultant report to satisfy the measure.*

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

Numerator Options:

Performance Met:	Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred **(G9969)**
OR	
Performance Not Met:	Clinician who referred the patient to another clinician did not receive a report from the clinician 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 [1,2,3]. 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 pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialists for only 51% of referrals [2].

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 [4].

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 [5]. 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 [2].

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 [6].

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CLINICAL RECOMMENDATION STATEMENTS:

None

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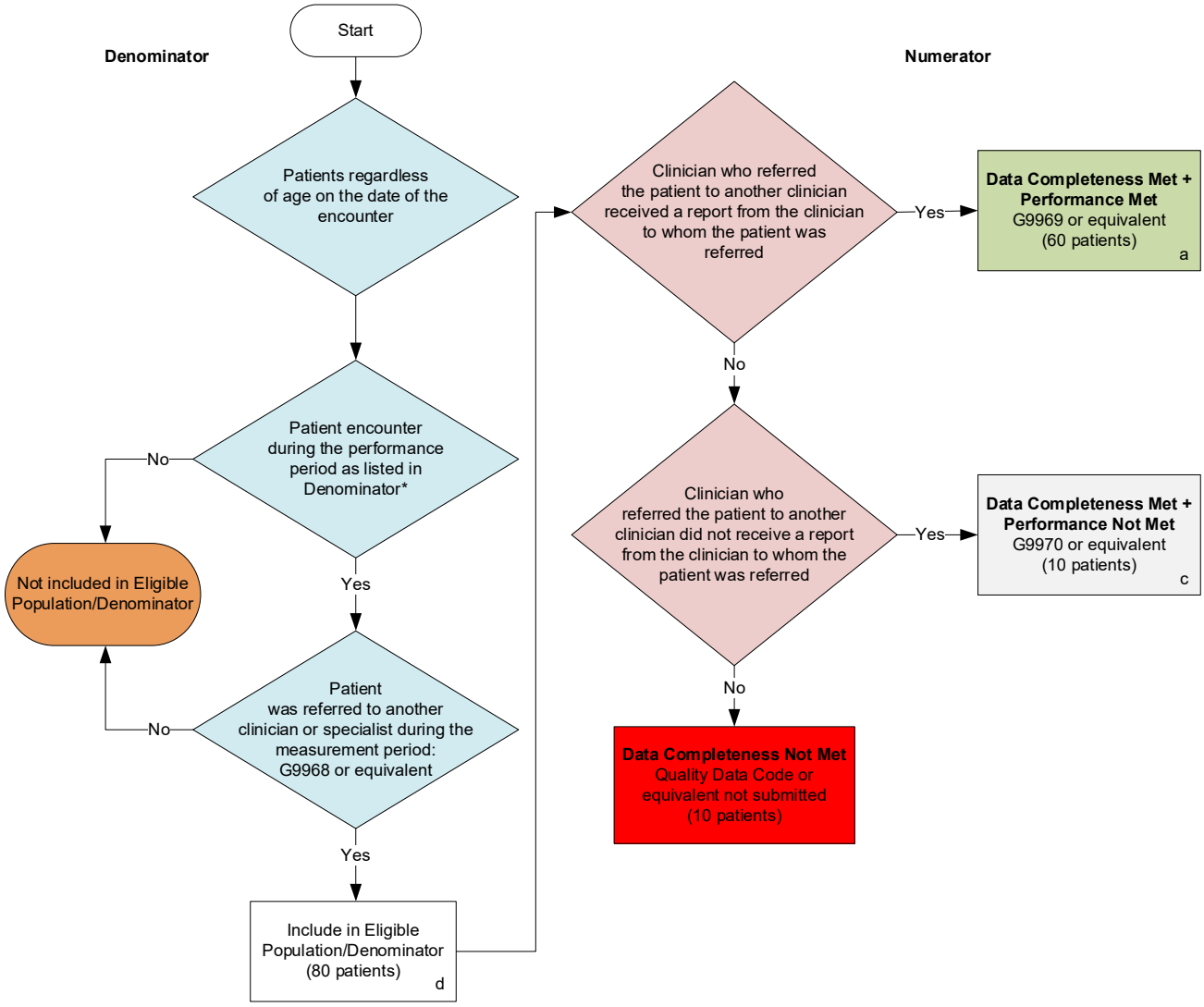
2024 Clinical Quality Measure Flow for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

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

2024 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 clinician or specialist during the measurement period.*
4. Check *Patient was referred to another clinician or specialist during the measurement period*:
    a. If *Patient was referred to another clinician or specialist during the measurement period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient was referred to another clinician or specialist during the measurement period* equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population
    - 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 *Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred*:
    a. If *Clinician who referred the patient to another clinician received a report from the clinician 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 *Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred* equals No, proceed to check *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred.*
8. Check *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred:*
    a. If *Clinician who referred the patient to another clinician did not receive a report from the clinician 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 *Clinician who referred the patient to another clinician did not receive a report from the clinician 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.

*Documented Assessment After Mammogram (DBM-E)**

***This measure was supported by Cooperative Award NU380T000303 from the Centers for Disease Control and Prevention and the National Network of Public Health Institutes (NNPHI). Its contents are the sole responsibility of the authors (NCQA) and do not necessarily represent the official position of the Centers for Disease Control and Prevention, the US Department of Health and Human Services, the US government, or the NNPHI.**

SUMMARY OF CHANGES TO HEDIS MY 2025

- This is a first-year measure.

Description	The percentage of episodes of mammograms documented in the form of a BI-RADS assessment within 14 days of the mammogram for members 40–74 years of age.
Measurement period	January 1–December 31.
Clinical recommendation statement	The National Comprehensive Cancer Network recommends breast cancer screening follow-up actions in alignment with the Breast Imaging Reporting and Data System (BI-RADS) scoring categories. The BI-RADS categorization offers specific recommendations for different findings: Category 0: Incomplete — Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison, advises additional imaging. Category 1: Negative or Category 2: Benign advises resuming routine screening. Category 3: Probably Benign, recommends diagnostic mammograms at 6 months, followed by repeat screenings every 6–12 months for 1–2 years, if appropriate. Category 4: Suspicious and Category 5: Highly Suggestive of Malignancy, the recommendation is for tissue diagnosis using core needle biopsy (preferred) or needle localization excisional biopsy with specimen radiograph. When a needle biopsy (aspiration or core needle biopsy) is performed, obtaining concordance between the pathology report and the imaging finding is crucial. For Category 6: Known Biopsy-Proven Malignancy, the recommendation depends on the primary tumor, size of the invasive component, estimated disease volume, histological grade and other relevant characteristics. All recommendations are Category 2A recommendations. Based on lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Citations	Sickles, Edward A., Carl J. D'Orsi, Lawrence W. Bassett, Catherine M. Appleton, Wendie A. Berg, and Elizabeth S. Burnside. "Acr bi-rads® mammography." ACR BI-RADS® atlas, breast imaging reporting and data system 5 (2013): 2013. Gradishar, W.J., M.S. Moran, J. Abraham, et al. 2022. "Breast Cancer, Version 3.2022, NCCN Clinical Practice Guidelines in Oncology." *J Natl Compr Canc Netw.* 20(6):691–722. doi:10.6004/jnccn.2022.0030

Characteristics

Scoring	Proportion.
Type	Process.
Stratification	• Documented assessment after mammogram. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** The denominator for this measure is based on episodes, not on members. **Allocation:** The member was enrolled with a medical benefit on the date of the episode through 14 days after the episode date with no gaps in enrollment. **Reporting:** Commercial, Medicaid, Medicare (report each product line separately).
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the participation period.
Participation period	The episode date through 14 days after the episode date.
Intake Period	December 18 of the prior measurement period to December 17 of the measurement period. The intake period is used to capture the episode date.
Episode Date	The date of service for an eligible encounter during the intake period with a mammogram procedure.
BI-RADS Assessment	Clinically documented BI-RADS score. BI-RADS is a standardized classification system proposed by the American College of Radiology, used for imaging of mammography, ultrasound and MRI of the breast.
Initial population	Episodes of mammograms (Mammography Value Set) during the intake period, for members 40–74 years of age as of the episode date.

Exclusions	• Members who die any time during the measurement period. • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.
Denominator	The initial population, minus exclusions.
Numerator	Episodes of mammograms that receive a BI-RADS score (BIRADS Assessment Value Set) on or within 14 days after the episode date (15 days total).

Data Elements for Reporting

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

Table DBM-E-A-1/2/3: Data Elements for Documented Assessment After Mammogram

Metric	Data Element	Reporting Instructions
DocumentedMammogram Assessment	InitialPopulationByEHR	Report once
	InitialPopulationByCaseManagement	Report once
	InitialPopulationByHIERegistry	Report once
	InitialPopulationByAdmin	Report once
	InitialPopulation	(Sum over SsoRs)
	ExclusionsByEHR	Report once
	ExclusionsByCaseManagement	Report once
	ExclusionsByHIERegistry	Report once
	ExclusionsByAdmin	Report once
	Exclusions	(Sum over SsoRs)
	Denominator	Report once
	NumeratorByEHR	Report once
	NumeratorByCaseManagement	Report once
	NumeratorByHIERegistry	Report once
	NumeratorByAdmin	Report once
	Numerator	(Sum over SsoRs)
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

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

Rules for Allowable Adjustments of Documented Assessment After Mammogram

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"). The denominator age may be expanded.
Allocation	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 initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Initial Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Value sets and logic may not be changed.
Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions: Hospice and deceased member	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Denominator	**Adjustments Allowed (Yes/No)**	**Notes**
Denominator	No	The logic may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Mammograms with BI-RADS score	No	Value sets and logic may not be changed.

*Follow-Up After Abnormal Mammogram Assessment (FMA-E)**

***This measure was supported by Cooperative Award NU380T000303 from the Centers for Disease Control and Prevention and the National Network of Public Health Institutes (NNPHI). Its contents are the sole responsibility of the authors (NCQA) and do not necessarily represent the official position of the Centers for Disease Control and Prevention, the US Department of Health and Human Services, the US government, or the NNPHI.**

SUMMARY OF CHANGES TO HEDIS MY 2025

- This is a first-year measure.

Description	The percentage of episodes for members 40-74 years of age with inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of the assessment.
Measurement period	January 1–December 31.
Clinical recommendation statement	The National Comprehensive Cancer Network recommends breast cancer screening follow-up, in alignment with the Breast Imaging Reporting and Data System (BI-RADS) scoring categories, which offer recommendations for different findings: Category 0: Incomplete — Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison, advises additional imaging. Category 1: Negative Finding or Category 2: Benign, advises resuming routine screening; Category 3: Probably Benign, the recommendation is for diagnostic mammograms at 6 months, followed by repeat screenings every 6–12 months for 1–2 years, if appropriate; Category 4: Suspicious and Category 5: Highly Suggestive of Malignancy, the recommendation is for tissue diagnosis using core needle biopsy (preferred) or needle localization excisional biopsy with specimen radiograph. When a needle biopsy (aspiration or core needle biopsy) is performed, obtaining concordance between the pathology report and the imaging finding is crucial. For Category 6: Known Biopsy-Proven Malignancy, the recommendation depends on the primary tumor, size of the invasive component, estimated disease volume, histological grade and other relevant characteristics. All recommendations are Category 2A recommendations—based on lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Citations	Sickles, Edward A., Carl J. D'Orsi, Lawrence W. Bassett, Catherine M. Appleton, Wendie A. Berg, and Elizabeth S. Burnside. "Acr bi-rads® mammography." ACR BI-RADS® atlas, breast imaging reporting and data system 5 (2013): 2013. Gradishar, W.J., M.S. Moran, J. Abraham, et al. 2022. "Breast Cancer, Version 3. NCCN Clinical Practice Guidelines in Oncology." *J Natl Compr Canc Netw* 20(6):691–722. doi:10.6004/jnccn.2022.0030

Characteristics

Scoring	Proportion.
Type	Process.
Stratification	• Follow-Up After Abnormal Mammogram Assessment. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** The denominator for this measure is based on episodes, not on members. **Allocation:** The member was enrolled with a medical benefit on the date of the episode through 90 days after the episode date with no gaps in enrollment. **Reporting:** Commercial, Medicaid, Medicare (report each product line separately).
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the participation period.
Participation period	The episode date through 90 days after the episode date.
Intake period	October 3 of the year prior to the measurement period to October 2 of the measurement period. The intake period is used to capture the episode date.
Episode date	The dates of service during the intake period when a high-risk or inconclusive BI-RADS score was documented.
BI-RADS assessment	Clinically documented BI-RADS score. BI-RADS is a standardized classification system proposed by the American College of Radiology, used for the imaging of mammography, ultrasound and MRI of the breast.
Initial population	For members 40–74 years of age as of the episode date, episodes where the member had a high-risk (High Risk BIRADS Value Set) or inconclusive (Inconclusive BIRADS Value Set) BI-RADS assessment during the intake period.

Exclusions	• Members who die any time during the measurement period. • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.
Denominator	The initial population, minus exclusions.
Numerator	High-risk and inconclusive BI-RADS assessment during the Intake Period that received appropriate follow-up. Appropriate follow-up is defined as either of the following: • A high-risk BI-RADS assessment (High Risk BIRADS Value Set) result (Category 4: Suspicious – Category 5: Highly Suggestive of Malignancy), that received a breast biopsy (Breast Biopsy Value Set) on or within 90 days after the episode date (91 days total). • An inconclusive BI-RADS assessment (BI-RADS 0: Incomplete — Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison), (Inconclusive BIRADS Value Set) that received a mammogram (Mammography Value Set) or ultrasound (Breast Ultrasound Value Set) on or within 90 days after the episode date (91 days total).

Data Elements for Reporting

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

Table FMA-E-A-1/2/3: Data Elements for Follow-Up After Abnormal Mammogram Assessment

Metric	Data Element	Reporting Instructions
FollowUpMammogramAssessment	InitialPopulationByEHR	Report once
	InitialPopulationByCaseManagement	Report once
	InitialPopulationByHIERegistry	Report once
	InitialPopulationByAdmin	Report once
	InitialPopulation	(Sum over SsoRs)
	ExclusionsByEHR	Report once
	ExclusionsByCaseManagement	Report once
	ExclusionsByHIERegistry	Report once
	ExclusionsByAdmin	Report once
	Exclusions	(Sum over SsoRs)
	Denominator	Report once
	NumeratorByEHR	Report once
	NumeratorByCaseManagement	Report once
	NumeratorByHIERegistry	Report once
	NumeratorByAdmin	Report once
	Numerator	(Sum over SsoRs)
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

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

Rules for Allowable Adjustments of Follow-Up After Abnormal Mammogram Assessment

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"). The denominator age may be expanded.
Allocation	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 initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Initial Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Value sets and logic may not be changed.
Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions: Hospice and deceased member	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Denominator	**Adjustments Allowed (Yes/No)**	**Notes**
Denominator	No	The logic may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Follow-up after abnormal assessment	No	Value sets and logic may not be changed.

2	**Implement the National Culturally and Linguistically Appropriate Services (CLAS) Standards, developed by the U.S. Department of Health and Human Services Office of Minority Health. Implementation shall include:** **1. Completing an organizational evaluation of current practices and identifying a plan for implementing CLAS Standards that are not yet in place.** **2. Building and supporting a culturally and linguistically diverse practice team.** **3. Offering language assistance services to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of attributed members.** **4. Designing, implementing and improving programs that provide culturally appropriate services that meet the needs of the attributed members.** **15% of Annual Payment**	
	Milestone Measurement Program Year 2 (October 1, 2023 – September 30, 2024)	**Milestone Measurement Program Year 3** (October 1, 2024 – September 30, 2025)
	By September 30, 2024: A. Upload the completed National CLAS Standards implementation checklist and a plan for implementing CLAS Standards that are not yet in place. B. Upload documentation demonstrating how the practice recruits and supports a culturally and linguistically diverse practice team. C. Attest that the processes described in milestone 2B (Standards 2-4) have been implemented by 9/30/2024. D. NCQA ONLY- Upload documentation that the practice expects will satisfy the requirements for:	*By September 30, 2025:* E. Upload documentation demonstrating how the practice implements CLAS Standards 5-13. F. Attest that the processes described in milestone 2E have been implemented by 9/30/2025. G. NCQA ONLY- Upload documentation that the practice expects will satisfy the requirements for: a. NCQA HE 3.A, b. NCQA HE 3.B,

	a. NCQA HE 1.A and b. NCQA HE 1.B.	c. NCQA HE 3.C, d. NCQA HE 3.D, e. NCQA HE 5.A (Factors 1-5), f. NCQA HE 5.B, and g. NCQA HE 6.D (Factors 2, 4, and 6).

Core Component 2 Specifications	
System Collaboration Opportunities	Entities are responsible for implementing CLAS standards specific to the patient population they are responsible for. Practices are responsible for their attributed members, Plans are responsible for their enrollees, and AHCCCS is responsible for all members. Although Plans and AHCCCS have the largest responsibility, experience in this work, and resources to efficiently correspond with all members, providers are best equipped to collect patient and provider attributes. Communicating to the member that there is an adequate network of diverse and culturally competent providers increases their comfortability in seeking services.
Additional Resources	AZ CLAS Supplemental Toolkit (ADHS), Adult PCP Document Validation **Example Implementation Plan Template:** http://cfs.cbcs.usf.edu/projects-research/_docs/Implementation_Resources.pdf
CLAS Training Resources	**HHS: CLAS in Maternal Healthcare- E-Learning (free):** https://thinkculturalhealth.hhs.gov/education/maternal-health-care?utm_campaign=fyi_newsletter&utm_medium=email&utm_source=govdelivery **HHS: Fundamentals of CLAS- Youtube video (free):** https://www.youtube.com/watch?v=HOkFwCTVHSU **Quality Interactions: Variety- E-Learning (varies by price):** https://www.qualityinteractions.com/courses **Washington Governor's Interagency Council on Health Disparities: 4 E-Learning Modules (free):** https://healthequity.wa.gov/councils-work/clas-standards-training-and-resources

Core Component 2 Specifications	
	U of A: Introduction to Culturally and Linguistically Appropriate Services (CLAS) and Minority Health Disparities- E-Learning ($38): https://www.vlh.com/shared/courses/course_info.cfm?courseno=1802 **MATTC: Free CLAS Training- Instructor Led Virtual Training (free 8/7/2024, else $4K):** https://attcnetwork.org/news/free-clas-training/
Methodology (Attributed Members)	Provider attribution is consistent with the methodology used for performance measures (currently TI 1.0 Y6 methodologies). Generally: PCP participants are responsible for AHCCCS members seen for primary care services and patients empaneled-to but not seen by the practice when the patient does not seek PCP services from another outpatient facility. AHCCCS and ASU welcome feedback to improve these attribution methodologies in a standardized format with available data (e.g., "we'll send you a list of members" satisfies neither criteria). AHCCCS requires Health Plans to reconcile PCP assignment with the member's claims history by October, 2024 (and quarterly thereafter).
Examples	**Practices can meet this milestone in many ways, but should roughly approximate the level of effort described in the following example.** **Example:** an organization identifies through analyses of its patient population that its American Indian populations have lower rates of diabetes control compared to the population average. The organization interviews patients and local community organizations and identifies that American Indians experience challenges going to their providers' office and, once they arrive, they do not feel that providers consider their preferences. The organization requires cultural competence training for all practice staff to better understand the patients' concerns and preferences before developing a treatment plan. The organization also partners with local American Indian organizations to hold regular pop-up clinics in the community where patients can go to receive education, routine screening, and treatment for diabetes.

Core Component	Review Criteria
2 - Plan and implement the National Culturally and Linguistically Appropriate Services (CLAS) Standards	**M2A. Upload** a completed National CLAS Standards implementation checklist, including a plan for implementing CLAS standards that are not yet in place. (i.e., standards for which the practice selected Planning to Implement or Not Planning to Implement at this Time). The plan must include: ☐ Organization review of standards 2-13 (2.2 through 2.13), ☐ The timeframe in which the practice aims to implement each standard, ☐ The individual(s) who leading implementation of each standard, ☐ A list of actions the practice is taking to implement each standard, and ☐ A description of additional resources the practice may need to implement each standard and how the practice plans to obtain such resources. **M2A Naming Convention:** CLAS Implementation Checklist and Implementation Plan
	M2B. Upload documentation that demonstrates how the practice recruits and supports a diverse practice team. The documents must include a description of: ☐ How the practice team reflects the diversity of the population the practice serves, ☐ How the practice's current recruiting and hiring processes support diversity, ☐ How the practice promotes diversity among various staff roles (e.g., clinical staff, practice management, clerical), ☐ At least one opportunity to improve diversity throughout the practice (e.g., conducting regular assessments of hiring, retention and workforce demographics) and the practice's plan to act on that opportunity (e.g., promoting mentoring opportunities; building diversity-related performance metrics into management and leadership job descriptions and goals) ☐ How the practice includes information on providing culturally and linguistically appropriate care in staff training materials, and ☐ How the practice offers and incentivizes completion of training (in person or virtual) to all employees on providing culturally and linguistically appropriate care. Examples for how to improve recruitment of diverse staff include: development of community-based internships; collaboration with local schools, training programs and faith-based organizations; advertisement of job postings through

	minority job fairs, job boards and newsletters; development of job postings that are in multiple languages, use gender neutral language, and that consider lived experience; and updating the hiring process to blind-review resumes. **M2B Naming Convention:** Recruiting and Supporting a Diverse Practice Team
	M2C. Attest, through the TI 2.0 Application Portal once available in Fall 2024, that the processes described in 2B (Standards 2-4) have been implemented by 9/30/2024. **Participants do not need to upload or provide documentation to validate unless there is a discrepancy**.
	M2D. NCQA ONLY - Upload documentation that the practice expects will satisfy the requirements for: ☐ NCQA HE 1.A (Building a Diverse Staff), detailing: ☐ activities completed ☐ activities to be completed ☐ key milestones ☐ key dates for completion ☐ HE 1.B. (Promoting DEI amongst staff), detailing: ☐ activities completed ☐ activities to be completed ☐ key milestones ☐ key dates for completion AHCCCS will confirm it meets other milestone elements (at minimum) and provide suggestions for what additional documentation NCQA may be looking for. **M2D Naming Convention:** NCQA- HE1.A and HE1.B

Quality ID #502: Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder

2024 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Patient-Reported Outcome-based Performance Measure (PRO-PM) – High Priority

DESCRIPTION:
The percentage of patients aged 18 and older with a mental and/or substance use disorder who demonstrated improvement or maintenance of functioning based on results from the 12-item World Health Organization Disability Assessment Schedule (WHODAS 2.0) or Sheehan Disability Scale (SDS) 30 to 180 days after an index assessment.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients with mental and substance use disorder who are seen during the performance period. This measure is intended to reflect the quality of services provided for patients aged 18 and older with a mental and/or substance use disorder and an encounter with an index assessment completed using the 12-item WHODAS 2.0 or Sheehan Disability Scale (SDS) during the denominator identification period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NOTE: *Patient encounters for this measure conducted via telehealth (including but not limited to encounters coded with GQ, GT, 95, POS 02, POS 10) 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:
Patients aged 18 years and older with a mental and/or substance use disorder and an encounter with an index assessment completed using the 12-item WHODAS 2.0 or Sheehan Disability Scale (SDS) during the denominator identification period

Definitions:
Denominator identification period – Period in which patients had an encounter with an index assessment using the WHODAS 2.0 or SDS. The "denominator identification period" is defined by a 12-month window starting 6 months prior to the measurement year through the first 6 months of the measurement year (July 1 of the previous year through June 30 of the current year).
Index assessment – The outpatient encounter where the patient first completed the WHODAS 2.0 or SDS is counted as the "index assessment". If there are multiple assessments during the denominator identification period, the first assessment completed is counted as the "index assessment".
WHODAS 2.0 – **"**WHODAS 2.0" assesses change-over-time in functioning for all individuals with mental health and/or substance use disorders. The domains covered in the tool are communication and understanding, mobility, self-care, social functioning, life activities (work and home), and participation in society. Response

options include: (0) None, (1) Mild, (2) Moderate, (3) Severe, and (4) Extreme or Cannot Do. A 12-item and 36-item version of the WHODAS 2.0 are available. Summed scores on the 12-item and 36-item "WHODAS 2.0" are converted to a summary scale from 0 to 100 (where 0 = no disability; 100 = full disability). There is no recommended cutoff score. A higher score on the "WHODAS 2.0" equates to a lower level of functioning (Ustun et al., 2010). Available at: https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health/who-disability-assessment-schedule.

Sheehan Disability Scale (SDS) – SDS assesses change-over-time in functioning for individuals with mental health and/or substance use disorders. The domains covered in the tool are work/school, social life/leisure activities, and family life/home responsibilities. Response options include: (0) Not at all, (1-3) Mildly, (4-6) Moderately, (7-9) Markedly, and (10) Extremely, regarding how current symptoms have disrupted activities in each of the domains covered by the assessment. The 3 items are summed into a single dimensional measure of global functioning from 0 to 30 (where 0 = unimpaired and 30 = highly impaired). There is no recommended cutoff score. A higher score on the SDS equates to a lower level of functioning (Sheehan et al., 2008). Available at: https://eprovide.mapi-trust.org/instruments/sheehan-disability-scale.

DENOMINATOR NOTE: **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 aged 18 years and older as of the date of the index encounter

AND

Diagnosis for any mental, behavioral, or substance use disorder (ICD-10-CM): F10.10, F10.11, F10.120, F10.121, F10.129, F10.130, F10.131, F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.21, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.90, F10.91, F10.920, F10.921, F10.929, F10.930, F10.931, F10.932, F10.939, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, F11.10, F11.11, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.21, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.90, F11.91, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.10, F12.11, F12.120, F12.121, F12.122, F12.129, F12.13, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.21, F12.220, F12.221, F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.90, F12.91, F12.920, F12.921, F12.922, F12.929, F12.93, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.10, F13.11, F13.120, F13.121, F13.129, F13.130, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.21, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.90, F13.91, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.10, F14.11, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.90, F14.91, F14.920, F14.921, F14.922, F14.929, F14.93, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.10, F15.11, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.21, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.90, F15.91, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.10, F16.11, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.90, F16.91, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F17.200, F17.201, F17.203, F17.208, F17.209, F17.210, F17.211, F17.213, F17.218, F17.219, F17.220, F17.221,

F17.223, F17.228, F17.229, F17.290, F17.291, F17.293, F17.298, F17.299, F18.10, F18.11, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.21, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F18.91, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.10, F19.11, F19.120, F19.121, F19.122, F19.129, F19.130, F19.131, F19.132, F19.139, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.90, F19.91, F19.920, F19.921, F19.922, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.81, F32.89, F32.9, F32.A, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.0, F34.1, F34.81, F34.89, F34.9, F39, F40.00, F40.01, F40.02, F40.10, F40.11, F40.210, F40.218, F40.220, F40.228, F40.230, F40.231, F40.232, F40.233, F40.240, F40.241, F40.242, F40.243, F40.248, F40.290, F40.291, F40.298, F40.8, F40.9, F41.0, F41.1, F41.3, F41.8, F41.9, F42.2, F42.3, F42.4, F42.8, F42.9, F43.0, F43.10, F43.11, F43.12, F43.20, F43.21, F43.22, F43.23, F43.24, F43.25, F43.29, F43.81, F43.89, F43.9, F44.0, F44.1, F44.2, F44.4, F44.5, F44.6, F44.7, F44.81, F44.89, F44.9, F45.0, F45.1, F45.20, F45.21, F45.22, F45.29, F45.41, F45.42, F45.8, F45.9, F48.1, F48.2, F48.8, F48.9, F50.00, F50.01, F50.02, F50.2, F50.81, F50.82, F50.89, F50.9, F51.01, F51.02, F51.03, F51.04, F51.05, F51.09, F51.11, F51.12, F51.13, F51.19, F51.3, F51.4, F51.5, F51.8, F51.9, F52.0, F52.1, F52.21, F52.22, F52.31, F52.32, F52.4, F52.5, F52.6, F52.8, F52.9, F53.0, F53.1, F54, F55.0, F55.1, F55.2, F55.3, F55.4, F55.8, F59, F60.0, F60.1, F60.2, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F60.89, F60.9, F63.0, F63.1, F63.2, F63.3, F63.81, F63.89, F63.9, F64.0, F64.1, F64.2, F64.8, F64.9, F65.0, F65.1, F65.2, F65.3, F65.4, F65.50, F65.51, F65.52, F65.81, F65.89, F65.9, F66, F68.10, F68.11, F68.12, F68.13, F68.8, F68.A, F69, F90.0, F90.1, F90.2, F90.8, F90.9, F91.0, F91.1, F91.2, F91.3, F91.8, F91.9, F93.0, F93.8, F93.9, F94.0, F94.1, F94.2, F94.8, F94.9, F95.0, F95.1, F95.2, F95.8, F95.9, F98.0, F98.1, F98.21, F98.29, F98.3, F98.4, F98.5, F98.8, F98.9, F99

AND

Patient encounter during the denominator identification period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90847, 90849, 90853, 90865, 90875*, 90876*, 90880, 90901, 90912, 96112, 96116, 96125, 96127, 96130, 96132, 96136, 96138, 96146, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99401*, 99402*, 99403*, 99404*, 99406, 99407, 99408*, 99409*, 99421, 99422, 99423, 99441, 99442, 99443

AND

Index assessment completed using the 12-item WHODAS 2.0 or SDS during the denominator identification period: M1340

AND NOT

DENOMINATOR EXCLUSIONS:

Patient situations, at any point during the denominator identification period, where the patient's functional capacity or motivation (or lack thereof) to improve may impact the accuracy of results of validated tools, such as delirium, dementia, intellectual disabilities, and pervasive and specific development disorders (ICD-10-CM): F01.50, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F02.80, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02.B0, F02.B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.90, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, F04, F05, F06.0, F06.1, F06.2, F06.30, F06.31, F06.32, F06.33, F06.34, F06.4, F06.70, F06.71, F06.8, F07.0, F07.81, F07.89, F07.9, F09, F70, F71, F72, F73, F78.A1, F78.A9, F79, F80.0, F80.1, F80.2, F80.4, F80.81, F80.82, F80.89, F80.9, F81.0, F81.2, F81.81, F81.89, F81.9, F82, F84.0, F84.2, F84.3, F84.5, F84.8, F84.9, F88, F89

OR
Patients who died during the performance period: M1342

NUMERATOR:
Patients who demonstrated improvement or maintenance of functioning, as demonstrated by results of follow-up assessment using the 12-item WHODAS 2.0 or Sheehan Disability Scale 30 to 180 days after the index assessment during the performance period

Definitions:
Follow-up Assessment – The "follow-up assessment" is the 12-item WHODAS 2.0 or Sheehan Disability Scale (SDS) assessment completed at an encounter 30 to 180 days after the encounter with the index assessment, within the 14-month performance period. If there are multiple assessments completed within the follow-up time window (i.e., a 150-day window, beginning 30 days after the index assessment), the assessment that will be counted as the follow-up is the last assessment completed during the window.
Improvement or Maintenance – **"**Improvement" is defined as any positive improvement in score at the follow-up assessment compared to the index assessment. "Maintenance" is defined as no change in score at the follow-up assessment compared to the index assessment.
Performance Period – A 17-month period starting 5 months prior to the performance year through the end of the performance year.

Numerator Options:

Performance Met:	Patients who had follow-up assessment 30 to 180 days after the index assessment who demonstrated positive improvement or maintenance of functioning scores during the performance period **(M1339)**
OR	
Performance Not Met:	Patients who had follow-up assessment 30 to 180 days after the index assessment who did not demonstrate positive improvement or maintenance of functioning scores during the performance period **(M1338)**
OR	
Performance Not Met:	Patients who did not have a follow-up assessment or did not have an assessment within 30 to 180 days after the index assessment during the performance period **(M1341)**

RATIONALE:
Mental and substance use disorders are among the 25 leading causes of years lived with disability and contribute significantly to the global burden of disease (Mokdad et al., 2018). Specifically, 19% of U.S. adults (46.6 million individuals aged 18 and older) have a mental illness and 7.6% (18.7 million individuals aged 18 and older) have a substance use disorder (McCance-Katz, 2019). Mental and substance use disorders often co-occur, with about 8.5 million adults aged 18 and older in the U.S. having both conditions (McCance-Katz, 2019). Individuals with mental and/or substance use disorders are more likely to report severe impairment in functioning compared to those with chronic medical conditions (Kostanjsek, 2011). In fact, the level and pattern of functional impairment is described as the best indicator of service needs, treatment outcomes, and quality care, with greater level of functional impairment being a risk factor for poor prognosis for both mental and substance use disorders as well other medical conditions (Kilbourne et al., 2018). Improvement or maintaining functioning is strongly predictive of a positive outcome. Improvement or maintaining functioning is strongly predictive of a positive outcome (Kilbourne et al., 2018).

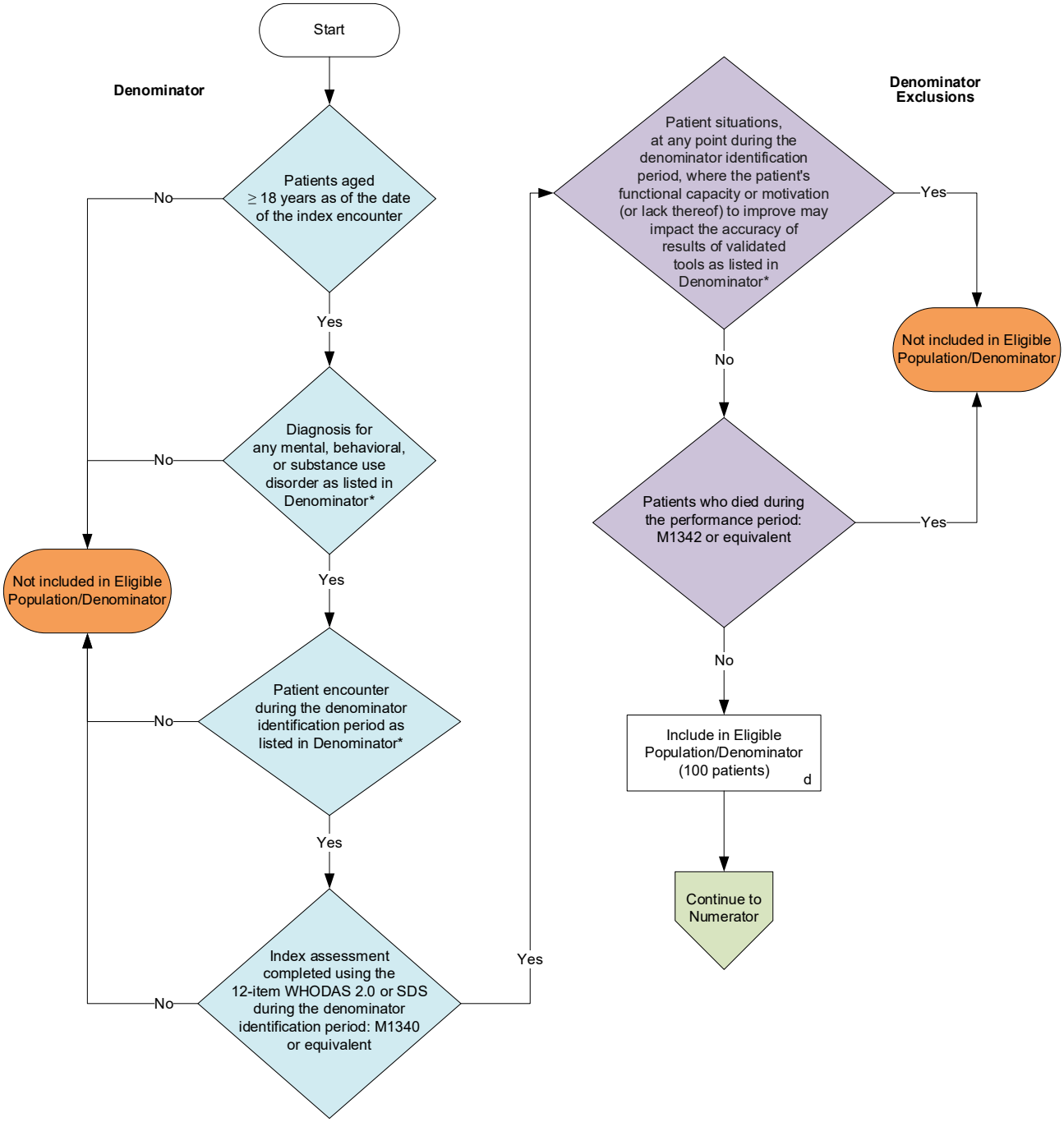
CLINICAL RECOMMENDATION STATEMENTS:
WHO Disability Assessment Scale 2.0 (WHODAS 2.0) (Ustun et al., 2010) assesses change-over-time in functioning for all individuals with mental health and/or substance use disorders. The domains covered in the tool are communication and understanding, mobility, self-care, social functioning, life activities (work and home), and participation in society.

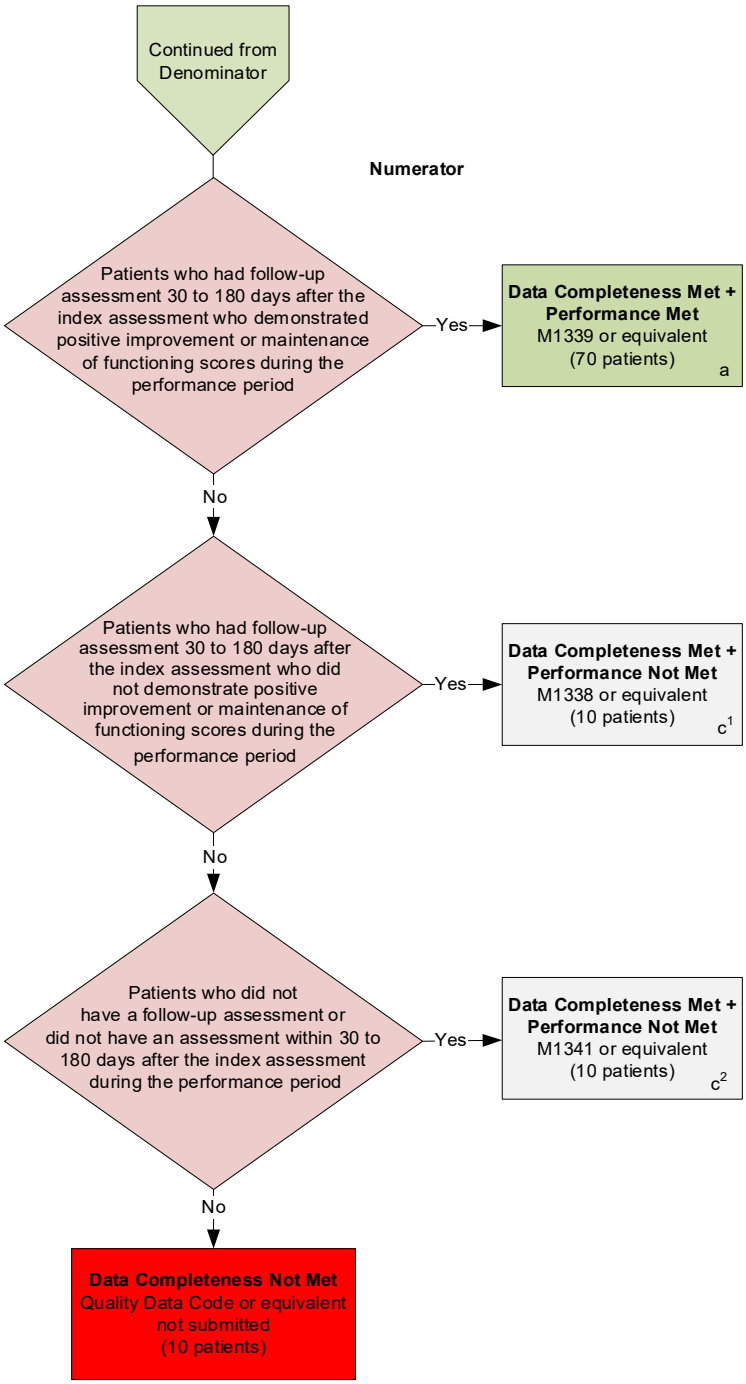
Response options include: (0) None, (1) Mild, (2) Moderate, (3) Severe, and (4) Extreme or Cannot Do. A 12-item and 36-item version of the WHODAS 2.0 are available. Summed scores on the 12-item and 36-item WHODAS 2.0 are converted to a summary scale from 0 to 100 (where 0 = no disability; 100 = full disability). There is no recommended cutoff score. A higher score on the WHODAS 2.0 equates to a lower level of functioning. Available at: https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health/who-disability-assessment-schedule.

Sheehan Disability Scale (SDS) (Sheehan et al., 2008) assesses change-over-time in functioning for individuals with mental health and/or substance use disorders. The domains covered in the tool are work/school, social life/leisure activities, and family life/home responsibilities. Response options include: (0) Not at all, (1-3) Mildly, (4-6) Moderately, (7-9) Markedly, and (10) Extremely, regarding how current symptoms have disrupted activities in each of the domains covered by the assessment. The 3 items are summed into a single dimensional measure of global functioning from 0 to 30 (where 0 = unimpaired and 30 = highly impaired). There is no recommended cutoff score. A higher score on the SDS equates to a lower level of functioning. Available at: https://harmresearch.org/about-us/david-v-sheehan-md-mba/sheehan-scales-and-structured-diagnostic-interviews/sheehan-disability-scale-sds.

2024 Clinical Quality Measure Flow for QID #502: Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder

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





SAMPLE CALCULATION

Data Completeness=

Performance Met (a=70 patients) + Performance Not Met (c^1+c^2=20 patients) / Eligible Population / Denominator (d=100 patients) = 90 patients / 100 patients = **90.00%**

Performance Rate=

Performance Met (a=70 patients) / Data Completeness Numerator (90 patients) = 70 patients / 90 patients = **77.78%**

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

2024 Clinical Quality Measure Flow Narrative for Quality ID #502: Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder

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

1. Start with Denominator

2. Check *Patients aged greater than or equal to 18 years as of the date of the index encounter:*

    a. If *Patients aged greater than or equal to 18 years as of the date of the index encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients aged greater than or equal to 18 years as of the date of the index encounter* equals Yes, proceed to check *Diagnosis for any mental, behavioral, or substance use disorder as listed in Denominator*.*

3. Check *Diagnosis for any mental, behavioral, or substance use disorder as listed in Denominator*:*

    a. If *Diagnosis for any mental, behavioral, or substance use disorder as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Diagnosis for any mental, behavioral, or substance use disorder as listed in Denominator** equals Yes, proceed to check *Patient encounter during the denominator identification period as listed in the Denominator**.

4. Check *Patient encounter during the denominator identification period as listed in the Denominator**:

    a. If *Patient encounter during the denominator identification period as listed in the Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patient encounter during the denominator identification period as listed in the Denominator** equals Yes, proceed to check *Index assessment completed using the 12-item WHODAS 2.0 or SDS during the denominator identification period.*

5. Check *Index assessment completed using the 12-item WHODAS 2.0 or SDS during the denominator identification period:*

    a. If *Index assessment completed using the 12-item WHODAS 2.0 or SDS during the denominator identification period* equals No, do not include in *Eligible Population/Denominator.* Stop processing.

    b. If *Index assessment completed using the 12-item WHODAS 2.0 or SDS during the denominator identification period* equals Yes, proceed to check *Patient situations, at any point during the denominator identification period, where the patient's functional capacity or motivation (or lack thereof) to improve may impact the accuracy of results of validated tools as listed in Denominator**

6. Check *Patient situations, at any point during the denominator identification period, where the patient's functional capacity or motivation (or lack thereof) to improve may impact the accuracy of results of validated tools as listed in Denominator*:*

    a. If *Patient situations, at any point during the denominator identification period, where the patient's functional capacity or motivation (or lack thereof) to improve may impact the accuracy of results of validated tools as listed in Denominator* equals* Yes, do not include in *Eligible Population/Denominator*. Stop processing.

b. If *Patient situations, at any point during the denominator identification period, where the patient's functional capacity or motivation (or lack thereof) to improve may impact the accuracy of results of validated tools as listed in Denominator** equals No, proceed to check *Patients who died during the performance period.*

7. Check *Patients who died during the performance period:*

    a. If *Patients who died during the performance period.* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients who died during the performance period* equals No, include in *Eligible Population/Denominator*.

8. Denominator Population:

    - 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 100 patients in the Sample Calculation.

9. Start Numerator

10. Check *Patients who had follow-up assessment 30 to 180 days after the index assessment who demonstrated positive improvement or maintenance of functioning scores during the performance period:*

    a. If *Patients who had follow-up assessment 30 to 180 days after the index assessment who demonstrated positive improvement or maintenance of functioning scores during the performance period* 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 70 patients in the Sample Calculation.

    b. If *Patients who had follow-up assessment 30 to 180 days after the index assessment who demonstrated positive improvement or maintenance of functioning scores during the performance period* equals No, proceed to check *Patients who had follow-up assessment 30 to 180 days after the index assessment who did not demonstrate positive improvement or maintenance of functioning scores during the performance period.*

11. Check *Patients who had follow-up assessment 30 to 180 days after the index assessment who did not demonstrate positive improvement or maintenance of functioning scores during the performance period:*

    a. If *Patients who had follow-up assessment 30 to 180 days after the index assessment who did not demonstrate positive improvement or maintenance of functioning scores during the performance period* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c_1 equals 10 patients in the Sample Calculation.

    b. If *Patients who had follow-up assessment 30 to 180 days after the index assessment who did not demonstrate positive improvement or maintenance of functioning scores during the performance period* equals No, proceed to check *Patients who did not have a follow-up assessment or did not have an assessment within 30 to 180 days after the index assessment during the performance period*.

12. Check *Patients who did not have a follow-up assessment or did not have an assessment within 30 to 180 days after the index assessment during the performance period:*

    a. If *Patients who did not have a follow-up assessment or did not have an assessment within 30 to 180 days after the index assessment during the performance period* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    b. If *Patients who did not have a follow-up assessment or did not have an assessment within 30 to 180 days after the index assessment during the performance period* equals No, proceed to check *Data Completeness Not Met*.

13. *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 70 patients) plus Performance Not Met (c^1 + c^2 equals 20 patients) divided by Eligible Population/Denominator (d equals 100 patients). All equals 90 patients divided by 100 patients. All equals 90.00 percent.

Performance Rate equals Performance Met (a equals 70 patients) divided by Data Completeness Numerator (90 patients). All equals 70 patients divided by 90 patients. All equals 77.78 percent.

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

NOTE: Submission Frequency: Patients-Periodic

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.

Health Equity Measure: Meaningful Access to Health Care Services for Persons Who Prefer a Language Other than English (LOE) and Persons Who Are Deaf or Hard of Hearing – MY2025

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a Health Equity Measure Workgroup.

URL of Specifications: N/A.

Measure Type:

☐HEDIS ☐Survey ■Other Specify: OHA-developed

Measure Utility:

■CCO Incentive ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Data Source: CCO attestation (annual survey for Component 1 and quantitative contract language access for Component 2)

Measurement Period: Measurement Year (MY) equals calendar year (January 1 – December 31 of the year).

Past Benchmark for OHA measurement year	2023*	2024*	2025
Component 1 – minimum points from must pass questions	77 points	83 points	97 points
Component 2 – reporting method and data collection requirement	Sampled hybrid reporting; must meet 80% data collection rate	Full population	Full population
Component 2 – benchmark for percentage of visits provided with interpreter services by OHA certified or qualified interpreters	75% with Minnesota Method improvement target	75% benchmark with Minnesota (MN) Method improvement target & 5 pct point floor	50% benchmark with Minnesota (MN) Method improvement target & 5 pct point floor
Source:	Committee consensus	Committee Consensus	Committee Consensus

*Must meet both components to get credit for the measure.

Note on telehealth: This measure is telehealth eligible, however, visits without human interaction can be excluded, such as online assessment forms or remote monitoring of blood sugar, blood pressure readings. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in specifications from MY2024 to MY2025:

- Changed limited English proficiency (LEP) to prefers a language other than English (LOE). This terminology change does not reflect a change in metric specifications. The change is meant to better reflect a strength-based approach.
- Added a section to clarify the applicable CCO population for reporting and for the incentive performance rate.

Component 1

- Updated self-attestation questions in Appendix 1. April 2024 changes are in blue text throughout the appendix. The change from LEP to LOE was not highlighted in blue change since the terminology represents the same population.

Component 2

- Added section for data source (contract report) and submission due date.
- Added exclusion for members who died in the measurement year.
- Added refusal reason 5 to capture refusals from the member who does not need interpreter services for the particular visit. Visits with member refusal reason 5 may qualify for denominator exclusion, but this does not exclude other visits from the same member.
- Clarified the definition of in language provider and which provider qualifies for in-language visit numerator credit.
    - Added native speaker and ALTA test for qualifying in language provider visits.
    - When initially verifying in-language providers' proficiency, tests within the last four years instead of three years are valid.
    - Increased proficiency test requirement for Language Line Solutions from 2+ to 3+ to align with current OHA standards.
    - Removed the retesting requirement for proficiency tests.
- For Appendix 3, April 2024 changes are in blue text. Additional hospital related fields added in red in November 2024; optional reporting for MY2025, required starting MY2026.
- For Appendix 4, claim lines containing modifier code 26 or place of service (POS) 81 are exclude. Some previously missing inpatient OHGs are added to the documentation. Additional codes are added to the telehealth identification logic.
- Added Appendix 5 for hospital fields.

Member type: ■CCOA ■CCOB ■CCOE ■CCOF ■CCOG

Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

CCOs are required to report services and data collection for all CCO members in Component 1, as well as all visits in Component 2 for all CCO members who have language access needs (defined in the Eligible Population and Denominator sections). OHA will flag the BHP and HOP/CAK members during the measurement period when reviewing the data submitted by the CCO and exclude them from the quality rate for the incentive program use.

Measure Details

Measure Components and Scoring

There are two components in this measure:

(1) CCO language access self-assessment survey
(2) Quantitative language access report

Component 1: CCO language access self-assessment survey

This measure promotes high quality language services for all Medicaid members. The self-assessment guides your CCO to progressively higher quality and a more robust infrastructure of language services over time. For each measurement year, the CCO must: (1) answer all survey questions, (2) pass all the questions required for that measurement period, and (3) meet the minimum points required for the must pass questions for each measurement year.

Total possible points Year 1 thru 3 =	**102**	
Year 1 total minimum points required =	46	45.1%
Year 2 total minimum points required =	56	54.9%
Year 3 total minimum points required =	77	75.5%
Total possible points Year 4 =	**115**	
Year 4 total minimum points required =	83	72.2%
Total possible points Year 5 thru 6 =	**121**	
Year 5 total minimum points required =	97	80.2%
Year 6 total minimum points required =	99	81.8%

Domain Name	MY2023 (year3)		MY2024 (year4)		MY2025 (year5)		MY2026 (year6)	
	Total available Points	**Minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**
Domain 1: Identification and assessment for communication needs - This domain assesses how well your CCO identifies and tracks services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve.	28	**23**	3	**3**	2	**2**	**0**	**0**

Domain Name	MY2023 (year3)		MY2024 (year4)		MY2025 (year5)		MY2026 (year6)	
	Total available Points	**Minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**
Domain 2: Provision of Language Assistance Services - This domain assesses how well you use data and work processes to effectively communicate with members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve.	57	**42**	10	**3**	1	**11**	**0**	**0**
Domain 3: Training of staff on policies and procedures - This domain assesses how well your staff who provide services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members is trained on language access policies and procedures.	8	**5**	0	**0**	1	**0**	**0**	**1**
Domain 4: Providing notice of language assistance services - This domain assesses how well your CCO translates outreach materials and explains how members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve may access available language assistance services.	9	**7**	0	**0**	2	**1**	**0**	**1**

CCO must attest to have met all the must-pass questions to meet Component 1 each year. No partial credit will be given. OHA reserves the right to request additional documentation and audit whether responses to self-assessment and language access plans are consistent with current workflows and processes for providing quality language access services.

See Appendix 1 for the survey template and annual due dates, and Appendix 2 for point value summary.

Component 2: Percent of member visits with interpreter need in which language access services were provided

Data source and submission: CCOs are required by the contract to report full population quantitative language access data quarterly, for a rolling 12-month period. Starting MY2024, MLA uses the quarterly contract report that aligns with the calendar year period. For example, the calendar year 2025 period in the contract report due on April 1, 2026 is used for MLS MY2025 quality rate review.

Note the other three quarterly reports required by the contract (e.g., 2024Q2 – 2025Q1 period due on July 1, 2025) are not used for MLA annual results, but OHA uses them for providing quality reviews.

Eligible population: Members who self-identified with interpreter needs; all visits for the members in the eligible population need to be included in the reporting denominator.

> The CCO must include all members who already have MMIS interpreter flags[1] during the measurement year for the Component 2 full-population reporting. Members can self-identify their spoken or sign language interpreter needs to OHA during the ONE eligibility process; this information is documented in MMIS for members with spoken language interpreter needs (IND_INTERPRETER = Y) or with a non-blank CDE_INTERPRETER_TYPE[2].
>
> Members can also self-identify their interpreter needs to the CCO or the provider through intake questionnaire in different settings or by self-initiating an interpreter service request. If the CCO attests collecting interpreter needs information in Component 1 survey questions 1 and 3 in addition to using the MMIS information and identifies additional members who do not have MMIS flags for interpreter needs, the CCO can include the additional members in the report[3]. When including these individuals in

[1] Note if a member has incorrect interpreter needs flags in MMIS which have been removed before the end of the measurement year, the member does not need to be included in the Component 2 full-population report. If the interpreter needs flags in error remain in the MMIS through the end of the measurement year, all visits for the member still need to be reported; in this case, the CCO can report Refusal Reason 2 (member confirms interpreter needs flag in MMIS is inaccurate) across all visits for the same member, so that the visits can be excluded from the denominator for the language service and quality rates calculations.

[2] The CCO must utilize MMIS IND_INTERPRETER = Y or a non-blank CDE_INTERPRETER_TYPE to meet the minimum requirements for the OHA denominator volume validation. To note, the additional MMIS field IND_SL_INTERPRETER previously used for the metric was discontinued after October 2022; a new CDE_INTERPRETER_TYPE field has been added to specify the type of interpreter needed by the member.

[3] CCOs can use 'Interpreter need flagged in MMIS' column in the Component 2 reporting template and report 'No' to identify additional members who did not self-identify during the ONE eligibility process. Note that for the additional members who are added to the report, all of their denominator-qualifying visits must be included in the report, regardless of whether the interpreter services were provided.

the denominator, all the member's visits for the year must be included even those where interpreter services were not received.

Continuous enrollment criteria: None.

Anchor date: None.

Data elements required denominator: Total number of visits during the measurement year from the Eligible Population (members who self-identified with interpreter needs), regardless of whether interpreter services were provided. Only visits during a member's enrollment span with a CCO are required to be reported.

The CCO is responsible for reporting all visits, at the visit level, using the data system(s) best suited for their collection method. The CCO is also required to indicate the visit date, Medicaid member ID and whether the member already has interpreter needs flag(s) in MMIS/834 file. The following stratifications are required by type of care:

- Physical health
- Mental/behavioral health
- Dental health

By care setting:

- Inpatient Stay
- Emergency Department
- Office Outpatient
- Home Health
- Telehealth
- Other

See Appendix 3 for quantitative interpreter services reporting template.

Data elements required denominator exclusion:

- Members who died in the measurement period.
- Visits only involving pharmacy, or other ancillary services (such as lab, DME, ambulance transportation, supportive housing, etc.) can be excluded from the denominator reporting.
- Telemedicine visits without human interaction can be excluded, such as online assessment forms or remote monitoring of blood sugar, blood pressure readings.
- CCOs should document the reasons a member refuses the interpreter service, and the visit can be excluded for the first two of the following reasons if the CCO also attests data collection for the corresponding reasons in the self-assessment Question 14:
  1. Member refusal because in-language visit is provided[4]
  2. Member confirms interpreter needs flag in MMIS is inaccurate[5]

[4] If the member confirms the provider for the visit can perform in-language service and therefore no interpreter service is needed, the visit can be excluded. To note, if the in-language service provider is OHA qualified or certified or has documented being a native speaker or passing an approved proficiency test in the members preferred language with the CCO, the visit does not need to be flagged as patient refusal and will be a numerator hit for the metric.

[5] If a member has interpreter needs indicated in MMIS but regularly refuses interpreter services, the CCO could work with the member to submit MMIS member information correction request with OHP member customer service.

3. Member unsatisfied with the interpreter services available – not eligible for exclusion.
4. Other reasons for patient refusal – not eligible for exclusion.
5. Member does not need interpreter services for the visit[6]

Note on OHA validation for the denominator visits: OHA performs validation on the portion of eligible population known to OHA (those with interpreter needs flagged in MMIS) and counts the total denominator visits from MMIS/DSSURS claims. Additional validation effort will be required if, for the members with interpreter needs flagged in MMIS, the CCO reports 15% more or fewer counts of total denominator visits than that of OHA's data. OHA utilizes an existing, homegrown Oregon Health Grouper (OHG) and re-categorize claims into the 'type of care' and 'care setting' stratifications for this measure; certain OHG categories are also identified for denominator exclusion. The grouping method and OHG-to-HEM crosswalk table is provided in Appendix 4. The OHG logic and OHG-to-HEM crosswalk method can be used by CCOs reporting the denominator visits based on claims data, but it is not required as the CCO may have its own data processing logic that can also achieve the type of care and care setting categorization.

Data for supporting Hospital QDP program: To support the hospital Qualified Directed Payments (QDP) program, OHA has added two additional fields to the language access reporting template (see Appendix 3), optional reporting starting MY2025 and required beginning MY2026:

- QDP Facility Name
- QDP Facility National Provider Identification (NPI)

These fields need to be reported when the visit is with a Hospital or Emergency Departmentfacility. See Appendix 5 for the hospitals..

Data elements required numerator: Total number of visits provided with interpreter or in language provider services. See Appendix 3 for quantitative interpreter services reporting template.

CCOs are responsible for tracking and reporting the numerator visits on the reporting with the following stratifications:

- Interpreter services provided by OHA certified, qualified, and non-OHA certified or qualified interpreters.
- In-language visits with primary performing providers who are either a native speaker or has passed the proficiency test in the member's preferred language[7] , and those providers who are not a native speaker and have not passed the language proficiency test.

[6] The member decides to refuse interpreter service for this reported visit, but the member may need language services for other visits. Each visit with refusal reason 5 can be excluded, but the member is not excluded from the measure all together.

[7] Providers who have a degree in high school or above in a country where instruction is primarily in the non-English language and the in-language provider is a native speaker of the non-English language. Reporting visits with an in-language primary performing provider is optional in MY2025. For the proficiency test (also referred to as Oral Proficiency Interview), the Equity & Inclusion Division (E&I) maintains proficiency tests on the Health Care Interpreter Training Programs website. Under Approved Testing Centers for Language Proficiency header, CCOs can find the approved tests (i.e., Language Line Solutions and Language Testing International). After completing the test, the provider would receive a certificate of completion with a score. This document should be sent to CCOs to confirm that the provider qualifies as passing the

* Incentive measure based on higher rate of denominator visits with interpreter services provided by OHA-certified or OHA-qualified interpreters, or in-language visit providers who are a native speaker or have passed the proficiency test for the member's preferred language.

- Modality of the interpreter services (in-person, telephonic, video remote) – reporting-only, measure is not incentivized for certain modalities of the services.
- Services provided by clinic staff versus contracted language provider – reporting-only.

The required reporting elements include:

Report In-person, telephonic or video interpreter services (or in-language provider visits, optional in MY2025) provided:
=> If Yes to any of the three modality fields, answer Was the interpreter (or in-language provider) OHA Certified or Qualified?
=> if the interpreter (or in-language provider) is OHA-certified or qualified, report the OHA Registry number.
=> If No to all three modality fields, answer Did the member refuse interpreter service (Yes/No)[8]

Data elements required numerator exclusion: none.

Incentive Measure Quality Language Access Rate Calculation: Percentage of visits provided by high quality interpreter services (or high quality in-language provider visit[9]) = Total number of visits with interpreter services provided by OHA-certified or qualified interpreters (or in-language visits with providers who are native speakers or have passed the proficiency test for members' preferred languages[10]) / Total number of visits for members in the eligible population[11]

Note: visits by the eligible members that were not provided with interpreter services (or in language provider services, if reporting), count as '0' for numerator hits; visits with interpreter services by providers that are not OHA certified or qualified and the provider has not documented being native

proficiency test in the member's preferred language. To pass the proficiency test, the provider must pass the proficiency test with a score of:

- 3+ or higher for Language Line Solutions' (LLS) proficiency test or a score of 'Competent' on LLS Bilingual Fluency Assessment (BFA) or LLS Bilingual Fluency Assessment for Clinicians (BFAC)
- Advanced-mid level or higher for American Council on the Teaching of Foreign Language (ACTFL) (i.e., Language Testing International's proficiency test)
- ALTA proficiency tests at ~~equivalent of 'advanced mid' ACTFL~~ 8 or above rating scale.
- In-language providers that have passed an OHA-approved Oral Proficiency Interview (OPI) also qualify for passing the language proficiency requirement.

When initially verifying in-language providers' proficiency, tests must be no more than four years old; after initial verification of proficiency, the test does not have to be retaken. The in-language provider reporting option is not available to general clinic staff, such as receptionist, certified nursing assistants, and schedulers.

[8] If no records of member refusal exist, it is considered that the member did not refuse (fill in No in template). If the member refuses interpreter services, reporting the refusal reasons is optional.

[9] Reporting visits with an in-language provider is optional in MY2025.

[10] Reporting visits with an in-language provider is optional in MY2025.

[11] The measure denominator is NOT restricted to only the visits when interpreter services were provided.

speaker or passing the proficiency test in the members preferred language with the CCO, count as '0' for numerator hits.

OHA will report other non-incentive rates for observations, including 'total percentage of visits provided with any interpreter services or are in-language visit,' percentage of visits provided with interpreter services by visit types (inpatient, outpatient, mental health, dental, etc.), and percentage of interpreter services by different modalities.

Version Control

Appendix 1: CCO language self-assessment: Meaningful language access to culturally- responsive health care services (starting MY2021)

Introduction

This online survey asks each Coordinated Care Organization (CCO) to conduct a self-assessment on language services available in your organization. Your responses will be used to determine whether your CCO meets the incentive metric reporting requirements. Completion of the survey does not guarantee that CCOs have met the metric.

CCOs must answer all questions and meet the minimum points required for the questions marked as must pass for that measurement year (e.g., Must pass beginning in measurement year 2021 – year 1). Questions have a point value and are organized by measurement year within each of the four domains. In general, each statement is worth one point and some questions have multiple statements.

Answers should be based on language services in place on the December 31st of the measurement year. Survey responses are due on or before the 3rd Monday of January following the measurement year (MY). These dates are as follows:

MY2023: Due January 15, 2024
MY2024: Due January 20, 2025
MY2025: Due January 19, 2026

Self-assessment requirements

This measure promotes high quality language services for all Medicaid members. The self-assessment guides your CCO to progressively higher quality and a more robust infrastructure of language services over time. For each measurement year, the CCO must: (1) answer all survey questions, (2) pass the questions required for that measurement period, and (3) meet the minimum points required for each measurement year.

Total possible points (Year 1 through 3) = 102

- Year 1 minimum points required = 46 or 45.1%
- Year 2 minimum points required = 56 or 54.9%
- Year 3 minimum points required = 77 or 75.5%

Total possible points (Year 4) = 115

- Year 4 minimum points required = 83 or 72.2%

Total possible points (Year 5 & 6) = 121

- Year 5 minimum points required = 96 or 79.3%%
- Year 6 minimum points required = 98 or 90.3%

Additional Information

OHA reserves the right to request additional or clarifying information to support responses provided through this survey, including but not limited to further detail on data collected, example policies, or translated materials.

For questions about this survey, or the CCO incentive metric, please contact Metrics Questions Metrics.Questions@odhsoha.oregon.gov.

Contact Information

The contact person is the one completing the survey and the first point of contact if OHA has any follow-up or clarifying questions about survey responses. If multiple individuals for the same CCO submit survey responses, OHA will follow-up with the CCO as to which of the respondents should be the primary contact.

Name: _____

CCO Name: _____

Email Address: _____

Domain 1: Identification and assessment for communication needs

CCOs should answer questions based on language services in place on December 31 of the measurement year.

Questions in this domain assess how well your CCO identifies and tracks services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve. Your responses will help OHA to evaluate how well your CCO is performing these critical and meaningful language access functions.

1) Please answer yes or no for each of the following statements on how your CCO identifies members needing communication access (e.g., LOE, sign language users). *Must pass beginning MY2021 (year 1) with minimum points required = 5; total points available =7.*

	Yes	No
A. The CCO has a **process to respond to individual requests** for language assistance services (including sign language).	( )	( )
B. The CCO has a **process for self-identification** by the Deaf or Hard of Hearing person, non-English speaker or individual who prefers a Language Other than English (LOE).	( )	( )
C. The CCO has a **process for using open-ended questions** to determine language proficiency on the telephone or in person.	( )	( )
D. The CCO customer service staff are **trained to use video relay or TTY** for patient services.	( )	( )
E. The CCO **uses "I Speak" language identification cards** or posters.	( )	( )
F. The CCO has a **process for responding to member complaints** about language access and clearly communicates this process to all members.	( )	( )
G. The CCO **uses MMIS/ enrollment data** from OHA about primary language.	( )	( )

2) Please answer yes or no for each of the following statements about collecting data. *Must pass beginning MY2021 (year 1) with minimum points required = 3; total points available =3.*

	Yes	No
A. The CCO collects data on the **number of members served who prefer a Language Other than English (LOE).**	( )	( )
B. The CCO collects data on the **number of members served who are Deaf or Hard of Hearing**.	( )	( )
C. The CCO collects data on the **number and prevalence of languages spoken by members** in your service area.	( )	( )

3) Please answer yes or no for each of the following data sources that your CCO uses to determine the needs and/or population size of the LOE and Deaf or Hard of Hearing members in your service area. *Must pass beginning MY2021 (year 1) with minimum points required = 5; total points available = 6.*

	Yes	No
A. OHA MMIS	( )	( )
B. CCO specific enrollment information on members interpreter needs.	( )	( )
C. Local community-based organizations (CBOs), Community Advisory Councils (CACs), or Regional Health Equity Coalitions (RHECs)	( )	( )
D. Online data (e.g., LEP.gov or US Census/American Community Survey (ACS))	( )	( )
E. REALD & SOGI repository	( )	( )
F. Members' interpreter needs collected by providers.	( )	( )

4) Does your CCO use any of the data sources listed in questions 1 and 2 above to assess LOE and Deaf or Hard of Hearing member needs, at least quarterly? *Must answer, no points available.*

( ) Yes

( ) No

5) Does your CCO use data sources in question 3 above to identify system gaps and improve services for LOE and Deaf or Hard of Hearing members, at least quarterly? Must answer, no points available.

( ) Yes

( ) No

6) Does your CCO record the interpreter needs and primary language from LOE or Deaf and hard of hearing members when they first contact your CCO, for example, at the CCO's new enrollee intake survey, or the first encounter with a health care provider and the information is shared back to the CCO? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

7) Does your CCO have a process for sharing information about members who need spoken and sign language interpretation services with all provider networks? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

8) If yes to question 7, please briefly describe how your CCO shares primary spoken language or hearing assistance needs with provider networks or service coordinators. *Must answer this question beginning MY2021 (year 1); total available points = 1.*

9) If yes to question 7, how frequently do you share this information? *Must answer this question beginning MY2021 (year 1); total available points = 1.*

( ) A. Weekly

( ) B. Monthly

( ) C. Quarterly

( ) D. Annually

10) ***Does your CCO have a process for sharing the monthly OHA credentialed health care interpreter registry file from OHA with all your service coordinators and provider network?*** *Must pass beginning MY2024 (year 4) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

11) If yes to the previous question, please briefly describe how your CCO shares the monthly registry files with service coordinators and provider networks. *Must answer this question beginning MY2024 (year 4) if Yes to previous question; total available points = 1.*

12) Does your CCO have the capability to identify the number of members needing spoken and sign language interpretation services that were not identified in form 834 from OHA? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

13) What are the top SIX most frequently encountered spoken and sign languages by members in your CCO for the measurement year? *CCOs must rank the languages members often request language services in to meet the must pass criteria for this question beginning MY2021 (year 1); total available points = 1.*

Write in language

14) Please answer yes or no for each of the following statements about members who refused, did not need, needed interpretation services but were not identified as needing interpreter services, or requested and received in language services from bilingual providers. *Must pass beginning MY2022 (year 2) with minimum points required = 3; total points available =5.*

	Yes	No
A. The CCO collects data on members served **who self-identified as preferring a language other than English (LOE) but refused interpretation services**.	( )	( )
B. The CCO collects data on members served **who are Deaf or Hard of Hearing but refused interpretation services**.	( )	( )
C. The CCO collects data on members served who **did not have MMIS language flag but requested interpreter services**.	( )	( )
D. The CCO collects data on members served who **had an MMIS language flag but did not need interpreter services.**	( )	( )
E. The CCO collects data on the members served who **requested and received in- language services from bilingual providers** and therefore trained interpreters were not needed for the visits.	( )	( )

15) Does your CCO have a process to follow up with and add/remove MMIS flags for members who confirmed the interpreter flag is inaccurate? *Must answer; no points available.*

( ) Yes

( ) No

16) Please answer yes or no for each of the following statements about appointment wait times (not the time to arrange interpreter service at a visit). *Must pass beginning MY2023 (year 3) with minimum points required = 2; total points available = 2.*

	Yes	No
A. The CCO collects quality data on average wait times for **LOE members** that need appointments with interpreter services.	( )	( )
B. The CCO collects quality data on average wait times for **Deaf or Hard of Hearing members** that need appointments with interpreter services.	( )	( )

17) Please mark the average wait time for each of the following groups (not the time to arrange interpreter service at a visit). (Choose only one answer per statement). *Must pass beginning MY2023 (year 3) with minimum points required = 2; total points available = 2.*

	Same day	1-3 days	4-7 days	More than 7 days
A. The average wait time for members who prefer a language other than English (LOE) needing interpretation services is:	( )	( )	( )	( )
B. The average wait time for Deaf or Hard of Hearing members needing interpretation services is:	( )	( )	( )	( )

18) What is the average wait time (not the time to arrange interpreter service at a visit) for members that do not need interpretation services? *Must answer, no points available.*

( ) A. Same day

( ) B. 1-3 days

( ) C. 4-7 days

( ) D. More than 7 days

( ) E. The CCO does not collect this information

19) Does your CCO verifiably track when members appointments are cancelled or rescheduled due to a lack of interpretation services? *Must answer, no points available.*

( ) Yes

( ) No

20) How frequently do you track the average number of encounters by spoken and sign languages and share the data with provider networks or service coordinators? *Must answer, no points available.*

( ) A. Weekly

( ) B. Monthly

( ) C. Quarterly

( ) D. Annually

21) Does your CCO have a process for identifying the total number of Deaf or Hard of Hearing members that prefer sign language or assistive communication devices to ensure effective communication in your CCO and provider network? *Must answer, no points available.*

( ) Yes

( ) No

Domain 2: Provision of language assistance services

CCOs should answer questions based on language services in place on December 31 of the measurement year. Questions in this domain assess how well you use data and work processes to effectively communicate with members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

22) Please answer yes or no to each of the following statements about tracking language assistance services at the CCO and provider network levels. *Must pass beginning MY2021 (year 1) with minimum points required = 3; total points available = 3.*

	Yes	No
A. The CCO tracks **the primary language** of persons encountered or served.	( )	( )
B. The CCO tracks **the use of language assistance services** such as interpreters and translators.	( )	( )
C. The CCO tracks **staff time (including bilingual providers) spent providing bilingual spoken and sign language** assistance services.	( )	( )

23) Please select yes or no to the types of language assistance services that are provided by your CCO and provider network. *Must pass beginning MY2021 (year 1) with minimum points required = 5; total points available = 7.*

	Yes	No
A. Bilingual clinic staff and providers	( )	( )
B. CCO in-house interpreters (spoken and sign)	( )	( )
C. CCO in-house translators (for documents)	( )	( )
D. Contracted in-person interpreter services	( )	( )
E. Contracted translators (for documents)	( )	( )
F. Contracted telephonic interpreter services	( )	( )
G. Contracted video interpreter services	( )	( )

24) Please select yes or no to the following care delivery settings in which your CCO provides spoken and sign language interpretation service for member visits. *Must pass beginning MY2021 (year 1) with minimum points required = 6; total points available = 8.*

	Yes	No
A. Medical (in-patient)	( )	( )
B. Medical (office/out-patient)	( )	( )
C. Emergency Department	( )	( )
D. Dental	( )	( )
E. Telehealth	( )	( )
F. Home Health	( )	( )
G. Pharmacy connected to a provider network	( )	( )
H. Lab services connected to a provider network	( )	( )

25) Please select yes or no to indicate whether your CCO provides spoken and sign language interpretation service for member visits in each of the following situations. *Must answer MY2024. Must pass beginning MY2025 (year 5) with minimum points required = 6; total points available = 6.*

	Yes	No
Scheduling appointments	( )	( )
Care navigation	( )	( )
During member appeals process	( )	( )
Customer Service Inquiry	( )	( )
Support for understanding member benefits	( )	( )
Member care consent process	( )	( )

26) Does your CCO utilize language triaging when LOE members call to make an appointment via telephone? *Must pass beginning MY2025 (year 5) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

27) Does your CCO and provider network have policies on the use of family members or friends to provide interpretation services? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

28) If yes to the previous question, please briefly describe your policies on when or how family members or friends can provide interpretation services. *Must answer this question beginning MY2021 (year 1); total available points = 1.*

29) Does your CCO provide staff who coordinate interpreter services with information on how to access OHA approved spoken and sign language interpreters? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

30) Does your CCO have a policy that your provider networks work with OHA certified and qualified spoken and sign language interpreters, consistent with OAR 950-050-0160? *Must pass beginning MY2024 (year 4) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

31) Does your CCO staff who coordinate interpreter services have a process for validating the OHA credentials of the following spoken and/or sign language interpreters before allowing the interpreter's visit to be reported as delivered by an OHA-certified and/or qualified health care interpreter? *Must pass beginning MY2025 (year 5) by answering "Yes" with minimum points required = 3; total available points = 3.*

	Yes	No
A. In-person interpreters	( )	( )
B. Telephonic interpreters	( )	( )
C. Video remote interpreters	( )	( )

32) Please select yes or no to each of the following statements about the translation of vital written documents into non-English languages. *Must pass beginning MY2021 (year 1) with minimum points required = 6; total points available = 6.*

	Yes	No
A. Consent forms are translated into non-English languages.	( )	( )
B. Complaint forms are translated into non-English languages.	( )	( )
C. Intake forms are translated into non-English languages.	( )	( )
D. Notices of rights are translated into non-English languages.	( )	( )
E. Notice of denial, loss or decrease in benefits or services are translated into non-English languages.	( )	( )
F. Information on programs or activities to receive additional benefits or services are translated into non-English languages.	( )	( )

33) Does your CCO's contract with interpreting services companies require the companies to work with OHA-credentialed spoken and sign language interpreters consistent with OAR 950-050-0160 when providing interpretation services to your CCO and/or provider network? *Must pass beginning MY2025 (year 5) by answering "Yes" or "*We do not have an interpreter services vendor*"; total available points = 1.*

( ) Yes

( ) No

( ) We do not have an interpreter services vendor

34) Are the translated documents available in alternate formats that include large prints or braille? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

35) When your CCO updates information on its website, does it also include non-English language translation of the content? *Must answer, no points available.*

( ) Yes

( ) No

36) Does your CCO track the following data regarding language assistance services provided by the CCO and provider network? Please mark yes or no for each of the following statements. *Must pass beginning MY2022 (year 2) with minimum points required = 3; total points available = 6.*

	Yes	No
A. The CCO **validates invoices** from interpreting agencies to ensure they include member level details.	( )	( )
B. The CCO **compares invoice information with an internal data system** (for example MMIS flag) to confirm member level details.	( )	( )
C. The CCO **tracks invoices by service modality** (in-person, telephonic, video remote).	( )	( )
D. The CCO has a system for **tracking the unit cost of each language assistance service provided.**	( )	( )
E. The CCO tracks **the cost of services provided by bilingual staff interpreters.**	( )	( )

F. The CCO tracks the **cost of translation of materials into non-English languages.**	( )	( )

37) Please answer yes or no to each of the following statements about tracking language assistance services at the CCO and provider network levels. *Must pass beginning MY2023 (year 3) with minimum points required = 3; total points available = 4.*

	Yes	No
A. The CCO tracks training and **OHA credentialing of contracted interpreters**.	( )	( )
B. The CCO tracks training and **OHA credentialing of staff members who interpret for patients** (such as full-time CCO staff interpreters or dual-role interpreters).	( )	( )
C. The CCO tracks the **total cost of interpreter services**.	( )	( )
D. The CCO tracks the **cost of translation of materials** into non-English languages.	( )	( )

38) Please select yes or no to the language assistance services on which your CCO can provide detailed member level information, such as member ID, date of service, and interpreter credentials. *Must pass beginning MY2023 (year 3) with minimum points required = 5; total points available = 7.*

	Yes	No
A. Bilingual clinic staff and providers	( )	( )
B. CCO in-house interpreters (spoken and sign)	( )	( )
C. CCO in-house translators (for documents)	( )	( )
D. Contracted in-person interpreters	( )	( )
E. Contracted translators	( )	( )
F. Contracted telephonic interpretation services	( )	( )
G. Contracted video interpretation services	( )	( )

39) When spoken and sign language interpretation services are provided during member visits, can your CCO collect detailed member level information (such as member ID, date of service, and interpreter credential) for

appointments in each of the following care delivery settings? Please select yes or no to the following statements. *Must pass beginning MY2023 (year 3) with minimum points required = 6; total points available = 8.*

	Yes	No
A. Medical (inpatient)	( )	( )
B. Medical (outpatient/office)	( )	( )
C. Emergency Department	( )	( )
D. Dental	( )	( )
E. Telehealth	( )	( )
F. Home Health	( )	( )
G. Pharmacy connected to a provider network	( )	( )
H. Lab services connected to a provider network	( )	( )

40) Please answer yes or no to the following statements related to standardized proficiency assessments for bilingual clinic staff interpreters (this question does not apply to in-language visit providers). *Must pass beginning MY2023 (year 3) with minimum points required = 2; total points available = 2.*

	Yes	No
A. For members who prefer a language other than English (LOE), the CCO requires a standardized proficiency assessment for bilingual clinic staff interpreters before allowing them to interpret or translate documents.	( )	( )
B. For Deaf or Hard of Hearing members, the CCO requires a standardized proficiency assessment for bilingual clinic staff interpreters before allowing them to interpret.	( )	( )

41) Does your CCO track and document the following elements related to standardized proficiency assessments for in-language service providers? *Must answer, no points.*

	Yes	No

A. Type of language proficiency assessment	( )	( )
B. Passing score of language proficiency assessment	( )	( )
C. Specific language assessed	( )	( )

*CCOs must attest 'yes' to A, B, and C to be able to count in language providers for numerator credit in component 2.

42) Does your CCO have a process for validating that the language of the member matches the language of the health care interpreter and the language of the in-language service provider? *Must answer 'yes' beginning MY2025 (year 5); total available points = 1.*

( ) Yes

( ) No

*CCOs must attest 'yes' to be able to count in language providers for numerator credit in component 2.

Domain 3: Training of staff on policies and procedures

CCOs should answer questions based on language services in place on December 31 of the measurement year.

Questions in this domain assess how well your CCO staff who provide services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members is trained on language access policies and procedures. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

43) Has your CCO developed a Language Access Plan (LAP) that describes how your CCO and provider network provide language access services to LOE and Deaf and hard of hearing members? *Must pass beginning MY2026 (year 6) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

44) Does your CCO staff procedures handbook include specific instructions on how to provide language assistance services to LOE and Deaf or Hard of Hearing members? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

45) Please select yes or no to each of the following CCO staff groups that receive training at regular intervals on working with members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members. *Must pass beginning MY2022 (year 2) with minimum points required = 3; total points available = 6.*

	Yes	No
A. Management or senior staff	( )	( )
B. Employees who interact with or are responsible for interactions with non-English speakers or LOE members	( )	( )
C. Bilingual CCO staff	( )	( )
D. New employees	( )	( )
E. All employees	( )	( )
F. Volunteers	( )	( )

46) Are all CCO staff members who interpret for patients (such as full-time staff interpreters or dual-role interpreters) and/or healthcare professionals who receive funds from your CCO for health care interpreter training certified or qualified by OHA? *Must pass beginning MY2023 (year 3) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

47) Do CCO staff who provide care or services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members receive training at regular intervals on how to request the translation of written documents into other languages and alternate formats? *Must answer, no points available.*

( ) Yes

( ) No

Domain 4: Providing notice of language assistance services

CCOs should answer questions based on language services in place on December 31 of the measurement year.

Questions in this domain assess how well your CCO translates outreach materials and explains how members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve may access available language assistance services. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

48) Does your CCO translate signs or posters announcing the availability of language assistance services? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

49) Please answer yes or no to the methods that your CCO uses to inform members and communities in your service area about the availability of language assistance services. *Must pass beginning MY2021 (year 1) with minimum points required = 5; total points available = 7.*

	Yes	No
A. Frontline and outreach by bilingual or multilingual staff (CCO staff and provider staff)	( )	( )
B. Posters in public areas in clinics	( )	( )
C. "I Speak" language identification cards distributed to frontline CCO and provider staff	( )	( )
D. CCO and providers websites	( )	( )
E. Social networking websites (e.g., Facebook, Twitter, other)	( )	( )
F. Email to members or a listserv	( )	( )
G. Community-based organizations (CBOs), Community Advisory Councils (CACs), or Regional Health Equity Coalitions (RHECs)	( )	( )

50) Does your CCO inform LOE and Deaf and hard of hearing members about resources they can use to schedule an appointment with a provider? *Must pass beginning MY2026 (year 6) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

51) Does your CCO inform LOE and Deaf or Hard of Hearing members about the availability of free language assistance services? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

52) Does the main page of your website include non-English information that is easily accessible to LOE members? *Must pass beginning MY2022 (year 2) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

Thank you for taking our survey. Your response is very important to us.

Appendix 2: CCO self-assessment available points and minimum required point value summary

Total possible points for Year 1 thru 3=	**102**	
Year 1 minimum points required =	46	45.1%
Year 2 minimum points required =	56	54.9%
Year 3 minimum points required =	77	75.5%
Total possible points Year 4 =	**115**	
Year 4 total minimum points required =	83	72.2%
Total possible points Year 5 thru 6 =	**121**	
Year 5 total minimum points required =	97	80.2%
Year 6 total minimum points required =	99	81.8%

	MY2023 (year3)		**MY2024 (year4)**		**MY2025 (year5)**		**MY2026 (year6)**	
	Total available Points	**Minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**
Domain 1: Identification and assessment for communication needs - This domain assesses how well your CCO identifies and tracks services to the members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve.	28	**23**	3	**3**	2	**2**	0	**0**
Domain 2: Provision of Language Assistance Services - This domain assesses how well you use data and work processes to effectively	57	**42**	10	**3**	1	**11**	0	**0**

communicate with the members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve.								
Domain 3: Training of staff on policies and procedures - This domain assesses how well your staff who provide services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve is trained on language access policies and procedures.	8	**5**	0	**0**	1	**0**	0	**1**
Domain 4: Providing notice of language assistance services - This domain assesses how well your CCO translates outreach materials and explains how members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve may access available language	9	**7**	0	**0**	2	**1**	0	**1**

assistance services.									

Point value for each question

Domain	New #	Old #	Change MY24-MY25	2024	minimum	2025	minimum	2026	minimum
	1	1		7	5				
	2	2		3	3				
	3	3	Change	4	3	2	2		
	4	4		0	0				
	5	5		0	0				
	6	6		1	1				
	7	7		1	1				
	8	8		1	1				
	9	9		1	1				
	10	10		1	1				
	11	11		1	1				
	12	12		1	1				
	13	13		1	1				
	14	14		5	3				
	15		New			0	0		
	16	15		2	2				
	17	16		2	2				
	18	17		0	0				
	19	18		0	0				
	20	19		0	0				
1	21	20		0	0				
	22	21		3	3				
	23	22		7	5				
	24	23		8	6				
	25	24		6			6		
	26		New			1	1		
	27	25		1	1				
	28	26		1	1				
	29	27		1	1				
	30	28		1	1				
	31	29		3			3		
	32	30		6	6				
	33	31		1			1		
2	34	32		1	1				

	35	33		0	0				
	36	34		6	3				
	37	35		4	3				
	38	36	Change	7	5				
	39	37		8	6				
	40	38		2	2				
	41		New			0	0		
	42		New			1	1		
		39	Removed	1	1	-1	-1		
	43		New			1			**1**
	44	40		1	1				
	45	41		6	3				
	46	42	Change	1	1				
3	47	43		0	0				
	48	44		1	1				
	49	45	Change	6	4	1	1		
	50		New			1			1
	51	46		1	1				
4	52	47		1	1				
Total new points by year				**13**	**6**	**6**	**14**	**0**	**2**
Total minimum required by year				**115**	**83**	**121**	**97**	**121**	**99**

Appendix 3: Quantitative Interpreter Services Reporting Template

This template has been updated for full population reporting. CCO should only submit a data table with 'one row per visit' using the columns specified below.

Data submission deadline is April 1st of the year following the measurement year:

MY2024: Due April 1, 2025
MY2025: Due April 1, 2026
MY2026: Due April 1, 2027

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
CCO Name	CCO Name	Corresponds to Health Analytics reporting CCO Name	Required
Member ID	Member's Medicaid ID		Required
Interpreter need flagged in MMIS	Yes No	Use this field to confirm whether the member has interpreter needs flags in MMIS. CCO can include additional visits from members needing or utilizing interpreter services but do not have interpreter information in OHA's system by selecting No in this field. See specifications, the Eligible Population section for detail.	Required
Type of Care	Physical Mental/Behavioral Dental	The person can have multiple types of care on the same day. See appendix 4 of the technical specifications for reference to potential methodology.	Required
Visit Type/Care Setting	Visit Type: Inpatient Stay Emergency Department Office Outpatient Home Health Telehealth Other	On a given visit date, each type of care should have only one visit type/care setting. The visit type listed is determined based on the following hierarchy: Inpatient Stay Emergency Department Office Outpatient Home Health Telehealth Other For example, if a person had an emergency room visit and was admitted for an inpatient hospital stay, CCOs should report the inpatient visit for one type of care. If a person had an office outpatient visit and a telehealth appointment for only one type of care, CCOs should report the office outpatient visit. If the person has more than one type of care in a day, report each type of care separately. If the member has a physical health office outpatient visit and a dental health office outpatient visit on the same day, report both visits separately. Please see appendix 4 of the technical specifications on the Oregon Health Grouper (OHG).	Required

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
Visit Date	YYYY/MM/DD	For an inpatient stay, CCOs should report the admission date as the visit date and one inpatient stay in a facility as one visit regardless of the total length of stay. If the patient is transferred to a different facility, CCOs should count as a separate visit.	Required
In-person Interpreter Service (or in-language visit[1])	Yes No	Answer Yes or No for all three fields. Reporting of in language provider visits is optional in MY2025. Indicate Yes if the CCOs data collection system for the measure indicates Yes for interpreter services (or in-language provider services, if reporting), or all possible data sources were reviewed for the use of language assistance services and it was found the member received interpreter services (or in-language provider services, if reporting) during the visit. Indicate No if the CCOs data collection system for the measure indicates No for interpreter services (or in-language provider services, if reporting), or all possible data sources were reviewed and cannot find any evidence that interpreter service (or in-language provider services, if reporting) was provided for the visit. Leave the modality fields blank if the visit does not exist in the CCOs data collection system for the measure, or there are other known data sources for language services and the CCO is unable to review and report on these data sources. For example, the clinic orders/pays for the interpreter services and keeps the records, but the data is not tracked at the member and visit-level detail (unable to capture the required reporting data elements), or the CCO cannot retrieve the data during the hybrid review process.	Required
Telephonic Interpreter Service (or in-language visit[1])	Yes No		Required
Video Remote Interpreter Service (or in-language visit[1])	Yes No		Required
Language Interpreted	3-Letter ISO 639 Language Code	Fill out field if the member received interpreter services or had an in-language provider visit. Field should reflect what non-English language was primarily spoken with the member during the visit.	Required
Was the Interpreter (or in-language provider[1]) OHA Certified or Qualified ?	OHA Certified OHA Qualified Not Certified or Qualified Blank - Unknown or Not Applicable	OHA Certified and OHA Qualified should be used for visits with interpreter services where the interpreter, provider, or bilingual staff has an OHA registry number. If OHA Certified or OHA Qualified is indicated, a valid OHA Registry number must be provided in the next field. Indicate Not Certified or Qualified if the interpreter, bilingual staff, or in language provider was not OHA certified or qualified.	Required if Yes for any of the three language service modality fields (In Person, Telephonic, Video Remote).

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
Interpreter's OHA Registry Number	OHA Registry Number	If multiple OHA certified and/or qualified health care interpreters were used, please report only one interpreter's OHA registry number. OHA will confirm the submitted value exists on the OHA registry number. Only records with valid OHA registry numbers count towards the incentive quality language access rate.	Required if OHA Certified or OHA Qualified is indicated
If visit had in language provider, was the provider a native speaker or did the provider pass a proficiency test[1]?	Yes No Blank	Yes – The primary performing provider was a native speaker or passed proficiency test No – The primary performing provider was not a native speaker and did not pass a proficiency test Blank - Unknown or Not Applicable Only the primary performing provider for the visit qualifies for these two options. This field is not available to other supporting providers or general clinic staff. Indicate yes for a provider who is a native speaker or passed proficiency test. The field should ONLY be indicated if the in-language provider is a native speaker of the same preferred language of the member or has passed the proficiency test in the member's preferred language (see requirements on page 7). The CCO must have documentation that the provider's native language and/or proficiency test languages match (e.g., a provider passed proficiency test for Korean does not qualify for a member with preferred language as Spanish). Only records with the provider meeting these requirements count towards the incentive quality language access rate. CCO must attest to tracking language proficiency tests and matching languages in Component 1 question #41 and #42 to qualify for numerator credits. Indicate No if the provider is not a native speaker of the member's preferred language and has not passed the proficiency test in the member's preferred language. Leave blank if native speaker or proficiency test records are not tracked.	Optional

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
Was the Interpreter a Bilingual Staff	Yes No Blank	Yes - Bilingual Staff No - No Bilingual Staff Blank - Unknown or Not Applicable Do not use this field for the primary performing provider who provides an in-language visit. Bilingual staff services do not automatically qualify for numerator hits unless the staff (is OHA qualified or certified for interpreter services, or the in-language visit provider has passed the proficiency test for the member's preferred language. This flag is for information that an outside/contracted interpreter is not used; it helps the CCO to identify staff who may receive training for becoming OHA qualified and certified, or take a proficiency test	Optional
Did the member refuse Interpreter Service	Yes No Blank	Yes - Member Refused Interpreter Services No - Member did not Refuse Interpreter Services Blank - Unknown or Not Applicable If no records of member refusal exists, member did not refuse (fill in No in template) can be indicated.	Required if No for all of the three language service modality fields (In Person, Telephonic, Video Remote)
Reason for Member Refusal	1 2 3 4 5 Blank	1 - Member refusal because in-language visit is provided 2 - Member confirms interpreter needs flag in MMIS is inaccurate 3 - Member unsatisfied with the interpreter services available 4 - Other reasons for patient refusal 5 – Member does not need interpreter services for the visit Blank - Unknown or Not Applicable Scenario 1: The member confirms the provider for the visit can perform in-language service and therefore refused interpreter service. To note, if the in-language service provider is OHA certified or qualified or has passed the language proficiency requirements, it could be a numerator hit for the metric. Scenario 2: OHA recommends initiating correction of the interpreter flag in MMIS. Scenario 5: The member decides to refuse interpreter service for this reported visit, but the member may need language services for other visits. Visits with refusal reasons 1,2 or 5 can be excluded IF the CCO attests collecting corresponding information in the CCO self-assessment survey question #14. Scenarios 3 and 4 do not qualify for denominator exclusion.	Required if No for all of the three language service modality fields (In Person, Telephonic, Video Remote)

Column Name	Valid Input Value	Instructions	Field Type
Hospital Facility Name	Text	Report facility name when the visit is with a hospital facility. See Appendix 5 for facility name reference table.	Hospital and Emergency Department visits[2] only; optional MY2025, required starting MY2026
Hospital Facility NPI	numeric	Report facility name when the visit is with a hospital facility. Provide the facility's NPI for the hospital location the patient is receiving services, as specified in OAR 410-120-0000(198). DO NOT provide the NPI or any other identifier associated with a health care professional. "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.	Hospital and Emergency Department visits[2] only; optional MY2025, required starting MY2026

[1] In language provider who is a native speaker or has passed a proficiency test in member's preferred language reporting is optional in MY 2025. See page 7 for requirements.

[2] Hospital visit means the member received a qualifying visit from an on or off campus-based hospital facility inclusive of inpatient, outpatient, emergency room, ambulatory surgery, and telehealth services. .

Appendix 4: Categorizing Denominator Visits based on Oregon Health Grouper (OHG) and modifications

OHA uses a homegrown Oregon Health Grouper (OHG) with recategorization and modifications to count denominator visits in the required stratifications for the measure[12].

Step1: All MMIS/DSSURS claims data are categorized into OHG categories, then rolled up into larger categories using the following crosswalk table below. Note, only paid claims are used, and claim lines containing modifier code 26 or place of service (POS) 81 are excluded[13].

OHG-to-HEM Crosswalk Table:

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
D-01	Dental Diagnostic	dental	Office Outpatient
D-02	Dental Preventative	dental	Office Outpatient
D-03	Dental Restorative	dental	Office Outpatient
D-04	Dental Endodontics	dental	Office Outpatient
D-05	Dental Periodontics	dental	Office Outpatient
D-06	Dental Prosthodontics Removable	dental	Office Outpatient
D-07	Dental Implants/ Prosthodontics Fixed	dental	Office Outpatient
D-08	Dental Oral Maxillofacial Surgery	dental	Office Outpatient
D-09	Dental Orthodontics	dental	Office Outpatient
D-10	Dental Anesthesia	dental	Office Outpatient
D-99	Dental Adjuctive General Services (Unbucketed)	dental	Office Outpatient
I-01	Ip-Ther-Abort-Ip-Hosp	physical	Inpatient
I-02A	Ip-Mh-Acute-Ip-A	mental/behavioral	Inpatient
I-02B	Ip-Mh-Acute-Ip-B	mental/behavioral	Inpatient
I-03	Ip-Acute-Detox	mental/behavioral	Inpatient
I-04	Ip-Steril-Maternity	physical	Inpatient
I-05	Ip-Hyster-Hosp	physical	Inpatient
I-06	Ip-Steril-Hosp-F	physical	Inpatient
I-07	Ip-Post-Hosp-Ext-Care	physical	Inpatient
I-08	Inpatient Maternity C-Section Delivery	physical	Inpatient
I-09	Inpatient Maternity Non-Delivery	physical	Inpatient
I-10	Inpatient Maternity Normal	physical	Inpatient
I-11A	Inpatient Newborn Complicated	physical	Inpatient

[12] More detail documentation in excel format is available on the metrics website: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

[13] This exclusion is to avoid counting visits from independent lab claims or providers interpretation of test results without provider and patient interpretation. With the visit setting hierarchy, higher level qualifying visits on the same day can still be identified and be included in the report.

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
I-11B	Inpatient Newborn Well	physical	Inpatient
I-12	Inpatient Rehabilitation	physical	Inpatient
I-13	Inpatient Medical/Surgical (Medical Only)	physical	Inpatient
I-14	Inpatient Medical/Surgical (Surgical Only)	physical	Inpatient
I-15	Inpatient Un-Bucketed Missing DRG	physical	Inpatient
I-15A	Ip-Or-Spec-Drg-Rehab	physical	Inpatient
I-15B	Ip-Or-Spec-Drg-NeoNates	physical	Inpatient
I-99	Inpatient Unbucketed	physical	Inpatient
M-01	Emergency Lifeflight	exclude	exclude
M-02	School Based Services	physical	Office Outpatient
M-03	Transportation Ambulance	exclude	exclude
M-04	Outpatient Basic ASC (ASC = Ambulatory Surgical Center)	physical	Office Outpatient
M-05	Physician Primary Care E-M (Evaluation & Management)	physical	Office Outpatient
M-05A	Physician Primary Care E-M (Evaluation & Management) Mental Health	mental/behavioral	Office Outpatient
M-06	Physician Other E-M (Evaluation & Management)	physical	Office Outpatient
M-06A	Physician Other E-M (Evaluation & Management) Mental Health	mental/behavioral	Office Outpatient
M-07	Evaluation & Management PCP (PCP = Primary Care Phsycian)	mental/behavioral	Office Outpatient
M-08	Mental Health ACT (ACT = Assertive Community Treatment)	mental/behavioral	Office Outpatient
M-09	Mental Health AFC (AFC = Adult Foster Care)	exclude	exclude
M-10	Mental Health Assessment & Evaluation	mental/behavioral	Office Outpatient
M-11	Mental Health Case Management	mental/behavioral	Other
M-12	Mental Health Consultation	mental/behavioral	Office Outpatient
M-13	Mental Health Crisis Services	mental/behavioral	Office Outpatient
M-14	Mental Health Interpretive Services	exclude	exclude
M-15	Mental Health Medication Management	mental/behavioral	Other
M-16	Mental Health Alternative to Inpatient	mental/behavioral	Outpatient
M-17	Mental Health MST (MST = Muti-Systemtic Treatment)	mental/behavioral	Office Outpatient
M-18	Mental Health PAITS (PAITS = Post Acute Intensive Treatment Services)	mental/behavioral	Office Outpatient
M-19	Mental Health PDTS (Psyciatric Day Treatment Services)	mental/behavioral	Office Outpatient
M-20	Mental Health Respite	mental/behavioral	Other

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
M-21	Mental Health RTF Part A (RTF = Residential Treatment Facility)	exclude	exclude
M-22	Mental Health RTF Part B (RTF = Residential Treatment Facility)	exclude	exclude
M-23A	Mental Health SCIP, SAIP, STS (SCIP = Secure Children's Inpatient Program 0 - 11, SAIP = Secure Adolenscent Inpatient Program 12 - 17, & STS = Stabilization Transition Services)	mental/behavioral	Inpatient
M-23B	Mental Health SCIP, SAIP, STS (SCIP = Secure Children's Inpatient Program 0 - 11, SAIP = Secure Adolenscent Inpatient Program 12 - 17, & STS = Stabilization Transition Services)	mental/behavioral	Inpatient
M-24	Mental Health Skills Training	mental/behavioral	Office Outpatient
M-25	Mental Health SRTF (SRTF = Secure Residential Treatment Facility 18+)	exclude	exclude
M-26	Mental Health Sub Acute	mental/behavioral	Office Outpatient
M-27	Mental Health Supportive Employment	exclude	exclude
M-28	Mental Health Therapy	mental/behavioral	Office Outpatient
M-29	Mental Health Therapy Inpatient	mental/behavioral	Inpatient
M-30	Mental Health Wrap-Around Services	mental/behavioral	Other
M-31	Mental Helath Intensive Rehab Services	mental/behavioral	Office Outpatient
M-32A	Physician Therapeutic Abortion Part A	physical	Office Outpatient
M-32B	Physician Therapeutic Abortion Part B	physical	Office Outpatient
M-33	Behavioral Rehab Services	mental/behavioral	Office Outpatient
M-34	Excluded Admin Exams	physical	Other
M-35	Targeted Case Management (TCM) Leveraged	physical	Other
M-36	Non-Emergent Transporation (NEMT)	exclude	exclude
M-37	Checmical Dependency OHP Outpatient (OHP = Oregon Health Plan)	mental/behavioral	Office Outpatient
M-40	Mental Health Outpatient Therapy	mental/behavioral	Office Outpatient
M-41	Mental Health Physician Outpatient	mental/behavioral	Office Outpatient
M-42	Mental Health Supportive Day Treatment	mental/behavioral	Office Outpatient
M-43	Mental Health Supportive Housing	exclude	exclude
M-44	Anesthesia	physical	Office Outpatient
M-45A	Outpatient Dental Anesthesia	dental	Office Outpatient
M-45B	Outpatient Dental Flouride	dental	Office Outpatient
M-46	Physician Family Planning Part B	physical	Office Outpatient
M-47	Physician Family Planning Part C	physical	Office Outpatient
M-48	Physician Hysterectomy	physical	Office Outpatient
M-49	Lab	exclude	exclude
M-50	Other Medical Maternity Management	physical	Office Outpatient
M-51	Other Medical Durable Medical Equipment	exclude	exclude
M-52	Other Medical Supplies	exclude	exclude
M-53	Maternity	physical	Office Outpatient
M-53A	Physcian Maternity Primary Care	physical	Office Outpatient
M-54	Neonate Newborn Care	physical	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
M-55	Radiology	physical	Other
M-56	Physician Sterilization	physical	Office Outpatient
M-57	Surgery	physical	Office Outpatient
M-58	Speech & Hearing	physical	Office Outpatient
M-59	Vision Exams & Therapy	physical	Office Outpatient
M-60	Physician Other Services	physical	Other
M-61	Other Drugs & Supplies	exclude	exclude
M-62	Community Detox	mental/behavioral	Office Outpatient
M-63	Chemical Dependency Assessment Screening	mental/behavioral	Office Outpatient
M-64	Chemical Dependency Methadone Treatment	mental/behavioral	Office Outpatient
M-65	Cemical Dependency Methadone AMH (AMH = Addictions and Mental Health)	mental/behavioral	Office Outpatient
M-66	Physicial Somatic Mental Health	mental/behavioral	Office Outpatient
M-67	Not Covered	exclude	exclude
M-68	SBIRT Part A (SBIRT = Screening, Brief Intervention, & Referral to Treatment)	mental/behavioral	Office Outpatient
M-69	SBIRT Part B (SBIRT = Screening, Brief Intervention, & Referral to Treatment)	mental/behavioral	Office Outpatient
M-70	Mental Health Children and Adolescent Needs Assessment	mental/behavioral	Office Outpatient
M-71	ABA Services - Mental Health	mental/behavioral	Office Outpatient
M-72A	Chemical Dependency Residential Treatment Child	mental/behavioral	Inpatient
M-72B	Chemical Dependency Residential Treatment Adult	mental/behavioral	Inpatient
M-72C	Psychiatric Residential Treatment Services	physical	Inpatient
M-75	Urgent Care Visits	physical	Office Outpatient
M-76	Preventative Well Baby Exams	physical	Office Outpatient
M-77	Preventative Immunizations	physical	Office Outpatient
M-78	Preventative Care Covered Service	physical	Office Outpatient
M-79	Preventative Care Non-Covered Service	physical	Office Outpatient
M-80	Inpatient Visits	physical	Inpatient
M-81	Outpatient	physical	Office Outpatient
M-98A		mental/behavioral	Other
M-98B		mental/behavioral	Other
M-98C		mental/behavioral	Other
M-99	Professional Unbucketed	physical	Other
O-01	Outpatient Therapeutic Abortion Outpatient Hospital	physical	Office Outpatient
O-02	Outpatient Excluded Administrative Exams	physical	Other
O-03	Outpatient Prescription Drugs Mental Health	mental/behavioral	Office Outpatient
O-04	Outpatient Mental Health Other Outpatient	mental/behavioral	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
O-05	Outpatient Emergency Room Somatic Mental Health	mental/behavioral	ED
O-06A	Outpatient Chemical Dependency -- Part A	mental/behavioral	Office Outpatient
O-06B	Outpatient Chemical Dependency -- Part B	mental/behavioral	Office Outpatient
O-07	Outpatient Hysterectomy	physical	Office Outpatient
O-08	Outpatient Sterilization -- Female	physical	Office Outpatient
O-09A	Outpatient Family Planning -- Part A -- No Modifier	physical	Office Outpatient
O-09B	Outpatient Family Planning -- Part B -- With Modifier	physical	Office Outpatient
O-09C	Outpatient Family Planning -- Part C -- With Modifier	physical	Office Outpatient
O-10	Outpatient Maternity	physical	Office Outpatient
O-11	Outpatient Prescription Drugs Basic	physical	Office Outpatient
O-11A	Outpatient Skilled Nursing Facility	physical	Office Outpatient
O-12	Outpatient Post Hospital Extended Care	physical	Office Outpatient
O-13	Outpatient Maternity Case Management	physical	Office Outpatient
O-14	Outpatient Hospice Services	physical	Office Outpatient
O-15	Outpatient Transportation Ambulance	exclude	exclude
O-16	Outpatient Emergency Room	physical	ED
O-17A	Outpatient Lab Services -- Part A	exclude	exclude
O-17B	Outpatient Radiology Services CT -- Part B (CT = Computerized Tomography	physical	Other
O-17C	Outpatient Radiology Services MRI -- Part C (MRI = Magnetic Resonance Imaging)	physical	Other
O-17D	Outpatient Radiology Services PET -- Part D (PET = Positron Emission Tomography)	physical	Other
O-18	Outpatient Home Health	physical	Home Health
O-19	Outpatient Somatic Mental Health	mental/behavioral	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
O-20	Outpatient Physician Administered Drugs	physical	Other
O-21	Outpatient Diagnostic Services Other	physical	Office Outpatient
O-22	Outpatient Lab Injections Other	exclude	exclude
O-23	Outpatient Supplies & Devices	exclude	exclude
O-24	Outpatient Operating Room Other	physical	Office Outpatient
O-25	Outpatient Anesthesia Other	physical	Office Outpatient
O-26	Outpatient Clinics	physical	Office Outpatient
O-27	Outpatient Therapy & Rehabilitation	physical	Office Outpatient
O-28	Outpatient Professional Fees	physical	Office Outpatient
O-29	Outpatient Surgery	physical	Office Outpatient
O-30	Preventative Care Covered Service	physical	Office Outpatient
O-31	Preventative Care Non-Covered Service	physical	Office Outpatient
O-99	Outpatient Unbucketed	physical	other
RX-01	Pharmacy Perscription Drugs Basic	exclude	exclude
RX-02	Pharmacy Over The Counter (OTC)	exclude	exclude
RX-03	Pharmacy Family Planning Contraceptives	exclude	exclude
RX-04	Pharmacy Carved-Out Drugs	exclude	exclude
RX-05	Pharmacy Immunization Drugs	exclude	exclude
RX-06	Pharmacy Durable Medical Equipment (Pill Splitters)	exclude	exclude
RX-07	Pharmacy Medication Assisted Treatment (MAT)	exclude	exclude

Step 2: Telehealth visits are identified separately for claims with:

- Procedure code: 98966-98972, 99421-99458, 99473, 99474, 99091, D9995, D9996, G0425-G0427, G0508, G0509, G2010, G2012, G2025, G2061-G2063, Q3014 or
- Modifier: GT, GQ, G0, 95, or
- Place of Service code: 02 or 10

Step 3: Claims are de-duplicated into unique visit dates, but report separately if a member had more than one type of care (physical, mental/behavioral or dental) on the same day.

Step 4: If multiple visit types/care settings occurred on the same day for a given type of care (physical, mental/behavioral or dental), only one category is selected based on the hierarchy: Inpatient Stay > Emergency Department > Office Outpatient > Home Health> Telehealth > Other.

Appendix 5: Hospital Facility Names and NPI

This list is not an exhaustive of all hospital facility NPIs in use and is meant to provide general guidance. NPIs will be updated on an annual basis. As previously noted, if choosing to report the hospital facility name and NPI, report the facility NPI of the hospital and not the professional health care provider level NPI. A known hospital facility NPI should still be reported even if it is not on the list below.

Facility Name	Primary NPI	Secondary NPI
Adventist Columbia Gorge Medical Center	1275880148	1306842752
Adventist Medical Center	1801887658	
Adventist Tillamook Regional Medical Center	1871575225	1184607020
Asante Ashland Community Hospital	1386644029	1407271398
Asante Rogue Valley Medical Center	1770587107	
Asante Three Rivers Medical Center	1801891809	1598895690
Bay Area Hospital	1225016561	
Blue Mountain Hospital	1356414395	
Columbia Memorial Hospital	1134146939	
Coquille Valley Hospital	1730223967	
Curry General Hospital	1487696985	
Good Shepherd Medical Center	1295789667	
Grande Ronde Hospital	1467446195	
Harney District Hospital	1285742338	
Kaiser Sunnyside Medical Center	1124182902	
Kaiser Westside Medical Center	1891048807	
Lake District Hospital	1376698522	
Legacy Emanuel Medical Center	1831112358	
Legacy Good Samaritan Hospital	1780608216	1679597108
Legacy Meridian Park Medical Center	1184647620	
Legacy Mount Hood Medical Center	1255354700	
Legacy Silverton Medical Center	1669424354	
Lower Umpqua Hospital	1003874819	1538249081
McKenzie-Willamette Medical Center	1568413573	
Mercy Medical Center	1023306800	1477590198
OHSU Health Hillsboro Medical Center	1275591984	
OHSU Hospital	1609824010	
PeaceHealth Cottage Grove Medical Center	1902892391	
PeaceHealth Peace Harbor Medical Center	1578552402	
PeaceHealth Sacred Heart Medical Center - Riverbend	1083888515	
Pioneer Memorial Hospital - Heppner	1376572099	
Providence Hood River Memorial Hospital	1255429338	

Providence Medford Medical Center	1689755670	
Providence Milwaukie Hospital	1215168711	1366536963
Providence Newberg Medical Center	1952482275	
Providence Portland Medical Center	1003991845	
Providence Seaside Hospital	1578500492	1952449985
Providence St Vincent Medical Center	1114015971	1083866933
Providence Willamette Falls	1912282369	
Saint Alphonsus Medical Center - Baker City	1386636355	1326313305
Saint Alphonsus Medical Center - Ontario	1891891792	1013276831
Salem Health Salem Hospital	1265431829	
Salem Health West Valley Hospital	1245237486	
Samaritan Albany General Hospital	1154372340	
Samaritan Good Samaritan Regional Medical Center	1962453134	1811235070
Samaritan Lebanon Community Hospital	1689625980	1790928125
Samaritan North Lincoln Hospital	1306897491	
Samaritan Pacific Communities Hospital	1801847066	
Santiam Memorial Hospital	1154302214	
Shriners Hospital for Children	1982793139	
Sky Lakes Medical Center	1659340370	
Southern Coos Hospital & Health Center	1417094145	1588684484
St Anthony Hospital	1649276734	
St Charles - Bend	1982621447	
St Charles - Bend Redmond Campus	1225056146	
St Charles - Madras	1356389894	
St Charles - Prineville	1972699106	1710160445
Wallowa Memorial Hospital	1558366229	
Willamette Valley Medical Center	1346269982	

Quality ID #398: Optimal Asthma Control

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Outcome – High Priority

DESCRIPTION:
Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients with a diagnosis of asthma seen 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 primary management of patients with asthma based on the services provided and the measure-specific denominator coding.

This measure will be calculated with 7 performance rates:

1) Overall Percentage for patients (aged 5-50 years) with well-controlled asthma, without elevated risk of exacerbation
2) Percentage of pediatric patients (aged 5-17 years) with well-controlled asthma, without elevated risk of exacerbation
3) Percentage of adult patients (aged 18-50 years) with well-controlled asthma, without elevated risk of exacerbation
4) Asthma well-controlled (submit the most recent specified asthma control tool result) for patients 5 to 17 with Asthma
5) Asthma well-controlled (submit the most recent specified asthma control tool result) for patients 18 to 50 with Asthma
6) Patient not at elevated risk of exacerbation for patients 5 to 17 with Asthma
7) Patient not at elevated risk of exacerbation for patients 18 to 50 with Asthma

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 (SUBMISSION CRITERIA 1):
Patients ages 5 to 17 with asthma

> ***DENOMINATOR NOTE:*** **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.*

Visits to a primary care setting, regardless of the reason for the visit or the scheduling status of the visit (e.g., walk-in) are to be included. In a multi-specialty clinic setting, patients who have visits from both the primary care setting and the urgent care setting during the performance period are to be included. M1021 may be used if the patient is only evaluated at an urgent care visit and is not considered an established patient to allow for care coordination or follow up.

Denominator Criteria (Eligible Cases) 1:
Patients aged 5-17 years
AND
Diagnosis for asthma (ICD-10-CM): J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
AND
Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period
AND
Established patient office or telehealth visit during the performance period (CPT): 99211, 99212, 99213, 99214,
99215, 99392*, 99393*, 99394*, 99395*, 99396*, 99421, 99422, 99423, 99441, 99442, 99443
AND NOT
DENOMINATOR EXCLUSIONS:
Diagnosis for chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure

- The following codes would be sufficient to define the Denominator Exclusion of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure: E84.0, E84.11, E84.19, E84.8, E84.9, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J68.4, J96.00, J96.01, J96.02, J96.20, J96.21, J96.22, J98.2, J98.3.

- For historical reference purposes, these ICD-9 codes if documented would be sufficient to define the Denominator Exclusion of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure: 277.00, 277.01, 277.02, 277.03, 277.09, 491.20, 491.21, 491.22, 492.0, 492.8, 493.20, 493.21, 493.22, 496, 506.4, 518.1, 518.2, 518.81

OR
Patient died prior to the end of the performance period
OR
Patient was a permanent nursing home resident any time during the performance period
OR
Patient was in hospice or receiving palliative care services at any time during the performance period
OR
Patient had only urgent care visits during the performance period: M1021

NUMERATOR (ALL OR NOTHING):
The number of asthma patients who meet ALL of the following targets

Numerator Options:
Each component should be submitted in order to determine the data completeness and performance rate for the overall percentage of patients that meet ALL targets represented as the numerator.

COMPONENT 1:

Asthma well-controlled (submit the most recent asthma control tool result available during the measurement period)

- Asthma Control Test™ (ACT) result of 20 or above - ages 12 and older
- Childhood Asthma Control Test™ (C-ACT) result of 20 or above - ages 11 and younger
- Asthma Control Questionnaire (ACQ) result of 0.75 or lower - ages 17 and older
- Asthma Therapy Assessment Questionnaire (ATAQ) result of 0 – Pediatric (ages 5 – 17) or Adult (ages 18 and older)

Component Options:

Performance Met: Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score and results documented **(G9432)**

OR

Performance Not Met: Asthma not well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score, OR specified asthma control tool not used, reason not given **(G9434)**

AND

COMPONENT 2:

Patient not at elevated risk of exacerbation

NUMERATOR NOTE: *To meet performance for this component, documentation of the sum of the patient's submitted values for the following questions must be less than two:*

- *Number of emergency department visits not resulting in a hospitalization due to asthma in last 12 months*
- *Number of inpatient hospitalizations requiring an overnight stay due to asthma in last 12 months.*

Component Options:

Performance Met: Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months **(G9521)**

OR

Performance Not Met: Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given **(G9522)**

DENOMINATOR (SUBMISSION CRITERIA 2):

Patients ages 18 to 50 with asthma

DENOMINATOR NOTE: **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.*

Visits to a primary care setting, regardless of the reason for the visit or the scheduling status of the visit (e.g., walk-in) are to be included. In a multi-specialty clinic setting, patients who have visits from both the primary care setting and the urgent care setting during the performance period are to be included. M1021 may be used if the patient is only evaluated at an urgent care visit and is not considered an established patient to allow for care coordination or follow up.

Denominator Criteria (Eligible Cases) 2:

Patients aged 18-50 years

AND

Diagnosis for asthma (ICD-10-CM): J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

AND

Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period

AND

Established patient office or telehealth visit during the performance period (CPT): 99211, 99212, 99213, 99214, 99215, 99392*, 99393*, 99394*, 99395*, 99396*, 99421, 99422, 99423, 99441, 99442, 99443

AND NOT

DENOMINATOR EXCLUSIONS:

Diagnosis for chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure

- The following codes would be sufficient to define the Denominator Exclusion of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure: E84.0, E84.11, E84.19, E84.8, E84.9, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J68.4, J96.00, J96.01, J96.02, J96.20, J96.21, J96.22, J98.2, J98.3.
- For historical reference purposes, these ICD-9 codes if documented would be sufficient to define the Denominator Exclusion of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure: 277.00, 277.01, 277.02, 277.03, 277.09, 491.20, 491.21, 491.22, 492.0, 492.8, 493.20, 493.21, 493.22, 496, 506.4, 518.1, 518.2, 518.81

OR

Patient died prior to the end of the performance period

OR

Patient was a permanent nursing home resident any time during the performance period

OR

Patient was in hospice or receiving palliative care services at any time during the performance period

OR

Patient had only urgent care visits during the performance period: M1021

NUMERATOR (ALL OR NOTHING):

The number of asthma patients who meet ALL of the following targets

Numerator Options:

Each component should be submitted in order to determine the data completeness and performance rate for the overall percentage of patients that meet ALL targets represented as the numerator.

COMPONENT 1:

Asthma well-controlled (submit the most recent asthma control tool result available during the measurement period)

- Asthma Control Test™ (ACT) result of 20 or above - ages 12 and older
- Asthma Control Questionnaire (ACQ) result of 0.75 or lower - ages 17 and older
- Asthma Therapy Assessment Questionnaire (ATAQ) result of 0 – Pediatric (ages 5 – 17) or Adult (ages 18 and older)

Component Options:

Performance Met:	Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score and results documented **(G9432)**
OR	
Performance Not Met:	Asthma not well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score, OR specified asthma control tool not used, reason not given **(G9434)**

AND

COMPONENT 2:

Patient not at elevated risk of exacerbation

NUMERATOR NOTE: *To meet performance for this component, documentation of the sum of the patient's submitted values for the following questions must be less than two:*

- *Number of emergency department visits not resulting in a hospitalization due to asthma in last 12 months*
- *Number of inpatient hospitalizations requiring an overnight stay due to asthma in last 12months*

Component Options:

Performance Met:	Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months **(G9521)**
OR	
Performance Not Met:	Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given **(G9522)**

RATIONALE:

Roughly 7% of adults and children in Minnesota are currently living with asthma. Asthma is a chronic disease associated with familial, infectious, allergenic, socioeconomic, psychosocial, and environmental factors. It is not curable but is treatable. Despite improvements in diagnosis and management, and an increased understanding of the epidemiology, immunology, and biology of the disease, asthma prevalence has progressively increased over the past 15 years.

CLINICAL RECOMMENDATION STATEMENTS:

From the National Quality Forum's 2013 report, Patient Reported Outcomes (PROs) in Performance Measurement:

Patient and family engagement is increasingly acknowledged as a key component of a comprehensive strategy, (along with performance improvement and accountability), to achieve a high quality, affordable health system. Emerging evidence affirms that patients who are engaged in their care tend to experience better outcomes and choose less costly but effective interventions.

Historically, with the exception of collecting feedback on satisfaction or experience with care, patients remain an untapped resource in assessing the quality of healthcare and of long-term support services. Patients are a valuable and, arguably, the authoritative source of information on outcomes beyond experience with care. These include health-related quality of life, functional status, symptom and symptom burden, and health behaviors.

Patient Reported Outcome Measures (PROMs) are standardized instruments that capture patients' self-assessment of their health and can provide timely information on patient health status, function, and symptoms over time that can be used to improve patient-centered care and inform clinical decision-making.

The Asthma Control Test™ (ACT) is a validated self-administered survey utilizing 5 questions to assess asthma control on a scale from 0 (poor control) to 5 (total control) in individuals 12 years and older. © 2002 by QualityMetric Incorporated. Asthma Control Test is a trademark of QualityMetric Incorporated.

The Childhood Asthma Control Test (C-ACT) is a caregiver-assisted, child-completed tool that can be used with or without lung function assessment to assess pediatric asthma control at home or in clinical practice for children ages 4-11 years. It consists of 7 questions of which 4 are child-reported and 3 are caregiver-reported questions. ©2007 The GlaxoSmithKline Group of Companies.

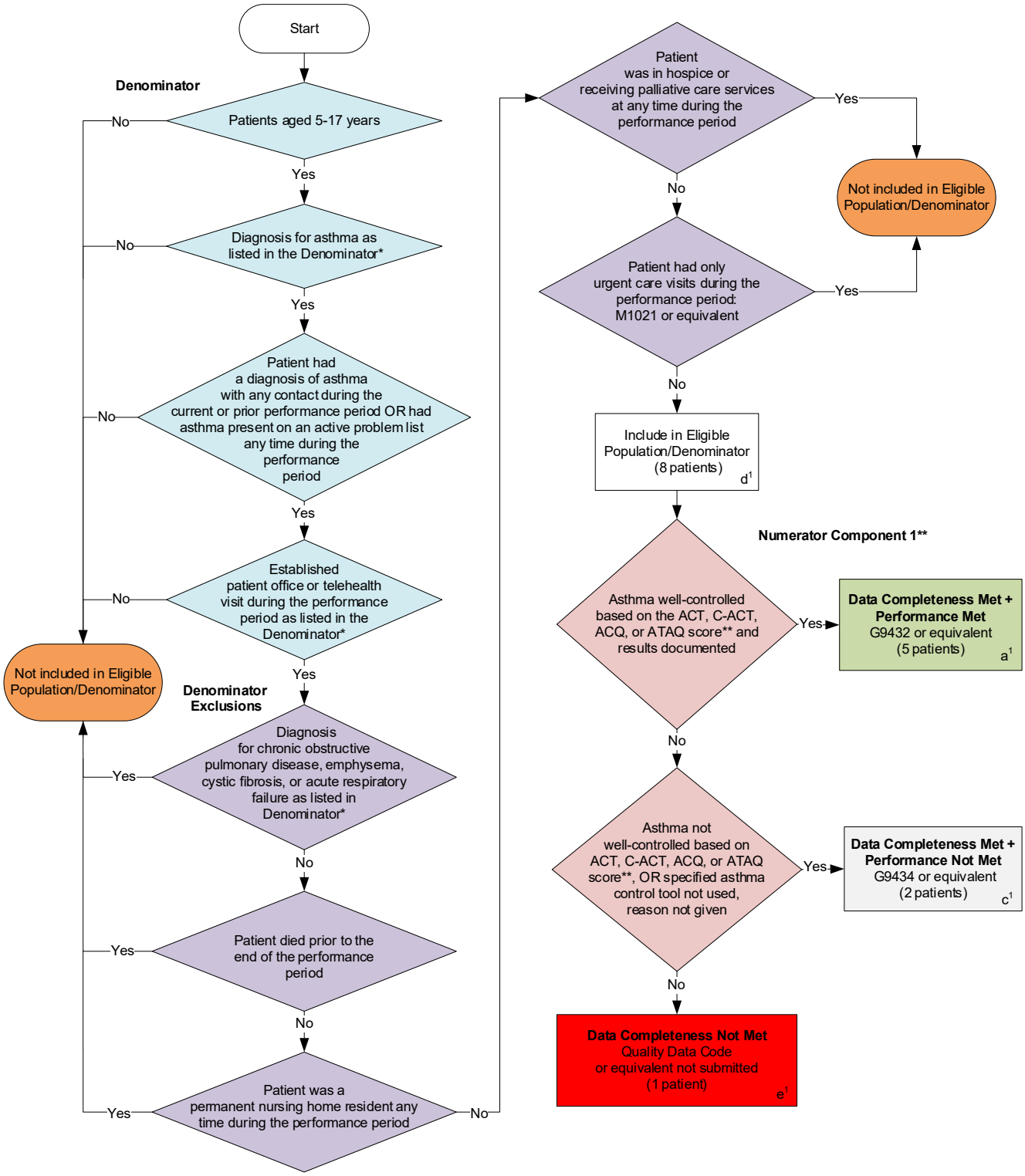
The Asthma Control Questionnaire (ACQ) is a validated, self-administered survey available in various formats from the developer, Elizabeth F. Juniper, MCSP, MSc. Link to ACQ Survey

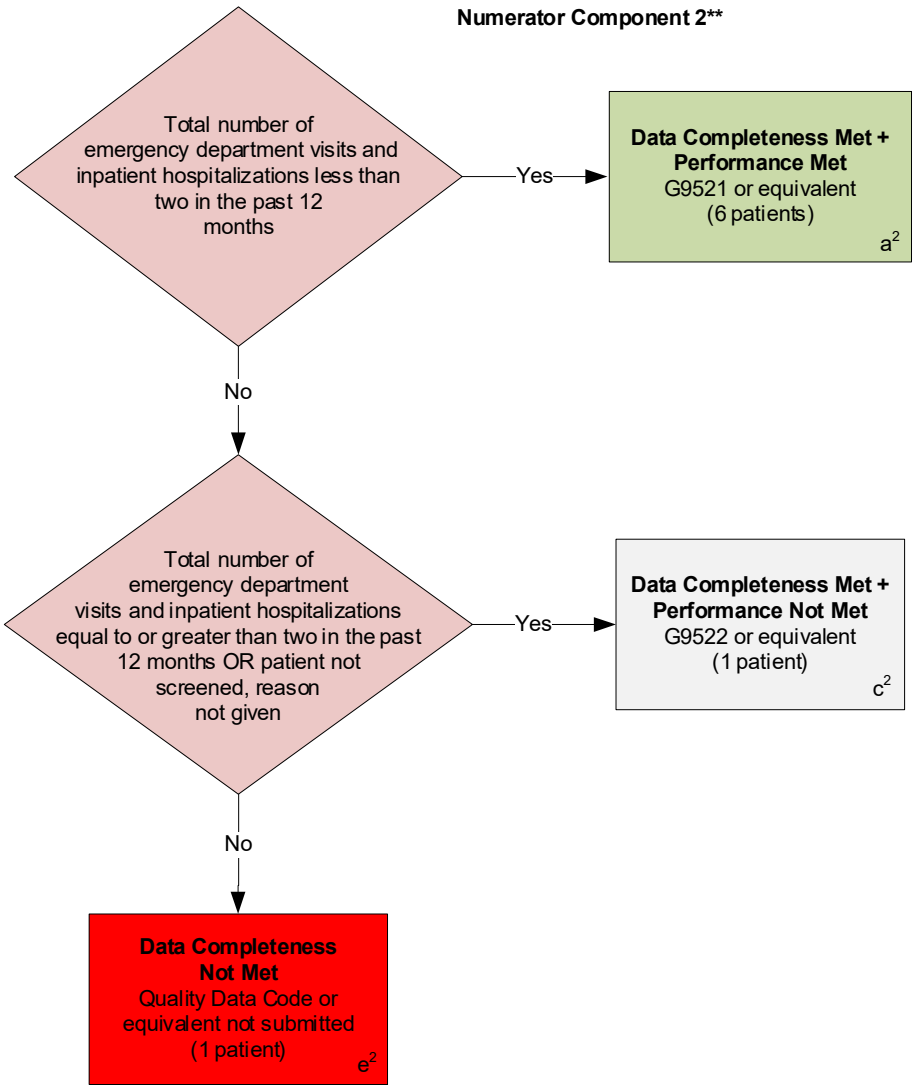
The Asthma Therapy Assessment Questionnaire (ATAQ) is available in a version for adults (18 and over) and a version for children and adolescents (5 – 17). © 2005 Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc.

2023 Clinical Quality Measure Flow for Quality ID #398:
Optimal Asthma Control
Submission Criteria One

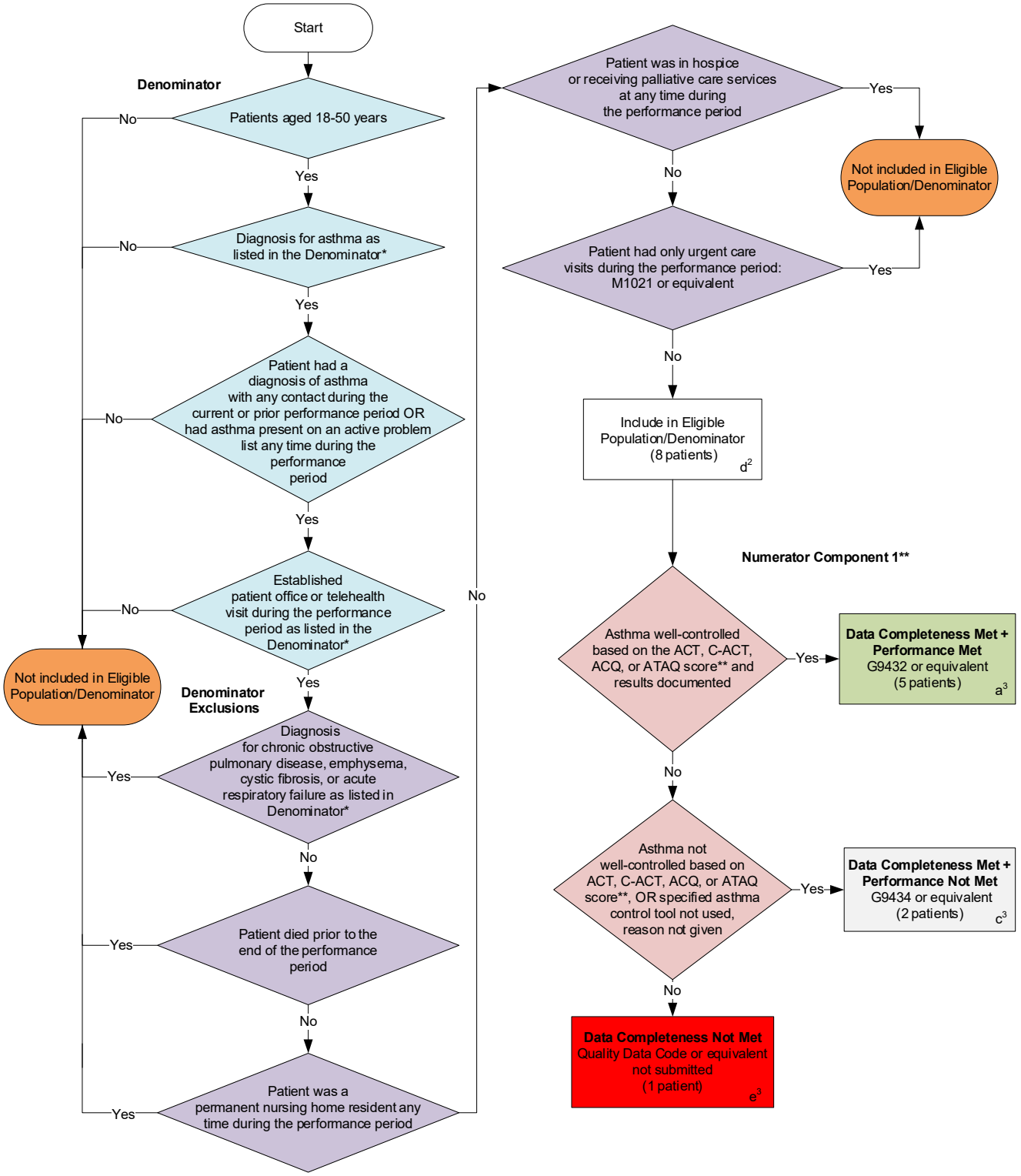
Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

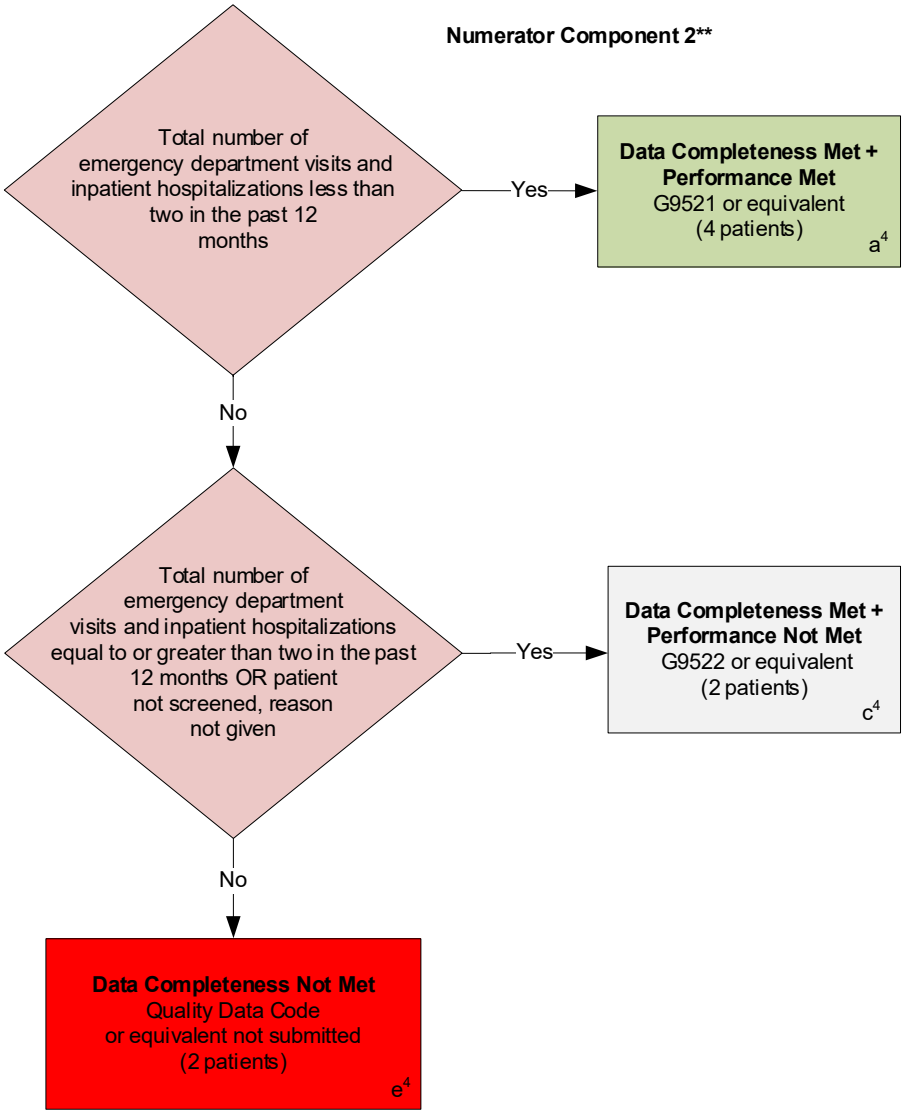
Multiple Performance Rates





Submission Criteria Two





Data Completeness Criteria 1	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8
Numerator Component 1	Met (a^1)	Met (a^1)	Met (a^1)	Met (a^1)	Met (a^1)	Not Met (c^1)	Not Met (c^1)	Not Reported (e^1)
Numerator Component 2	Met (a^2)	Met (a^2)	Met (a^2)	Met (a^2)	Met (a^2)	Met (a^2)	Not Met (c^2)	Not Reported (e^2)
Data Completeness Criteria 2	**Patient 9**	**Patient 10**	**Patient 11**	**Patient 12**	**Patient 13**	**Patient 14**	**Patient 15**	**Patient 16**
Numerator Component 1	Met (a^3)	Not Met (c^3)	Met (a^3)	Met (a^3)	Met (a^3)	Met (a^3)	Not Met (c^3)	Not Reported (e^3)
Numerator Component 2	Met (a^4)	Not Met (c^4)	Met (a^4)	Not Reported (e^4)	Met (a^4)	Met (a^4)	Not Met (c^4)	Not Reported (e^4)

SAMPLE CALCULATION: Data Completeness One***

Data Completeness=
Performance Met (a^1=5 patients) + Performance Not Met (c^1=2 patients) = 7 patients = **87.50%**
Eligible Population / Denominator (d^1=8 patients) = 8 patients

SAMPLE CALCULATION: Data Completeness Two***

Data Completeness=
Performance Met (a^2=6 patients) + Performance Not Met (c^2=1 patients) = 7 patients = **87.50%**
Eligible Population / Denominator (d^1=8 patients) = 8 patients

SAMPLE CALCULATION: Data Completeness Three***

Data Completeness=
Performance Met (a^3=5 patients) + Performance Not Met (c^3=2 patients) = 7 patients = **87.50%**
Eligible Population / Denominator (d^2=8 patients) = 8 patients

SAMPLE CALCULATION: Data Completeness Four***

Data Completeness=
Performance Met (a^4=4 patients) + Performance Not Met (c^4=2 patients) = 6 patients = **75.00%**
Eligible Population / Denominator (d^2=8 patients) = 8 patients

SAMPLE CALCULATION: Performance Rate One: Overall Percentage for patients (aged 5-50 years) with well-controlled asthma, without elevated risk of exacerbation

Submission Criteria 1 and 2:
Performance Rate=
Performance Met (a=9 patients) = 9 patients = **69.23%**
Data Completeness Numerator (13 patients) = 13 patients

SAMPLE CALCULATION: Performance Rate Two: Percentage of pediatric patients (aged 5-17 years) with well-controlled asthma, without elevated risk of exacerbation

Submission Criteria 1, Component 1 and 2:
Performance Rate=
Performance Met (a=5 patients) = 5 patients **= 71.43%**
Data Completeness Numerator (7 patients) = 7 patients

SAMPLE CALCULATION: Performance Rate Three: Percentage of adult patients (aged 18-50 years) with well-controlled asthma, without elevated risk of exacerbation

Submission Criteria 2, Component 1 and 2:
Performance Rate=
Performance Met (a=4 patients) = 4 patients = **66.67%**
Data Completeness Numerator (6 patients) = 6 patients

SAMPLE CALCULATION: Performance Rate Four: Asthma well-controlled (take the most recent tool result) for patients 5 to 17 with Asthma

Submission Criteria 1, Component 1:
Performance Rate=
Performance Met (a^1=5 patients) = 5 patients = **71.43%**
Data Completeness Numerator (7 patients) = 7 patients

SAMPLE CALCULATION: Performance Rate Five: Asthma well-controlled (take the most recent tool result) for patients 18 to 50 with Asthma

Submission Criteria 2, Component 1:
Performance Rate=
Performance Met (a^3=5 patients) = 5 patients = **71.43%**
Data Completeness Numerator (7 patients) = 7 patients

SAMPLE CALCULATION: Performance Rate Six: Patient not at elevated risk of exacerbation for patients 5 to 17 with Asthma

Submission Criteria 1, Component 2:
Performance Rate=
Performance Met (a^2=6 patients) = 6 patients = **85.71%**
Data Completeness Numerator (7 patients) = 7 patients

SAMPLE CALCULATION: Performance Rate Seven: Patient not at elevated risk of exacerbation for patients 18 to 50 with Asthma

Submission Criteria 2, Component 2:
Performance Rate=
Performance Met (a^4=4 patients) = 4 patients = **66.67%**
Data Completeness Numerator (6 patients) = 6 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
**Each component should be submitted in order to determine the data completeness and performance rate for the overall percentage of patients that meet ALL targets represented as the numerator.
***This measure should be calculated with 7 Performance Rates. Review the Sample Calculation to ensure the data completeness and performance rates are calculated accurately. It is anticipated for registry submission that for every Performance Rate, Data Completeness will be submitted. CMS will determine or use the overall Data Completeness and Performance Rate
NOTE: Submission Frequency: Patient-Intermediate

2023 Clinical Quality Measure Flow Narrative for Quality ID #398: Optimal Asthma Control

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

Multiple Performance Rates

Submission Criteria One:

1. Start with Denominator
2. Check *Patients aged 5-17 years*:
    a. If *Patients aged 5-17 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged 5-17 years* equals Yes, proceed to check *Diagnosis for asthma as listed in the Denominator**.
3. Check *Diagnosis for asthma as listed in the Denominator**:
    a. If *Diagnosis for asthma as listed in the Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for asthma as listed in the Denominator** equals Yes, proceed to check *Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period*.
4. Check *Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period*:
    a. If *Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period* equals Yes, proceed to check *Established patient office visit or telehealth visit during the performance period as listed in the Denominator**.
5. Check *Established patient office visit or telehealth visit during the performance period as listed in the Denominator**:
    a. If *Established patient office visit or telehealth visit during the performance period as listed in the Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Established patient office visit or telehealth visit during the performance period as listed in the Denominator** equals Yes, proceed to check *Diagnosis of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure as listed in Denominator**.
6. Check *Diagnosis of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure as listed in Denominator**:
    a. If *Diagnosis of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure as listed in Denominator** equals No, proceed to check *Patient died prior to the end of the*

performance period.

b. If *Diagnosis of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing

7. Check *Patient died prior to the end of the performance period*:

   a. If *Patient died prior to the end of the performance period* equals No, proceed to check *Patient was a permanent nursing home resident any time during the performance period*.

   b. If *Patient died prior to the end of the performance period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

8. Check *Patient was a permanent nursing home resident any time during the performance period*:

   a. If *Patient was a permanent nursing home resident any time during the performance period* equals No, proceed to check *Patient was in hospice or receiving palliative care services at any time during the performance period*.

   b. If *Patient was a permanent nursing home resident any time during the performance period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

9. Check *Patient was in hospice or receiving palliative care services at any time during the performance period*:

   a. If *Patient was in hospice or receiving palliative care services at any time during the performance period* equals No, proceed to check *Patient had only urgent care visits during the performance period*.

   b. If *Patient was in hospice or receiving palliative care services at any time during the performance period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

10. Check *Patient had only urgent care visits during the performance period*:

    a. If *Patient had only urgent care visits during the performance period* equals No, include in *Eligible Population/Denominator*.

    b. If *Patient had only urgent care visits during the performance period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

11. 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^1 equals 8 patients in the Sample Calculation.

12. Start Numerator Component 1** - Each component should be submitted in order to determine the data completeness and performance rate for the overall percentage of patients that meet ALL targets represented as the Numerator.

13. Check *Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score** and results documented*:

    a. If *Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score** and results documented* 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^1 equals 5 patients in the Sample Calculation.

b. If *Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score** and results documented* equals No, proceed to check *Asthma not well controlled based on ACT, C-ACT, ACQ, or ATAQ score, OR specified asthma control tool not used, reason not given*.

14. Check *Asthma not well controlled based on ACT, C-ACT, ACQ, or ATAQ score**, OR specified asthma control tool not used, reason not given*:

    a. If *Asthma not well controlled based on ACT, C-ACT, ACQ, or ATAQ score**, OR specified asthma control tool not used, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 2 patients in the Sample Calculation.

    b. If *Asthma not well controlled based on ACT, C-ACT, ACQ, or ATAQ score**, OR specified asthma control tool not used, reason not given* equals No, proceed to check *Data Completeness Not Met*.

15. Check *Data Completeness Not Met*:

        - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. Letter e^1 equals 1 patient has been subtracted from the Data Completeness Numerator in the Sample Calculation.

16. Start Numerator Component 2** - Each component should be submitted in order to determine the data completeness and performance rate for the overall percentage of patients that meet ALL targets represented as the Numerator

17. Check *Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months*:

    a. If *Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months* 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^2 equals 6 patients in the Sample Calculation.

    b. If *Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months* equals No, proceed to check *Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given*.

18. Check *Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given*:

    a. If *Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

- *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 1 patient in the Sample Calculation.

b. If *Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given* equals No, proceed to check *Data Completeness Not Met*.

19. *Check Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. Letter e^2 equals 1 patient has been subtracted from the Data Completeness Numerator in the Sample Calculation.

Submission Criteria Two:

1. Start with Denominator
2. Check *Patients aged 18-50 years*:

    a. If *Patients aged 18-50 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients aged 18-50 years* equals Yes, proceed to check *Diagnosis for asthma as listed in the Denominator**.

3. Check *Diagnosis for asthma as listed in the Denominator**:

    a. If *Diagnosis for asthma as listed in the Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Diagnosis for asthma as listed in the Denominator** equals Yes, proceed to check *Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period*.

4. Check *Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period*:

    a. If *Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patient had a diagnosis of asthma with any contact during the current or prior performance period OR had asthma present on an active problem list any time during the performance period* equals Yes, proceed to check *Established patient office visit or telehealth visit during the performance period as listed in the Denominator**.

5. Check *Established patient office visit or telehealth visit during the performance period as listed in the Denominator**:

    a. If *Established patient office visit or telehealth visit during the performance period as listed in the Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Established patient office visit or telehealth visit during the performance period as listed in the Denominator** equals Yes, proceed to check *Diagnosis of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure as listed in Denominator**.

6. Check *Diagnosis of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure as listed in Denominator**:

    a. If *Diagnosis of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure as listed in Denominator** equals No, proceed to check *Patient died prior to the end of the performance period*.

    b. If *Diagnosis of chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

7. Check *Patient died prior to the end of the performance period*:

    a. If *Patient died prior to the end of the performance period* equals No, proceed to check *Patient was a permanent nursing home resident any time during the performance period*.

    b. If *Patient died prior to the end of the performance period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

8. Check *Patient was a permanent nursing home resident any time during the performance period*:

    a. If *Patient was a permanent nursing home resident any time during the performance period* equals No, proceed to check *Patient was in hospice or receiving palliative care services at any time during the performance period*.

    b. If *Patient was a permanent nursing home resident any time during the performance period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

9. Check *Patient was in hospice or receiving palliative care services at any time during the performance period*:

    a. If *Patient was in hospice or receiving palliative care services at any time during the performance period* equals No, proceed to check *Patient had only urgent care visits during the performance period*.

    b. If *Patient was in hospice or receiving palliative care services at any time during the performance period* equals Yes, do not include in Eligible Population. Stop Processing.

10. Check *Patient had only urgent care visits during the performance period*:

    a. If *Patient had only urgent care visits during the performance period* equals No, include in *Eligible Population/Denominator*.

    b. If *Patient had only urgent care visits during the performance period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

11. 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^2 equals 8 patients in the Sample Calculation.

12. Start Numerator Component 1** - Each component should be submitted in order to determine the Data Completeness and Performance Rate for the overall percentage of patients that meet ALL targets represented as the Numerator.

13. Check *Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score** and results documented*:

    a. If *Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score** and results documented* 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^3 equals 5 patients in the Sample Calculation.

    b. If *Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score** and results documented* equals No, proceed to check *Asthma not well-controlled based on ACT, C-ACT, ACQ, or ATAQ score**, OR specified asthma control tool not used, reason not given*.

14. Check *Asthma not well-controlled based on ACT, C-ACT, ACQ, or ATAQ score**, OR specified asthma control tool not used, reason not given*:

    a. If *Asthma not well-controlled based on ACT, C-ACT, ACQ, or ATAQ score**, OR specified asthma control tool not used, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 2 patients in the Sample Calculation.

    b. If *Asthma not well-controlled based on ACT, C-ACT, ACQ, or ATAQ score**, OR specified asthma control tool not used, reason not given* equals No, proceed to check *Data Completeness Not Met*.

15. Check *Data Completeness Not Met*:

        - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. Letter e^3 equals 1 patient has been subtracted from the Data Completeness Numerator in the Sample Calculation.

16. Start Numerator Component 2** - Each component should be submitted in order to determine the Data Completeness and Performance Rate for the overall percentage of patients that meet ALL targets represented as the Numerator.

17. Check *Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months*:

    a. If *Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months* 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^4 equals 4 patients in the Sample Calculation.

    b. If *Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months* equals No, proceed to check *Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given*.

18. Check *Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given*:

a. If *Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given* 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^4 equals 2 patients in the Sample Calculation.

b. If *Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months OR patient not screened, reason not given* equals No, proceed to check *Data Completeness Not Met*.

19. Check *Data Completeness Not Met*:

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. Letter e^4 equals 2 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Sample Calculation: Data Completeness One***

Data Completeness equals Performance Met (a^1 equals 5 patients) plus Performance Not Met (c^1 equals 2 patients) divided by Eligible Population / Denominator (d^1 equals 8 patients). All equals 7 patients divided by 8 patients. All equals 87.5 percent.

Sample Calculation: Data Completeness Two***

Data Completeness equals Performance Met (a^2 equals 6 patients) plus Performance Not Met (c^2 equals 1 patients) divided by Eligible Population / Denominator (d^1 equals 8 patients). All equals 7 patients divided by 8 patients. All equals 87.5 percent.

Sample Calculation: Data Completeness Three***

Data Completeness equals Performance Met (a^3 equals 5 patients) plus Performance Not Met (c^3 equals 2 patients) divided by Eligible Population / Denominator (d^2 equals 8 patients). All equals 7 patients divided by 8 patients. All equals 87.5 percent.

Sample Calculations: Data Completeness Four***

Data Completeness equals Performance Met (a^4 equals 4 patients) plus Performance Not Met (c^4 equals 2 patients) divided by Eligible Population / Denominator (d^2 equals 8 patients). All equals 6 patients divided by 8 patients. All equals 75.00 percent.

Sample Calculation: Performance Rate One: Overall Percentage for patients (aged 5-50 years) with well-controlled asthma, without elevated risk of exacerbation

Submission Criteria 1 and 2:
Performance Rate equals Performance Met (a equals 9 patients) divided by Data Completeness Numerator (13 patients). All equals 9 patients divided by 13 patients. All equals 69.23 percent.

Sample Calculation: Performance Rate Two: Percentage of pediatric patients (aged 5-17 years) with well-controlled asthma, without elevated risk of exacerbation.

Submission Criteria 1, Component 1 and 2:

Performance Rate equals Performance Met (a equals 5 patients) divided by Data Completeness Numerator (7 patients). All equals 5 patients divided by 7 patients. All equals 71.43 percent.

Sample Calculation: Performance Rate Three: Percentage of adult patients (aged 18-50 years) with well-controlled asthma, without elevated risk of exacerbation

Submission Criteria 2, Component 1 and 2:
Performance Rate equals Performance Met (a equals 4 patients) divided by Data Completeness Numerator (6 patients). All equals 4 patients divided by 6 patients. All equals 66.67 percent.

Sample Calculation: Performance Rate Four: Asthma well-controlled (take the most recent tool result) for patients 5 to 17 with Asthma

Submission Criteria 1, Component 1:

Performance Rate equals Performance Met (a^1 equals 5 patients) divided by Data Completeness Numerator (7 patients). All equals 5 patients divided by 7 patients. All equals 71.43 percent.

Sample Calculation: Performance Rate Five: Asthma well-controlled (take the most recent tool result) for patients 18 to 50 with Asthma

Submission Criteria 2, Component 1:

Performance Rate equals Performance Met (a^3 equals 5 patients) divided by Data Completeness Numerator (7 patients). All equals 5 patients divided by 7 patients. All equals 71.43 percent.

Sample Calculation: Performance Rate Six: Patient not at elevated risk of exacerbation for patients 5 to 17 with Asthma

Submission Criteria 1, Component 2:

Performance Rate equals Performance Met (a^2 equals 6 patients) divided by Data Completeness Numerator (7 patients). All equals 6 patients divided by 7 patients. All equals 85.71 percent.

Sample Calculation: Performance Rate Seven: Patient not at elevated risk of exacerbation for patients 18 to 50 with Asthma

Submission Criteria 2, Component 2:

Performance Rate equals Performance Met (a^4 equals 4 patients) divided by Data Completeness Numerator (6 patients). All equals 4 patients divided by 6 patients. All equals 66.67 percent.

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

**Each component should be submitted in order to determine the data completeness and performance rate for the overall percentage of patients that meet ALL targets represented as the numerator.

***This measure should be calculated with 7 Performance Rates. Review the Sample Calculation to ensure the data completeness and performance rates are calculated accurately. It is anticipated for registry submission that for every Performance Rate, Data Completeness will be submitted. CMS will determine or use the overall Data Completeness and Performance Rate

NOTE: Submission Frequency: Patient-Intermediate

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.

Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting – National Quality Strategy Domain: Effective Clinical Care

2016 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 5 years and older with a diagnosis of persistent asthma who were prescribed long-term control medication

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for all patients with a diagnosis of persistent asthma seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure will be calculated with 3 performance rates:
1) Patients prescribed inhaled corticosteroids (ICS) as their long-term control medication
2) Patients prescribed alternative long-term control medications (non-ICS)
3) Total patients prescribed long-term control medication

Measure Reporting via Registry:
ICD-10-CM diagnosis codes, CPT codes, QDC code and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 5 years and older with a diagnosis of persistent asthma

Denominator Instructions: Documentation of persistent asthma must be present. One method of identifying persistent asthma is, at a minimum, daily use of short-acting bronchodilators

Denominator Criteria (Eligible Cases):
Patients aged ≥ 5 years on date of encounter
AND
Diagnosis for asthma (ICD-10-CM): J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Persistent Asthma (mild, moderate or severe) **(1038F)**

NUMERATOR:
Patients who were prescribed long-term control medication

Definition:
Long-Term Control Medication Includes:

Patients prescribed inhaled corticosteroids (the preferred long-term control medication at any step of asthma pharmacological therapy)
OR

Patients prescribed alternative long-term control medications (inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, methylxanthines) OR an acceptable alternative long-term control medication at one or more visits in the 12-month period OR patient already taking inhaled corticosteroid OR an acceptable alternative long-term control medication as documented in current medication list

Numerator Options:

Performance Met: Inhaled corticosteroids prescribed **(4140F)**

OR

Performance Met: Alternative long-term control medication prescribed **(4144F)**

OR

Patient Performance Exclusion: Documentation of patient reason(s) for not prescribing inhaled corticosteroids or alternative long-term control medication (eg, patient declined, other patient reason) **(4140F *with* 2P)**

OR

Performance Not Met: Inhaled corticosteroids or alternative long-term control medication **not** prescribed, reason not otherwise specified **(4140F *with* 8P)**

RATIONALE:

The following statement is quoted verbatim from the NHLBI/NAEPP guideline (NHLBI, 2007):

"The broad action of ICS on the inflammatory process may account for their efficacy as preventive therapy. Their clinical effects include reduction in severity of symptoms; improvement in asthma control and quality of life; improvement in PEF and spirometry; diminished airway hyper-responsiveness; prevention of exacerbations; reduction in systemic corticosteroid courses; emergency department (ED) care; hospitalizations, and deaths due to asthma; and possibly the attenuation of loss of lung function in adults". (Rafferty P 1985; Haahtela T 1991; Jeffery PK 1992; Van Essesn-Zandvliet EE 1992; Barnes NC 1993; Fabbri L 1993; Gustafsson P 1993; Kamada AK 1996; Suissa S 2000; Pauwels RA 2003; Barnes PJ October 1992)

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The Expert Panel recommends that long-term control medications be taken daily on a long-term basis to achieve and maintain control of persistent asthma. The most effective long-term control medications are those that attenuate the underlying inflammation characteristic of asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most potent and clinically effective long-term control medication for asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most effective long-term therapy available for patients who have persistent asthma, and, in general, ICS is well tolerated and safe at the recommended dosages. (Evidence A) (NHLBI, 2007)

The American Academy of Allergy Asthma and Immunology (AAAAI) and PCPI owned and developed measure, Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting, specifications are copied verbatim from the 2016 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.

Measure Type: Process

Component 3: Proportion of Days Covered: Statins (PDC-STA)

Description

The percentage of individuals ≥18 years of age who met the Proportion of Days Covered (PDC) threshold of 80% for statins during the measurement year.

A higher rate indicates better performance.

PQA Endorsed 2008 (NQF-Endorsed #0541).

Intended Use

Intended Use	Performance measurement for health plans.
Related Measures	• *Statin Use in Persons with Diabetes* (SUPD) (PQA) • *Proportion of Days Covered Composite [Pharmacy]* (PDC-CMP-PH) (PQA) • *Primary Medication Nonadherence [Pharmacy]* (PMN-PH) (PQA) • *Proportion of Days Covered: Statins [Pharmacy]* (PDC-STA-PH) (PQA)

Definitions

Statin Medications	Statin or statin combination products. See Medication Table STATINS: Statins.
Proportion of Days Covered (PDC)	The proportion of days in the treatment period "covered" by prescription claims for the same medication or another in its therapeutic category.
PDC Threshold	The level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (80% for diabetes and cardiovascular drugs, and many chronic conditions).
Index Prescription Start Date (IPSD)	The earliest date of service for a target medication during the measurement year.
Treatment Period	The individual's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Hospice Exclusion	Any individuals in hospice care at any time during the measurement year. • Hospice indicator from the enrollment database, if available (e.g. Medicare); or • ≥1 claim, encounter, or medical record during the measurement year. See Hospice Encounter Value Set and Hospice Intervention Value Set (e.g., Medicaid, commercial).
End-Stage Renal Disease Diagnosis Exclusion	Any individuals with ESRD at any time during the measurement year • ≥1 claim with ESRD in the primary diagnosis or any other diagnosis fields during the measurement year. See Value Set, ESRD.

Eligible Population

Ages

≥18 years of age as of the first day of the measurement year.

Continuous Enrollment

The treatment period.

Exclude individuals with more than one 1-day gap in enrollment during the treatment period.

Note:

- This allows for a 1-day gap to compensate for discrepancies in the enrollment data. For example, if an individual was eligible from 1/1-4/1 and 4/3-12/31, he/she would still be continuously enrolled despite the one-day gap in eligibility on 4/2.

Benefit

Medical and pharmacy.

Event/Diagnosis

Individuals with at least two prescription claims for any statin (Medication Table STATINS) on different dates of service in the treatment period.

Use the steps below to determine the eligible population.

Step 1 Identify individuals ≥18 years of age as of the first day of the measurement year.

Step 2 Identify individuals with ≥2 prescription claims on different dates of service for any statin (Medication Table STATINS) during the measurement year. The prescription claims can be for the same or different medications.

Step 3 Determine each individual's treatment period. The treatment period is the time period (in days) from the IPSD to the end of the measurement year, death or last day of enrollment, whichever occurs first.

Step 4 Identify individuals with a treatment period that is ≥91 days during the measurement year.

Step 5 Identify individuals meeting the continuous enrollment requirement during the treatment period.

Step 6 Exclude individuals with one or more of the following:

- Hospice: Hospice care at any time during the measurement year.
- ESRD: An ESRD diagnosis at any time during the measurement year.

Administrative Specification

Data Sources

Medical claims, prescription claims.

Denominator

The eligible population.

Numerator

The number of individuals who met the PDC threshold during the measurement year.

Follow the steps below for each individual to determine whether the individual meets the PDC threshold.

Measure Calculation

Step 1 Determine the individual's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.

Step 2 Within the treatment period, count the days the individual was covered by at least one drug in the class based on the date of service and days' supply on prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim.

Note:

- Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.

Step 3 Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each individual. Then, round the PDC to the nearest hundredth (e.g. 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of individuals who had a PDC of 80% or greater and then divide by the total number of eligible individuals.

An example of SAS code for steps 1-3 is available from PQA upon request, and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf

Rate Divide the numerator by the denominator and multiply by 100.

Stratification Commercial, Medicaid, Medicare (report each product line separately). For Medicare, see notes below.

Medication Tables

Table STATINS: Statins[a]

Statin Medications and Combinations		
• atorvastatin (+/- amlodipine) • Fluvastatin • lovastatin (+/- niacin)	• pitavastatin • pravastatin	• rosuvastatin (+/- ezetimibe) • simvastatin (+/- ezetimibe, niacin)

[a] Active ingredients are limited to oral formulations only.

Statin Therapy for Patients With Cardiovascular Disease (SPC)

SUMMARY OF CHANGES TO HEDIS MY 2025

- Added a required exclusion for muscular reactions to statins.

Description

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Definitions

IPSD — Index prescription start date. The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year.

Treatment period — The period of time beginning on the IPSD through the last day of the measurement year.

PDC — Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.

Calculating number of days covered for multiple prescriptions

If multiple prescriptions for different medications are dispensed on the same day, calculate the number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day in the treatment period only once toward the numerator.

If multiple prescriptions for the same medication are dispensed on the same day or on different days, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply. Sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. For example, a dispensing event from the Amlodipine Atorvastatin High Intensity Medications List and a dispensing event from the Amlodipine Atorvastatin Moderate Intensity Medications List are dispensing events for different medications.

Eligible Population: *Rate 1*—Received Statin Therapy

Product line

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

Age

Report two age/gender stratifications and a total rate:

- Males 21–75 years as of December 31 of the measurement year.
- Females 40–75 years as of December 31 of the measurement year.
- Total.

Continuous enrollment

The measurement year and the year prior to the measurement year.

Allowable gap

No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

December 31 of the measurement year.

Benefit

Medical. Pharmacy during the measurement year.

Event/diagnosis

Members are identified for the eligible population in two ways: by event or by diagnosis. The organization must use *both* methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure.

Event. Any of the following during the year prior to the measurement year meet criteria:

- *MI.* Discharged from an inpatient setting with an MI (MI Value Set; Old Myocardial Infarction Value Set) on the discharge claim. To identify discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- *CABG.* Members who had CABG (CABG Value Set) in any setting.
- *PCI.* Members who had PCI (PCI Value Set) in any setting.
- *Other revascularization*. Members who had any other revascularization procedures (Other Revascularization Value Set) in any setting.

Diagnosis. Identify members who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year. The following encounters meet criteria:

- An outpatient visit, telephone visit, e-visit, virtual check-in or acute inpatient encounter (Outpatient, Telehealth and Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).
- At least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) 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.

Required exclusions

Exclude members who meet any of the following criteria:

- Members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- In vitro fertilization (IVF Value Set) in the measurement year or the year prior to the measurement year.
- Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year.
- ESRD (ESRD Diagnosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- Dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year.
- Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Myalgia or rhabdomyolysis caused by a statin (Muscular Reactions to Statins Value Set) any time during the member's history through December 31 of the measurement year.
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year 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 year.

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medications List).

Estrogen Agonists Medications

Description	Prescription
Estrogen agonists	• Clomiphene

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		
Dementia combinations	• Donepezil-memantine		

Administrative Specification: *Rate 1*—Received Statin Therapy

Denominator The Rate 1 eligible population.

Numerator The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication (High and Moderate Intensity Statin Medications List) during the measurement year.

High- and Moderate-Intensity Statin Medications

Description	Prescription	Medication Lists
High-intensity statin therapy	• Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List
High-intensity statin therapy	• Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity statin therapy	• Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List

Description	Prescription	Medication Lists
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pitavastatin 1-4 mg	Pitavastatin Moderate Intensity Medications List

Eligible Population: *Rate 2*—Statin Adherence 80%

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

Age Report two age/gender stratifications and a total rate:

- Males 21–75 years as of December 31 of the measurement year.
- Females 40–75 years as of December 31 of the measurement year.
- Total.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. 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 Medical. Pharmacy during the measurement year.

Event/diagnosis All members who meet the numerator criteria for Rate 1.

Administrative Specification: *Rate 2*—Statin Adherence 80%

Denominator The Rate 2 eligible population.

Numerator The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any high-intensity or moderate-intensity statin medication during the measurement year. Use all the medication lists above to identify statin medication dispensing events.

Step 2 To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3 Count the days covered by at least one prescription for any high-intensity or moderate-intensity statin medication during the treatment period. To ensure that days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a member has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Step 5 Sum the number of members whose PDC is ≥80% for the treatment period.

Note

- *All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 eligible population.*

Data Elements for Reporting

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

Table SPC-1/2/3: Data Elements for Statin Therapy for Patients With Cardiovascular Disease

Metric	Gender	Data Element	Reporting Instructions
ReceivedTherapy	F	Benefit	Metadata
Adherence	M	EligiblePopulation	For each Metric and Stratification
	Total	ExclusionAdminRequired	Only for ReceivedTherapy Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

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

Rules for Allowable Adjustments of Statin Therapy for Patients With Cardiovascular Disease

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Using product line criteria is not required. Including any product line, combining product lines, or not including product line criteria is allowed.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (ages 21–75 or 40–75 years). The denominator age may not be expanded.
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 enrollment criteria; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Only events that contain (or map to) codes in the value sets may be used to identify discharges. Value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets and medication lists. The hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Rate 1: Received Statin Therapy • Rate 2: Statin Adherence 80%	No	Medication lists, value sets and logic may not be changed.

Timely Follow-Up After Acute Exacerbations of Chronic Conditions

CBE ID: 3455

1.4 Project: Management of Acute Events, Chronic Disease, Surgery, and Behavioral Health

Endorsement Status: Endorsed **1.1 New or Maintenance:** Maintenance

Previous Endorsement Cycle: Spring 2024 **Is Under Review:** No

Next Maintenance Cycle: Spring 2029

1.3 Measure Description:
This is a measure of follow-up clinical visits for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions (eight categories) of interest (coronary artery disease [CAD] {high or low acuity}, hypertension {high or medium acuity}, heart failure [HF], diabetes, asthma, and chronic obstructive pulmonary disease [COPD]) and are among adult Medicare Fee-for-Service (FFS) beneficiaries who are attributed to entities participating in the CMMI Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model. Results of the measure are aggregated on an Accountable Care Organization (ACO) level for Standard and New Entrant ACOs. The Yale-New Haven Health Center for Outcomes Research & Evaluation (CORE) has respecified the Timely Follow-Up After Acute Exacerbations of Chronic Conditions Measure, which was originally specified by IMPAQ, CBE #3455.

Measure Specs | Importance | Feasibility | Scientific Acceptability | Equity | Use

General Information
Numerator
Denominator
Exclusions
Measure Calculation

1.5 Measure Type:
Process

1.6 Composite Measure:
No

1.7 Electronic Clinical Quality Measure (eCQM):
No

1.8 Level Of Analysis:
- Accountable Care Organization

Supplemental Attachment

Point of Contact

1.9 Care Setting:

- Clinician Office/Clinic
- Emergency Department
- Home Health
- Hospital: Critical Access
- Hospital: Inpatient
- Hospital: Outpatient
- Other Care Setting (Please specify)

1.9b Specify Other Care Setting:

Hospital: Rural Emergency

1.10 Measure Rationale:

The Timely Follow Up After Acute Exacerbations of Chronic Conditions Measure (hereafter, “TFU measure”) captures follow-up clinical visits for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions (with eight categories) of interest (coronary artery disease [CAD] {high or low acuity}, hypertension {high or medium acuity}, heart failure [HF], diabetes, asthma, and chronic obstructive pulmonary disease [COPD]) and are among adult Medicare Fee-for-Service (FFS) beneficiaries who are attributed to entities participating in the CMMI Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model. The goal of this measure is to encourage Model Participants to deliver clinically appropriate follow-up care for the specified conditions, improve care coordination, and produce long-term savings for a given healthcare system. Because the measure is stratified by social risk factor variables, this measure also helps to promote health equity in underserved communities.

The Yale-New Haven Health Center for Outcomes Research & Evaluation (CORE) has respecified the Timely Follow-Up After Acute Exacerbations of Chronic Conditions Measure (TFU), which was originally specified by IMPAQ, CBE #3455.

Rationale:

Patients hospitalized or seen acutely in the Emergency Department (ED) for exacerbations of chronic conditions are at high risk of

readmission and poorly coordinated care, which may increase healthcare spending, worsen healthcare outcomes, and result in poor quality of life.

The intent of the Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU) measure is to encourage appropriate follow-up care and improve care coordination at discharge. Better coordination of care and time spent with providers can lead to improved quality of care and quality of life, and reduced healthcare costs.

The TFU measure is a pay-for-performance quality measure for the Realizing Equity, Access, and Community Health (ACO REACH) model, which aims to reduce administrative burden by simplifying billing code practices—freeing time and resources to focus on advanced primary care and care coordination for patients with complex, chronic conditions. The measure is claims-based and low-burden to align with this intent of the ACO REACH model.

Evidence has shown that delivering clinically appropriate follow-up care and improving care coordination can improve healthcare outcomes, reduce readmissions, and reduce healthcare costs. Outpatient follow-up rates vary significantly, and there are disparities for patients with social risk, indicating potential for improving care for the target population. Early outpatient follow-up can prevent ED visits and readmissions, and their associated costs, clinical sequelae, and impact on patient experience. (See question **2.2 Evidence** for further detail on evidence and supporting literature.)

1.11 Measure Webpage:

http://example.com

1.20 Testing Data Sources:

- Administrative Data
- Claims Data
- Other Data Source

1.20a Specify Other Data Source:

2019 Area Deprivation Index

1.25 Data Sources:

To calculate the measure score, CMS uses final-action claims for Medicare FFS Part A and B, administrative (enrollment data) from the Medicare Beneficiary Summary File. Measure scores are calculated for REACH ACOs and their aligned beneficiaries, as well as non-REACH ACO provider groups (TINs and CCNs that bill Medicare FFS Parts A and B) and beneficiaries aligned using the same ACO REACH Model alignment criteria. Non-REACH ACO provider groups must have at least 1000 aligned and eligible beneficiaries to be included in the benchmarking population.

This is a claims-based measure, and the measure score is calculated automatically from 100% final-action claims; claims data are routinely generated during the delivery of care. We did not encounter any difficulties with respect to data feasibility, reliability, or validity.

As described in Section 1.19, we also use the 2019 Area Deprivation Index data and the RTI_RACE_CD variable from the Integrated Data Repository for race/ethnicity stratification.

Timely Follow-Up After Acute Exacerbations of Chronic Conditions

CBE ID: 3455

1.4 Project: Management of Acute Events, Chronic Disease, Surgery, and Behavioral Health

Endorsement Status: Endorsed **1.1 New or Maintenance:** Maintenance

Previous Endorsement Cycle: Spring 2024 **Is Under Review:** No

Next Maintenance Cycle: Spring 2029

1.3 Measure Description:
This is a measure of follow-up clinical visits for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions (eight categories) of interest (coronary artery disease [CAD] {high or low acuity}, hypertension {high or medium acuity}, heart failure [HF], diabetes, asthma, and chronic obstructive pulmonary disease [COPD]) and are among adult Medicare Fee-for-Service (FFS) beneficiaries who are attributed to entities participating in the CMMI Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model. Results of the measure are aggregated on an Accountable Care Organization (ACO) level for Standard and New Entrant ACOs. The Yale-New Haven Health Center for Outcomes Research & Evaluation (CORE) has respecified the Timely Follow-Up After Acute Exacerbations of Chronic Conditions Measure, which was originally specified by IMPAQ, CBE #3455.

Measure Specs | Importance | Feasibility | Scientific Acceptability | Equity | Use

General Information
Numerator
Denominator
Exclusions
Measure Calculation

1.14 Numerator:
The numerator is the sum of acute exacerbations for which follow-up care was received within the timeframe recommended by clinical practice guidelines, as detailed below:

- Hypertension: Follow up within 14 days of the date of discharge for high-acuity patients or within 30 days for medium-acuity patients
- Asthma: Follow up within 14 days of the date of discharge

Supplemental Attachment

Point of Contact

- Heart Failure: Follow up within 14 days of the date of discharge
- Coronary Artery Disease: Follow up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients
- Chronic Obstructive Pulmonary Disease: Follow up within 30 days of the date of discharge
- Diabetes: Follow up within 14 days of the date of discharge for high-acuity patients

1.14a Numerator Details:

The final measure score (the ACO-level Timely Follow-Up rate) is **the total number of qualifying follow-up visits after an acute exacerbation** (the numerator) over the total sum of all qualifying acute exacerbations of any of the six conditions (hypertension, asthma, HF, COPD, CAD, and diabetes) (the denominator), aggregated on an ACO level. The score is expressed as a percentage.

Qualifying follow up visits that contribute to **the numerator** are those for which follow-up care was received within the timeframe recommended by clinical practice guidelines, as detailed below:

- Hypertension: Follow up within 14 days of the date of discharge for high-acuity patients or within 30 days for medium-acuity patients
- Asthma: Follow up within 14 days of the date of discharge
- Heart Failure: Follow up within 14 days of the date of discharge
- Coronary Artery Disease: Follow up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients
- Chronic Obstructive Pulmonary Disease: Follow up within 30 days of the date of discharge

- Diabetes: Follow up within 14 days of the date of discharge for high-acuity patients

Numerator events (timely follow up) are identified by matching claims (at the patient level) that indicate an acute exacerbation (ED visit, observation stay, inpatient admission) for the conditions listed above, to the follow up visit. To qualify as a numerator event, the follow-up visit must occur within the condition-specific timeframe noted above. Follow up visits are identified in claims as non-emergency outpatient visits after the discharge date of the initial exacerbation, using CPT or HCPCS code indicating appropriate follow up as defined by clinical guidelines and clinical coding experts. The follow-up visit may be a general office visit or telehealth visit and can also take place in certain chronic care or transitional care management settings. For a list of individual codes for timely follow-up, please refer to the 'Final Condition Codes' tab in the Value Set (i.e. Data Dictionary) and their rules as described in the denominator details section of this document.

For two conditions, CAD and hypertension, the cohort is subdivided based on the acuity of the exacerbation; and the code set for each portion of the cohort has its own follow-up window. The follow-up visit timeframes are based on the most recent, evidence-based clinical guidelines.

Timely Follow-Up After Acute Exacerbations of Chronic Conditions

CBE ID: 3455

1.4 Project: Management of Acute Events, Chronic Disease, Surgery, and Behavioral Health

Endorsement Status: Endorsed **1.1 New or Maintenance:** Maintenance

Previous Endorsement Cycle: Spring 2024 **Is Under Review:** No

Next Maintenance Cycle: Spring 2029

1.3 Measure Description:
This is a measure of follow-up clinical visits for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions (eight categories) of interest (coronary artery disease [CAD] {high or low acuity}, hypertension {high or medium acuity}, heart failure [HF], diabetes, asthma, and chronic obstructive pulmonary disease [COPD]) and are among adult Medicare Fee-for-Service (FFS) beneficiaries who are attributed to entities participating in the CMMI Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model. Results of the measure are aggregated on an Accountable Care Organization (ACO) level for Standard and New Entrant ACOs. The Yale-New Haven Health Center for Outcomes Research & Evaluation (CORE) has respecified the Timely Follow-Up After Acute Exacerbations of Chronic Conditions Measure, which was originally specified by IMPAQ, CBE #3455.

Measure Specs | Importance | Feasibility | Scientific Acceptability | Equity | Use

- General Information
- Numerator
- Denominator
- Exclusions
- Measure Calculation

1.15 Denominator:
The denominator is the sum of all acute exacerbations among the target population during the performance period. An acute exacerbation is defined as an ED visit, observation stay, or inpatient stay, for any one of six conditions (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes) for an ACO-attributed patient.

1.15a Denominator Details:
The denominator is the count of all acute exacerbation events for six clinical conditions attributed to an ACO during the performance

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period. Of note, if a patient has multiple qualifying acute exacerbation events during the performance period, these would all be included in the measure outcome calculation. Exacerbations are defined as an acute-care visit (i.e., ED visit, observation stay, or inpatient hospitalization) for any of the six conditions of interest (with eight category cohorts): coronary artery disease (CAD) [high or low acuity], hypertension [high or medium acuity], heart failure (HF), diabetes, asthma, and chronic obstructive pulmonary disease (COPD). The cohorts for hypertension, CAD, and diabetes were divided based on acuity of condition because clinical guidelines reflected heterogeneity in follow-up timeline recommendations for exacerbations of different acuities; therefore, because CAD and HTN were subdivided into high and lower acuity categories, the measure structure reflects eight condition cohorts for the six conditions of interest.

Please refer to the codes in the 'Inpat, Obs, ED, Discharge' tab of the Value Set for codes that are used to identify the denominator (exacerbations or acute-care visits). Inpatient admissions are identified using codes listed in the "Inpatient" tab in the value set. ED visits and observation stays are identified using codes listed in the 'Emergency Department' and 'Observation Stay' tabs of the Value Set professional claims (i.e. carrier claims). Billing/Claim type codes used to identify outpatient claims are listed on the 'TOB-Outpatient' tab of the Value Set.

Assigning Condition Categories

The value set contains both sufficient codes, which are unambiguously linked to the associated condition, and related codes, which are codes that often occur in conjunction with the condition. This system of code assignment was created by the team that initially developed the measure and was retained by our team during respecification efforts. Additionally, our team of clinical experts reviewed each code that had been included in the value set and, through a consensus process, determined whether the preexisting code assignments were appropriate.

Distinctions are also made between principal and secondary diagnoses when assigning a visit to a specific clinical condition

cohort. The first diagnosis code in the header for each claim is used as the principal diagnosis code. All other diagnosis codes in the header are referred to as secondary diagnosis codes. Using the sufficient and related ICD codes listed on the 'Final Condition Codes' tab in the Value Set, claims are assigned to one of the eight condition cohorts listed above.

For all six conditions, an acute encounter is assigned to [condition] if the principal diagnosis is a sufficient code for [condition].

OR

If the principal diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].

For conditions with different levels of acuity (e.g., high-acuity hypertension and medium-acuity CAD), the encounter is then assigned to the highest-acuity condition for which a code is present. The value set includes codes for low-acuity hypertension and diabetes conditions to appropriately classify events; however, low-acuity hypertension and diabetes cohorts are not included in this measure given that these conditions do not generally require outpatient follow-up as urgently as the other chronic conditions of interest.

In cases where the encounter has a related code applicable to two or more conditions that qualify as primary diagnoses and a sufficient code in an additional diagnosis position, the encounter is assigned to the condition with a higher follow-up priority in the following order: high-acuity coronary artery disease (CAD), high-acuity diabetes, heart failure (HF), asthma, high-acuity hypertension, medium-acuity hypertension, chronic obstructive pulmonary disease (COPD), and low-acuity CAD.

The following explains how the rules about sufficient and related codes and principal and secondary diagnoses can be applied.

Asthma, COPD, and HF do not have acuity levels. For these conditions, the following must be satisfied: (1) a sufficient code as a primary diagnosis **or** (2) a related code as a primary diagnosis and a sufficient code as a secondary diagnosis.

CAD, diabetes, and hypertension all have low- to high-acuity levels. However, each of these conditions has a different satisfaction criterion outlined below.

For the CAD condition, the following must be satisfied: (1) a high or low acuity sufficient code as a primary diagnosis **or** (2) a high or low acuity related code as a primary diagnosis **and** a high or low acuity sufficient code as a secondary diagnosis.

- High acuity can only be satisfied with (1) a high acuity sufficient code as a primary diagnosis **or** (2) a high or low acuity related code as a primary diagnosis **and** a high acuity sufficient code as a secondary diagnosis **or** (3) a high acuity related code as a primary diagnosis **and** a high or low acuity sufficient code as a secondary diagnosis.
- If criteria for a high-acuity CAD condition is not satisfied, then low acuity is met.

For the diabetes condition, the following must be satisfied: (1) a high, medium, or low sufficient code as a primary diagnosis **or** (2) a high or medium acuity related code as a primary diagnosis **and a** high, medium, or low acuity sufficient code as a secondary diagnosis.

- High acuity can only be satisfied with (1) a high acuity sufficient code as a primary diagnosis **or** (2) a high or medium acuity related code as a primary diagnosis **and** a high acuity sufficient code as a secondary diagnosis **or** (3) a high acuity related code as a primary diagnosis **and** a high, medium, or low acuity sufficient code as a secondary diagnosis.
- Note that only high acuity diabetes conditions are eligible for this measure.

For the hypertension condition, the following must be satisfied: (1) a high acuity or low acuity sufficient code as a primary diagnosis **or** (2) a high, medium, or low acuity related code as a primary

diagnosis **and a** high or low acuity sufficient code as a secondary diagnosis.

- High acuity can only be satisfied with (1) a high acuity sufficient code as a primary diagnosis **or** (2) a high, medium, or low acuity related code as a primary diagnosis **and** a high acuity sufficient code as a secondary diagnosis **or** (3) a high acuity related code as a primary diagnosis **and** a high or low acuity sufficient code as a secondary diagnosis.
- If the criteria for the high-acuity condition is not satisfied, then the medium-acuity condition is satisfied with the following: a medium acuity related code as a primary diagnosis **and** a high or low acuity sufficient code as a secondary diagnosis.
- Note that only high and medium acuity hypertension conditions are eligible for this measure.

Each unique claim—based upon the from and through dates as well as the claim type (i.e., inpatient, outpatient, carrier)—is assigned to a condition/severity group. If a claim meets the criteria for more than one condition/severity group, the condition/severity group with the shortest follow-up period is assigned, as this represents the more urgent clinical situation. If a beneficiary has a unique claim that begins on the same or the following day of another unique claim, the claims are considered part of one continuous acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. And, if the unique claims that make up an acute event are assigned to different condition/severity groups, the acute event is assigned to the condition/severity group that occurs last chronologically. Following this methodology, only one condition is recorded in the denominator per acute encounter.

Timely Follow-Up After Acute Exacerbations of Chronic Conditions

CBE ID: 3455

1.4 Project: Management of Acute Events, Chronic Disease, Surgery, and Behavioral Health

Endorsement Status: Endorsed **1.1 New or Maintenance:** Maintenance

Previous Endorsement Cycle: Spring 2024 **Is Under Review:** No

Next Maintenance Cycle: Spring 2029

1.3 Measure Description:
This is a measure of follow-up clinical visits for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions (eight categories) of interest (coronary artery disease [CAD] {high or low acuity}, hypertension {high or medium acuity}, heart failure [HF], diabetes, asthma, and chronic obstructive pulmonary disease [COPD]) and are among adult Medicare Fee-for-Service (FFS) beneficiaries who are attributed to entities participating in the CMMI Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model. Results of the measure are aggregated on an Accountable Care Organization (ACO) level for Standard and New Entrant ACOs. The Yale-New Haven Health Center for Outcomes Research & Evaluation (CORE) has respecified the Timely Follow-Up After Acute Exacerbations of Chronic Conditions Measure, which was originally specified by IMPAQ, CBE #3455.

Measure Specs | Importance | Feasibility | Scientific Acceptability | Equity | Use

General Information
Numerator
Denominator
Exclusions
Measure Calculation

1.15b 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 two months for all the condition groups, except

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the low-acuity CAD group, which requires continuous enrollment of three months.

3. Acute events where the discharge status of the last claim is not "to community" (e.g., "left against medical advice" is not a discharge to community). For a list of the appropriate codes, please refer to the "Discharge to Community" codes on the 'Inpat, Obs, ED, Discharge' tab in the Value Set.
4. Acute events for which the calendar year ends before the follow-up window ends (e.g., Acute asthma events occurring fewer than 14 days before December 31 will not be included.).
5. Acute events where the patient enters a skilled nursing facility (SNF), non-acute care, or hospice care within the follow-up interval. For a list of the appropriate codes to identify non-acute care, please refer to the "NonAcute" tab in the Value Set.

1.15c Denominator Exclusions Details:

Please see above question **1.15b Denominator Exclusions** for detail on how to calculate denominator exclusions.

Timely Follow-Up After Acute Exacerbations of Chronic Conditions

CBE ID: 3455

1.4 Project: Management of Acute Events, Chronic Disease, Surgery, and Behavioral Health

Endorsement Status: Endorsed **1.1 New or Maintenance:** Maintenance

Previous Endorsement Cycle: Spring 2024 **Is Under Review:** No

Next Maintenance Cycle: Spring 2029

1.3 Measure Description:
This is a measure of follow-up clinical visits for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions (eight categories) of interest (coronary artery disease [CAD] {high or low acuity}, hypertension {high or medium acuity}, heart failure [HF], diabetes, asthma, and chronic obstructive pulmonary disease [COPD]) and are among adult Medicare Fee-for-Service (FFS) beneficiaries who are attributed to entities participating in the CMMI Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model. Results of the measure are aggregated on an Accountable Care Organization (ACO) level for Standard and New Entrant ACOs. The Yale-New Haven Health Center for Outcomes Research & Evaluation (CORE) has respecified the Timely Follow-Up After Acute Exacerbations of Chronic Conditions Measure, which was originally specified by IMPAQ, CBE #3455.

Measure Specs | Importance | Feasibility | Scientific Acceptability | Equity | Use

General Information
Numerator
Denominator
Exclusions
Measure Calculation

1.13 Attach Data Dictionary:
Attachment A_Value Set_Timely Follow-Up Measure CBE #3455_Update 05012024_final.xlsx

1.13a Data dictionary not attached:
No

1.16 Type of Score:
Rate/proportion

1.17 Measure Score Interpretation:

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Better quality = Higher score

1.18 Calculation of Measure Score:

1. Denominator events (acute exacerbations) for the six conditions of interest are identified in claims using codes that indicate an inpatient admission, observation stay, or ED visit, using the appropriate codes listed in the Value Set.
2. Exclusions are applied to the population to produce the eligible patient population for the measure (i.e., the count of all qualifying events).
3. For each qualifying event, numerator events (timely follow up) are identified by matching patient-level claims that satisfy the follow-up requirement for that particular qualifying event (e.g., a diabetes acute event receiving follow-up within the appropriate timeframe for diabetes from a 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 multiplied by 100.

1.19 Measure Stratification Details:

To promote improvements in disparities in care for patients with social risk factors, REACH ACO measure scores are stratified by three social risk factors: (1) dual eligibility (DE); (2) low socioeconomic status (SES) as defined by the Area Deprivation Index (ADI); and (3) race/ethnicity other than white (i.e., non-white). As of the 2022 model performance year (Calendar Year 2022), CMS provides the stratified results to ACOs quarterly, in Quarterly Quality Reports (QQRs), and annually, in Annual Quality Reports (AQRs). The stratified results are provided to ACOs confidentially.

The three social risk factors used in stratified reporting are defined as:

1. Dual eligibility: Full-benefit dually eligible status for at least 1 month during the performance period.

2. Living in a low-SES neighborhood: Defined as a neighborhood with an ADI percentile value of 81 or higher. We continue to use the 2019 version of ADI data due to differences between 2010 and 2020 Census boundaries and the limited prevalence of the 2020 boundaries among addresses within claims data. For beneficiaries with addresses that have no ADI match, we impute a county-level average ADI. More information about the ADI is available here.
3. Non-white: Race/ethnicity other than white based on RTI_RACE_CD variable from the IDR.

The stratified results are calculated through the following steps:

1. The finder file, which is the first file created and used for building analytic files for each quality measure, creates the health equity indicator variables that are used for stratified reporting.
2. Once the finder file is created, the health equity indicator variables are used to calculate the Timely Follow-Up measure for the ACOs included in the ACO REACH model as well as the benchmark population, which are non-ACO REACH provider groups.
3. Summary statistics for each of the stratified populations are provided to ACOs in the QQRs. Values are not reported if the denominator volume (acute events) is less than 20.

1.26 Minimum Sample Size:

Not applicable. This measure is not based on a sample.

*Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)**

***Adapted with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA) and with permission from the measure developer, the American Medical Association (AMA).**

SUMMARY OF CHANGES TO HEDIS MY 2025

- Removed "Programming Guidance" from the *Characteristics* section.
- Removed the *Data criteria (element level)* section.
- Added a laboratory claim exclusion to a direct reference code.

Description	The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care. • *Unhealthy Alcohol Use Screening*. The percentage of members who had a systematic screening for unhealthy alcohol use. • *Follow-Up Care on Positive Screen*. The percentage of members receiving brief counseling or other follow-up care within 60 days (2 months) of screening positive for unhealthy alcohol use.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide brief behavioral counseling interventions to those who misuse alcohol. (B recommendation)
Citations	U.S. Preventive Services Task Force. 2018. "Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions." *JAMA* 320(18):1899–1909. DOI:10.1001/jama.2018.16789.
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Unhealthy Alcohol Use Screening. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (as of the start of the measurement period, for each product line): ▪ 18–44 years. ▪ 45–64 years. ▪ 65 years and older.

<table>
<tr><td></td><td>

- Follow-Up on Care Positive Screen.
  - Product line:
    - Commercial.
    - Medicaid.
    - Medicare.
  - Age (as of the start of the measurement period, for each product line):
    - 18–44 years.
    - 45–64 years.
    - 65 years and older.

</td></tr>
<tr><td>Risk adjustment</td><td>None.</td></tr>
<tr><td>Improvement notation</td><td>A higher rate indicates better performance.</td></tr>
<tr><td>Guidance</td><td>Allocation:
The member was enrolled with a medical benefit throughout the measurement period.

No more than one gap in enrollment of up to 45 days during the measurement period.

The member must be enrolled on the last day of the measurement period.

Reporting:
The total is the sum of the age stratifications.</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>Unhealthy Alcohol Use Screening</td><td>A standard assessment instrument that has been normalized and validated for the adult patient population. Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Screening Instrument</th><th>Total Score LOINC Codes</th><th>Positive Finding</th></tr>
<tr><td>Alcohol Use Disorders Identification Test (AUDIT) screening instrument</td><td>75624-7</td><td>Total score ≥8</td></tr>
<tr><td>Alcohol Use Disorders Identification Test Consumption (AUDIT-C) screening instrument</td><td>75626-2</td><td>Total score ≥4 for men

Total score ≥3 for women</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Alcohol Counseling or Other Follow-Up Care</td><td>
<table>
<tr><th>Screening Instrument</th><th>Total Score LOINC Codes</th><th>Positive Finding</th></tr>
<tr><td>Single-question screen (for men): “How many times in the past year have you had 5 or more drinks in a day?”</td><td>88037-7</td><td>Response ≥1</td></tr>
<tr><td>Single-question screen (for women and all adults older than 65 years): “How many times in the past year have you had 4 or more drinks in a day?”</td><td>75889-6</td><td>Response ≥1</td></tr>
</table>
Any of the following on or up to 60 days after the first positive screen:

Feedback on alcohol use and harms.
Identification of high-risk situations for drinking and coping strategies.
Increase the motivation to reduce drinking.
Development of a personal plan to reduce drinking.
Documentation of receiving alcohol misuse treatment.

</td></tr>
<tr><td>Initial population</td><td>Initial population 1
Members 18 years and older at the start of the measurement period who also meet criteria for participation.

Initial population 2
Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>Exclusions 1

Members with alcohol use disorder (Alcohol Use Disorder Value Set) that starts during the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).
Members with history of dementia (Dementia Value Set) any time during the member’s history through the end of the measurement period. Do not include laboratory claims (claims with POS code 81).
Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.
Members who die any time during the measurement period.

Exclusions 2
Same as exclusions 1.</td></tr>
</table>

Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** All members in numerator 1 with a positive finding for unhealthy alcohol use screening between January 1 and November 1 of the measurement period.
Numerator	**Numerator 1—Unhealthy Alcohol Use Screening** Members with a documented result for unhealthy alcohol use screening performed between January 1 and November 1 of the measurement period. **Numerator 2—Follow-Up Care on Positive Screen** Members receiving alcohol counseling or other follow-up care. Either of the following on or up to 60 days after the date of the first positive screen (61 days total) meets criteria: • Alcohol Counseling or Other Follow Up Care Value Set. • A diagnosis of encounter for alcohol counseling and surveillance (ICD-10-CM code Z71.41). Do not include laboratory claims (claims with POS code 81).

Data Elements for Reporting

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

Table ASF-E-1/2/3: Data Elements for Unhealthy Alcohol Use Screening and Follow-Up

Metric	Age	Data Element	Reporting Instructions
Screening	18-44	InitialPopulation	For each stratification, repeat per metric
FollowUp	45-64	ExclusionsByEHR	For each stratification, repeat per metric
	65+	ExclusionsByCaseManagement	For each stratification, repeat per metric
	Total	ExclusionsByHIERegistry	For each stratification, repeat per metric
		ExclusionsByAdmin	For each stratification, repeat per metric
		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)

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

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

Rules for Allowable Adjustments of Unhealthy Alcohol Use Screening and Follow-Up

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, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range (18 years and older). Organizations must consult UPSTSF guidelines when considering whether to expand the age ranges outside of the current thresholds.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Initial Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Value sets, direct reference codes and logic may not be changed for denominator 2.
Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Apply exclusions according to specified direct reference codes.
Exclusions: Hospice and deceased member	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Denominator	**Adjustments Allowed (Yes/No)**	**Notes**
Denominators	No	The logic may not be changed.

Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
• Unhealthy Alcohol Use Screening • Counseling Or Other Follow-Up On Positive Screen	No	Value sets, direct reference codes and logic may not be changed.