Health Insurance Exchange

Draft 2023 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey

Proposed QRS and QHP Enrollee Survey Program Refinements

February 2023

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List of Exhibits

1. Purpose of the 2023 QRS and QHP Enrollee Survey Call Letter

The *Draft 2023 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (referred to hereafter as the Draft 2023 QRS and QHP Enrollee Survey Call Letter) serves to communicate changes and request comments on the Centers for Medicare & Medicaid Services' (CMS') proposed refinements to the QRS and QHP Enrollee Survey programs.[1] The topics in this document focus on:

- Proposed refinements to measures in the QRS measure set,
- Proposed expansion of additional data collection and reporting methods,
- Potential revisions to the QRS scoring methodology, and
- Potential QRS and QHP Enrollee Survey refinements.

This document does not include all potential refinements to the QRS and QHP Enrollee Survey. For example, other types of QHP Enrollee Survey revisions may be addressed through the information collection request process per the Office of Management and Budget (OMB) and Paperwork Reduction Act (PRA) requirements, as appropriate.

This Draft 2023 QRS and QHP Enrollee Survey Call Letter does not propose changes to regulation; rather, it offers details on proposed changes to the QRS and QHP Enrollee Survey program operations.

1.1 Instructions for Submitting Comments and Questions

We encourage interested parties to submit comments on the information presented in this Draft 2023 QRS and QHP Enrollee Survey Call Letter to Marketplace_Quality@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-Draft 2023 QRS and QHP Enrollee Survey Call Letter" in the subject line by the close of the comment period (March 22, 2023).

After reviewing stakeholder feedback, CMS will finalize decisions on these proposed changes, and will communicate final changes about the QRS and QHP Enrollee Survey programs in the *Final 2023 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (referred to hereafter as the Final 2023 QRS and QHP Enrollee Survey Call Letter), which CMS anticipates publishing in the late spring of 2023.

In the early spring of 2023, CMS intends to publish the *2024 Quality Rating System Measure Technical Specifications* (referred to hereafter as 2024 QRS Measure Technical Specifications), which will include the measure specifications for all potential measures in the 2024 QRS measure set (i.e., any measures proposed for addition or removal in this Draft 2023 QRS and QHP Enrollee Survey Call Letter).

In the fall of 2023, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024* (hereafter referred to as the 2024 QRS and QHP Enrollee Survey Technical Guidance), reflecting applicable finalized changes announced in the Final 2023 QRS and QHP Enrollee Survey Call Letter. The 2024 QRS and QHP Enrollee

[1] The QRS and QHP Enrollee Survey requirements for the 2023 ratings year (the 2023 QRS) are detailed in the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2023* (2023 QRS and QHP Enrollee Survey Technical Guidance), which was released in October 2022 and is available on CMS' Marketplace Quality Initiatives (MQI) website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.

Survey Technical Guidance will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2024 ratings year. Additionally in the fall of 2023, CMS will release an updated version of the 2024 QRS Measure Technical Specifications that includes guidance on the finalized data submission requirements for the 2024 QRS measure set. Specifically, CMS will include callout boxes summarizing the decisions regarding measures and/or measure rates finalized for addition or removal via the Final 2023 QRS and QHP Enrollee Survey Call Letter.

1.2 Timeline for Call Letter Publication

The anticipated annual cycle for the QRS and QHP Enrollee Survey Call Letter follows a winter-to-spring (approximately February through May) timeline as shown in Exhibit 1, followed by the publication of the QRS and QHP Enrollee Survey Technical Guidance in the fall.

Exhibit 1. Annual Cycle for Soliciting Public Comment via the QRS and QHP Enrollee Survey Call Letter Process

Date	Description
February	**Publication of Draft Call Letter:** CMS proposes changes to the QRS and QHP Enrollee Survey program operations and provides interested parties with the opportunity to submit feedback via a 30-day public comment period.
March	**Publication of QRS Measure Technical Specifications:** CMS provides measure specifications for all potential measures in the QRS measure set (i.e., any measures proposed for addition and removal in this Call Letter).
March–April	**Analysis of Public Comment:** CMS reviews the stakeholder feedback received during the 30-day public comment period and finalizes changes to the QRS and QHP Enrollee Survey program operations.
May	**Publication of Final QRS and QHP Enrollee Survey Call Letter:** CMS communicates final changes to the QRS and QHP Enrollee Survey program operations and addresses the themes of the public comments.
September/October	**Publication of QRS and QHP Enrollee Survey Technical Guidance:** CMS provides technical guidance regarding the QRS and QHP Enrollee Survey and specifies requirements for QHP issuers offering coverage through the Health Insurance Exchanges (Exchanges). **Publication of Updated QRS Measure Technical Specifications:** CMS publishes an updated version of the QRS Measure Technical Specifications, as needed, that indicates final decisions regarding changes to the measures and/or measure rates (i.e., any measures finalized for addition or removal in the Final Call Letter).[2]

[2] CMS anticipates releasing an updated version of the QRS Measure Technical Specifications to provide guidance on the measure specifications and guidelines for years when refinements to QRS measures and/or measure rates are addressed via the QRS and QHP Enrollee Survey Call Letter process and finalized via the Final Call Letter.

1.3 Key Terms for the QRS and QHP Enrollee Survey Call Letter

Exhibit 2 provides descriptions of key terms used throughout this document.

Exhibit 2. Key Terms for the QRS and QHP Enrollee Survey Call Letter

Term	Description
Measurement Year	The measurement year refers to the year reflected in the data submission. All measure data are retrospective. The exact period of time represented by a measure is dependent on the technical specifications of the measure. ▪ QRS clinical measure data submitted for the 2023 ratings year (the 2023 QRS) generally represent calendar year 2022 data as the measurement year. Some measures require more than one year of continuous enrollment for data collection so the measurement year for those measures will include years prior to 2022. ▪ For QRS survey measure data in the 2023 QRS, the QHP Enrollee Survey is fielded based on enrollees who are currently enrolled as of January 6, 2023, but the survey requests that enrollees report on their experience "In the last 6 months."
Ratings Year	The ratings year refers to the year the data are collected (including fielding of the QHP Enrollee Survey), validated, and submitted, and ratings are calculated. For example, "2023 QRS" refers to the 2023 ratings year. ▪ As part of the 2023 plan year certification process, which occurred during the spring and summer of 2022, QHP issuers attested that they will adhere to 2023 quality reporting requirements, which include requirements to report data for the 2023 QRS and QHP Enrollee Survey. ▪ Requirements for the 2023 QRS, and details as to the data collection, validation, and submission processes, are documented in the 2023 QRS and QHP Enrollee Survey Technical Guidance, which was published in October 2022. ▪ Ratings calculated for the 2023 QRS are displayed for QHPs offered during the 2024 plan year, in time for open enrollment, to assist consumers in selecting QHPs.

2. CMS' Strategic Priorities and Initiatives in Upcoming Years

As part of the CMS National Quality Strategy, CMS is committed to aligning a core set of quality measures across all our programs and ensuring we measure quality across the entire care continuum in a way that promotes the best, safest, and most equitable care for all individuals. Improving alignment of measures across federal programs and with private issuers would reduce provider and issuer burden while also improving the effectiveness of quality programs. CMS is considering including a "Universal Foundation" of quality measures, which is a core set of measures that are aligned across our quality rating and value-based care programs where applicable. This "Universal Foundation" would be a building block upon which programs would add additional aligned or program-specific measures.[3]

Having measures for the "Adult" and "Pediatric" components of the "Universal Foundation" would support efforts to ensure high quality care for the more than 150 million Americans covered by our programs and serve as an alignment standard for the rest of the health care system. The "Universal Foundation" would 1) focus provider and issuer attention, 2) reduce provider and issuer burden, 3) allow for consistent stratification of measures to identify disparities in care, 4) accelerate the transition to interoperable, digital quality measures, and 5) allow for cross-comparisons across quality and value-based care programs, to better understand what drives quality and equity improvement and what does not.

[3] For more information on CMS' alignment of quality measures via the "Universal Foundation," see https://www.nejm.org/doi/full/10.1056/NEJMp2215539.

As a start, each program is considering which measures included in the "Universal Foundation" are not currently included in their programs and the steps necessary to add them over time through the Call Letter process and notice and comment rulemaking, as appropriate. The preliminary set of measures included in the Adult "Universal Foundation" and the Pediatric "Universal Foundation" are listed in Exhibit 3 and Exhibit 4, respectively, with information about whether the measures are currently in the QRS measure set.

Measures denoted with an asterisk (*) are measures currently included in the 2023 QRS measure set and those that will be included in the 2024 QRS measure set. Measures denoted with a Yen sign (¥) are those CMS is proposing for addition to the measure set and if finalized as proposed, would be included beginning with the 2024 QRS measure set.

Exhibit 3. Preliminary Adult Universal Foundation Measures

Meaningful Measure 2.0 Domain	Measure
Wellness and Prevention	Colorectal Cancer Screening*
	Breast Cancer Screening*
	Adult Immunization Status¥
Chronic Conditions	Controlling High Blood Pressure*
	Diabetes: Hemoglobin A1c Poor Control (>9%)¥
Behavioral Health	Screening for Depression and Follow-Up Plan¥
	Initiation and Engagement of Substance Use Disorder Treatment*
Seamless care coordination	Plan all-cause readmissions or all-cause Hospital Readmission*
Person-centered care	Consumer Assessment of Healthcare Providers and Systems (CAHPS): Overall Rating Measures*[4]
Equity	Social Drivers of Health/Social Need Screening and Intervention¥[5]

Exhibit 4. Preliminary Pediatric Universal Foundation Measures

Meaningful Measure 2.0 Domain	Measure
Wellness and Prevention	Well-Child Visits: Well-Child Visits in the First 30 Months of Life*; Child and Adolescent Well-Care Visits*
	Immunization: Childhood Immunization Status*; Immunizations for Adolescents*
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
	Oral Evaluation, Dental Services¥
Chronic Conditions	Asthma Medication Ratio*
Behavioral Health	Screening for Depression and Follow-Up Plan¥
	Follow-up after Hospitalization for Mental Illness*

[4] The QHP Enrollee Survey is based on the CAHPS Health Plan 5.0 survey. Some of the QRS survey measures align with the NQF-endorsed CAHPS Health Plan measures (e.g., Rating of All Health Care, Rating of Health Plan).
[5] CMS is proposing the inclusion of the *Social Need Screening and Intervention* (SNS-E) beginning with the 2024 ratings year, which similarly to the *Social Drivers of Health Screening* measure, assess social needs of the patient population.

Meaningful Measure 2.0 Domain	Measure
	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
Person-centered care	Consumer Assessment of Healthcare Providers and Systems (CAHPS): Overall Rating Measures

CMS welcomes feedback on the preliminary measures included in the Adult "Universal Foundation" measures and the Pediatric "Universal Foundation" measures with respect to applicability for the QRS and the QHP Enrollee Survey**.**

3. Proposed QRS Revisions for the 2023 Ratings Year

CMS is not proposing refinements to the QRS and QHP Enrollee Survey for the 2023 ratings year in the Draft 2023 QRS and QHP Enrollee Survey Call Letter.[6]

4. Proposed QRS and QHP Enrollee Survey Revisions for the 2024 Ratings Year and Beyond

CMS is soliciting comments on a series of proposed refinements to the QRS and QHP Enrollee Survey that would apply beginning with the 2024 ratings year, including:

- Removal of measures from the QRS measure set,
- Addition of measures to the QRS measure set,
- Transition of a measure,
- Expansion of a data reporting method, and
- Expansion of stratified race and ethnicity data collection to advance health equity.

Exhibit 5 and Exhibit 6 contain a summary of the proposed measure set refinements for the 2024 ratings year and beyond. See Appendix A for the comprehensive, proposed 2024 QRS measure set and measure changes.

Exhibit 5. Summary of Proposed Removal and Replacement or Transition of Measures Beginning with the 2024 QRS Measure Set

Measures Proposed for Removal	Proposed Replacement or Transition of Measures (Measures proposed for transition are indicated by an asterisk *)
Annual Dental Visit	Oral Evaluation, Dental Services
Flu Vaccinations for Adults Ages 18 – 64	Adult Immunization Status (AIS-E)

[6] See the *QRS and QHP Enrollee Survey Technical Guidance for 2023* for further details on the final QRS and QHP Enrollee Survey requirements for the 2023 ratings year available at the CMS Marketplace Quality Initiatives (MQI) website: https://www.cms.gov/files/document/2023-qrs-qhp-enrollee-survey-technical-guidance.pdf.

Measures Proposed for Removal	Proposed Replacement or Transition of Measures (Measures proposed for transition are indicated by an asterisk *)
Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c control (<8.0%)	Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c poor control (>9.0%)*
Appropriate Testing for Pharyngitis	None[7]

Exhibit 6. Summary of Proposed Addition of New Measures Beginning with the 2024 QRS Measure Set

New Measures Proposed for Addition
Social Need Screening and Intervention (SNS-E)
Depression Screening and Follow-up for Adolescents and Adults (DSF-E)

As detailed in section 4.2 below, for measures CMS is proposing for inclusion in the QRS measure set (i.e., *Oral Evaluation, Dental Services; Adult Immunization Status* [AIS-E]; *Hemoglobin A1c [HbA1c] Control for Patient with Diabetes: HbA1c poor control* [>9.0%]; *Social Need Screening and Intervention* [SNS-E], *Depression Screening and Follow-Up for Adolescents and Adults* [DSF-E]), CMS will allow for one year of data collection prior to inclusion in scoring. For example, if the new measures are added as proposed, data collection would begin for the 2024 ratings year (i.e., 2023 measurement year), but CMS would not include the measures in scoring until the 2025 ratings year (i.e., 2024 measurement year), at the earliest.

4.1 Proposed Removal of Select Measures

CMS is considering the removal of the *Annual Dental Visit*, *Flu Vaccinations for Adults Ages 18 – 64*, and *Appropriate Testing for Pharyngitis* measures from the QRS measure set beginning with the 2024 ratings year. CMS is proposing removal of the *Annual Dental Visit* and *Flu Vaccinations for Adults Ages 18 – 64* measures in alignment with the measure steward's (i.e., National Committee for Quality Assurance [NCQA]) retirement of the measures. CMS is proposing removal of the *Appropriate Testing for Pharyngitis* measure due to the redundancy with other measures that already capture antibiotic stewardship in the QRS measure set and to align with CMS' priorities, such as reducing burden and including measures most valuable to the Exchange population.

4.1.1 Removing the *Annual Dental Visit* Measure

For the 2024 ratings year and beyond, CMS proposes removing the *Annual Dental Visit* measure from the QRS measure set in alignment with the measure steward's (NCQA) retirement of the measure. NCQA is retiring this measure beginning with the 2023 measurement year because the measure focuses more on access to dental care, rather than quality of dental care.

CMS will continue to collect the *Annual Dental Visit* measure and use it for scoring in the 2023 ratings year. Incorporating this change beginning with the 2024 ratings year would align the QRS

[7] As explained below, our analysis concluded that the removal of this measure would not result in a gap in measurement of this quality topic area.

with the measure steward's timeframe for retiring the measure. As detailed below in section 4.2.1, to avoid a gap in measuring dental quality, CMS proposes to replace the *Annual Dental Visit,* measure with a new measure, *Oral Evaluation, Dental Services*, beginning with the 2024 ratings year.

4.1.2 Removing the *Flu Vaccinations for Adults Ages 18 – 64* Measure

Beginning with the 2024 ratings year, CMS proposes removing the *Flu Vaccinations for Adults Ages 18-64* measure from the QRS measure set in alignment with the measure steward's (NCQA) retirement of the measure. NCQA is retiring the *Flu Vaccinations for Adults Ages 18-64* measure reported using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health plan survey method to streamline reporting of immunization measures through electronic data.

CMS will continue to collect the *Flu Vaccinations for Adults Ages 18-64* measure and use it for scoring in the 2023 ratings year. Incorporating this change beginning with the 2024 ratings year would align the QRS with the measure steward. As detailed below in section 4.2.2, to avoid a gap in measuring quality in this area, CMS proposes to replace the *Flu Vaccinations for Adults Ages 18-64* measure with a new measure, *Adult Immunization Status* (AIS-E), beginning with the 2024 ratings year.

In addition, in alignment with the proposed removal of the *Flu Vaccinations for Adults Ages 18 – 64* measure, CMS proposes removing the following question from the QHP Enrollee Survey for the 2024 ratings year and beyond:

Have you had either a flu shot or flu spray in the nose since July 1, 2023?

- Yes
- No
- Don't know

The removal of the question would occur if CMS finalizes the removal of the *Flu Vaccinations for Adults Ages 18 – 64* measure from the QRS measure set and is intended to reduce the burden placed on respondents completing the survey.[8]

4.1.3 Removing the *Appropriate Testing for Pharyngitis* Measure

For the 2024 ratings year and beyond, CMS proposes removing the *Appropriate Testing for Pharyngitis* measure from the QRS measure set. CMS is proposing removal of this measure due to redundancy with other measures in the QRS measure set that already capture antibiotic stewardship (i.e., *Appropriate Treatment for Upper Respiratory Infection* and *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*).

Additionally, CMS continues to holistically review the QRS measure set to confirm the measures provide value to interested parties and meet CMS priorities and goals for the QRS (e.g., alignment with other quality reporting program measure sets, reducing burden). As part of this effort, CMS identified the *Appropriate Testing for Pharyngitis* measure for removal as it does not address a high priority condition for the Exchange population. Further, due to the redundancy with other measures that already capture antibiotic stewardship in the QRS measure set, removal of the *Appropriate*

[8] CMS will comply with applicable PRA requirements for implementing changes to the QHP Enrollee Survey. The QHP Enrollee Survey information collection is approved under OMB number 0938-1221.

Testing for Pharyngitis measure would not lead to a gap in measurement of this topic area in the QRS.

CMS will continue to collect the *Appropriate Testing for Pharyngitis* measure and use it for scoring in the 2023 ratings year. If finalized for removal, this change would be incorporated beginning with the 2024 ratings year.

4.2 Proposed Addition of Select Measures

CMS is considering the addition of four new measures beginning with the 2024 QRS measure set: *Oral Evaluation, Dental Services*; *Adult Immunization Status* (AIS-E); *Social Need Screening and Intervention* (SNS-E); and *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E). CMS is proposing the addition of the *Oral Evaluation, Dental Services* measure to replace the *Annual Dental Visit* measure, which CMS proposes removing beginning with the 2024 ratings year. CMS is also proposing the addition of the *Adult Immunization Status* (AIS-E) measure to replace the *Flu Vaccinations for Adults Ages 18-64* measure, which CMS proposes removing beginning with the 2024 ratings year. Additionally, CMS is proposing the addition of two other new measures - *Social Need Screening and Intervention* (SNS-E) and *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) measures - to continue CMS' commitment to advancing health equity[9] and to increase reporting on behavioral health-related topics, which is a priority Meaningful Measures 2.0 topic area. [10]

If CMS incorporates these new measures into the QRS measure set, an initial year of data collection would occur before the measures would be included in the calculation of QRS scores and ratings (i.e., if the new measures are added as proposed, data collection would begin for the 2024 ratings year, but CMS would not include the measures in scoring until the 2025 ratings year, at the earliest).

4.2.1 Adding the *Oral Evaluation, Dental Services* Measure

CMS is considering adding the *Oral Evaluation, Dental Services* measure to the QRS measure set and proposes to include this measure in the QRS measure set beginning with the 2024 ratings year.

The *Oral Evaluation, Dental Services* measure was adapted by the measure steward (i.e., NCQA) for HEDIS® with the permission of the Dental Quality Alliance (DQA) and American Dental Association (ADA)[11] and developed to replace the *Annual Dental Visit* measure. This new measure specifically evaluates the percentage of members under 21 years of age who receive a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Dental cavities are one of the most common chronic conditions affecting children. Addition of the *Oral Evaluation, Dental Services* measure to the QRS measure set has the potential to improve oral health by encouraging consistent dental care and reducing the incidence of future dental decay. The intent of the measure is to highlight the quality of dental care (i.e., identification of problems, conditions, and diagnoses needed; and treatment planning) patients receive by measuring annual, specific comprehensive oral evaluations. This measure supports CMS' goal of alignment with other CMS quality reporting programs (i.e., Medicaid Child Core Set) and would avoid a gap in measuring

[9] See the CMS Framework for Health Equity 2022-2032: https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf.
[10] For more information on Meaningful Measures 2.0, see: https://www.cms.gov/medicare/meaningful-measures-framework/meaningful-measures-20-moving-measure-reduction-modernization.
[11] © 2022 DQA on behalf of ADA, all rights reserved.

dental quality. This measure also addresses CMS' Meaningful Measures 2.0 priority area of wellness and prevention.[12]

The draft measure technical specifications for the *Oral Evaluation, Dental Services* measure are included in Appendix B.[13]

4.2.2 Adding the *Adult Immunization Status* (AIS-E) Measure

CMS is considering the addition of the *Adult Immunization Status* (AIS-E) measure[14] to the QRS measure set and proposes to include this measure in the QRS measure set beginning with the 2024 ratings year.

NCQA (i.e., the measure steward) is retiring the *Flu Vaccinations for Adults Ages 18-64* measure beginning with the 2023 measurement year, and capturing flu vaccination information for this population via the *Adult Immunization Status* (AIS-E) measure. The *Adult Immunization Status* (AIS-E) measure captures information on a more comprehensive set of vaccinations than the *Flu Vaccinations for Adults Ages 18-64* measure as it assesses the percentage of adults ages 19 years and older who are up to date on recommended vaccinations, including: influenza (Flu), tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, and pneumococcal vaccinations. Consistent with the measure steward's specifications, this measure would be collected through the Electronic Clinical Data System (ECDS) reporting method.

Addition of the *Adult Immunization Status* (AIS-E) measure to the QRS measure set addresses CMS' Meaningful Measures 2.0 priority area of wellness and prevention, and focus on digital quality measurement.[15] Additionally, the measure is included in the proposed Adult "Universal Foundation" measure set, furthering CMS' goal of aligning a core set of measures across all programs, reducing burden, and improving effectiveness of quality reporting programs. Its addition beginning with the 2024 ratings year would also avoid a gap in capturing flu vaccination information. The draft measure technical specifications for the *Adult Immunization Status* (AIS-E) measure are included in Appendix C.[16]

4.2.3 Adding the *Social Need Screening and Intervention* (SNS-E) Measure

CMS is considering adding the *Social Need Screening and Intervention* (SNS-E) measure to the QRS measure set and proposes to include this measure in the QRS measure set beginning with the 2024 ratings year.

The *Social Need Screening and Intervention* (SNS-E) measure was developed by NCQA (i.e., the measure steward) to advance health equity and hold health plans accountable for assessing and

[12] See supra note 10.
[13] The *Oral Evaluation, Dental Services* measure technical specifications included in Appendix B are subject to change and may differ from those published in the 2024 QRS Measure Technical Specifications to align with changes made by the measure steward.
[14] NCQA developed the *Adult Immunization Status (*AIS-E) measure with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO).
[15] See supra note 10.
[16] The *Adult Immunization Status* (AIS-E) measure technical specifications included in Appendix C are subject to change and may differ from those published in the 2024 QRS Measure Technical Specifications to align with changes made by the measure steward.

addressing health-related social needs of their patient populations.[17] The *Social Need Screening and Intervention* (SNS-E) measure assesses screening for unmet food, housing and transportation needs, and referral to intervention for those who screened positive. Consistent with the measure steward's specifications, this measure would be collected through the ECDS reporting method and would focus on whether members were screened at least once during the measurement year and whether members who screened positively received a referral to an intervention. As CMS continues its commitment to advancing health equity, this measure would highlight potential issues related to unmet food, housing, and transportation needs.

Addition of the *Social Need Screening and Intervention* (SNS-E) measure to the QRS measure set would address CMS' Meaningful Measures 2.0 priority area of advancing health equity.[18] The addition of this measure would also align with a priority outlined in CMS' Framework for Health Equity to expand the collection, reporting, and analysis of standardized data.[19] Additionally, inclusion of this measure that addresses social drivers of health aligns with other CMS quality reporting program approaches and is informed by recommendations from CMS Office of Minority Health and CMS' framework for advancing health equity.[20,21] This proposed addition would also align with recent updates to the quality improvement strategy (QIS) standards applicable to QHP issuers participating in Exchanges that requires health and health care disparities be addressed as a specific topic area in issuers' quality improvement strategies, beginning in calendar year 2023 for the 2024 Plan Year.[22]

The draft measure technical specifications for the *Social Need Screening and Intervention* (SNS-E) measure are included in Appendix D.[23]

4.2.4 Adding the *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) Measure

CMS is considering adding the *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) measure[24] to the QRS measure set and proposes to include this measure in the QRS measure set beginning with the 2024 ratings year.

The *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) measure was adapted by the measure steward (i.e., NCQA) from a provider-level measure (i.e., *Screening for Depression and Follow-Up Plan*) with financial support from CMS, and is collected through the ECDS reporting method. This measure evaluates the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received

[17] See The Future of HEDIS®: Health Equity available at https://www.ncqa.org/wp-content/uploads/2022/10/FOH-Using-HEDIS-to-Improve-Health-Equity-Oct-6-2022.pdf
[18] See supra note 10.
[19] See supra note 9.
[20] See CMS OMH's "The Path Forward: Improving Data to Advance Health Equity Solutions" available at https://www.cms.gov/files/document/path-forwardhe-data-paper.pdf
[21] See supra note 9.
[22] See the HHS Notice of Benefit and Payment Parameters for 2023; Final Rule, 87 FR 27208 at 27341 – 27345 (May 6, 2022).
[23] The *Social Need Screening and Intervention* (SNS-E) measure technical specifications included in Appendix D are subject to change and may differ from those published in the 2024 QRS Measure Technical Specifications to align with changes made by the measure steward.
[24] NCQA adapted the *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) measure with financial support from CMS.

follow-up care. The *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) measure aligns with recommendations released by the U.S. Preventive Services Task Force (USPSTF) for routine screening for depression in the primary care setting and providing early intervention for depression.[25] Addition of this measure to the QRS measure set would also support early identification and treatment of clinical depression, filling an important behavioral health need that is not currently covered by the behavioral health measures in the QRS measure set.

Incorporation of the *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) measure would support CMS' goal of alignment with other CMS quality reporting programs (e.g., Medicaid Child and Adult Core Sets, Merit Based Incentive Payment System [MIPS], Medicare Shared Savings) which use a similar version of the measure to evaluate this behavioral health area. Addition of this measure also considers stakeholder feedback for a measure that focuses on early identification and treatment of mental health conditions. Addition of this measure would also address CMS' Meaningful Measures 2.0 priority area of behavioral health and allows the QRS measure set to better align with the proposed Adult Universal Foundation measure set.[26]

The draft measure technical specifications for the *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) measure are included in Appendix E.[27] CMS also encourages feedback on the addition of other measures that address behavioral health and should be considered for addition to the QRS measure set for future years (i.e., 2025 ratings year and beyond).

4.3 Proposed Transition of the Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c control (<8.0%) Measure to the Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c poor control (>9.0%) Measure

CMS previously solicited comments on the proposed transition of the *HbA1c Control for Patient with Diabetes: HbA1c control (<8.0%)* measure to the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure via the Draft 2021 Call Letter for the QRS and QHP Enrollee Survey.[28] Most of the interested parties that submitted comments regarding the proposed transition from the *HbA1c Control for Patient with Diabetes: HbA1c control (<8.0%)* measure to the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure supported the proposal. However, as explained in the Final 2021 Call Letter for the QRS and QHP Enrollee Survey, CMS did not finalize this proposed transition due to the removal of the *Comprehensive Diabetes Care: Medical Attention from Nephropathy* measure, which would have resulted in inclusion of only half of the diabetes-related measures for the 2022 ratings year (i.e., *Eye Exam for Patients with Diabetes* and *Proportion of Days Covered [Diabetes All Class]*) in scoring.[29]

[25] See USPSTF's Final Recommendation Statement on Screening for Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/depression-in-adults-screening

[26] See supra note 10.

[27] The *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) measure technical specifications included in Appendix E are subject to change and may differ from those published in the 2024 QRS Measure Technical Specifications to align with changes made by the measure steward.

[28] See the Draft 2021 Call Letter for the QRS and QHP Enrollee Survey for more information: https://www.cms.gov/files/document/draft-2021-call-letter-qrs-qhp-enrollee-survey.pdf.

[29] See the Final 2021 Call Letter for the QRS and QHP Enrollee Survey for more information: https://www.cms.gov/files/document/final-2021-call-letter-qrs-and-qhp-enrollee-survey.pdf.

CMS is once again considering transition of the *HbA1c Control for Patient with Diabetes: HbA1c control (<8.0%)* measure to the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure beginning with the 2024 ratings year to align with other CMS quality reporting programs, the proposed Adult "Universal Foundation" measure set, and interested party feedback. CMS is soliciting comments to confirm continued support of transitioning from the *HbA1c Control for Patient with Diabetes: HbA1c control (<8.0%)* measure to the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure. If finalized for inclusion in the QRS measure set as proposed, CMS would begin collecting the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure for the 2024 ratings year, with scoring for the measure beginning with the 2025 ratings year at the earliest. The addition of the *Kidney Health Evaluation for Patient with Diabetes* measure to the QRS measure set beginning with the 2023 ratings year and scoring for the measure beginning with the 2024 ratings year resolves concerns about half of the diabetes-related measures included in scoring.[30]

Additionally, if finalized as proposed, QHP issuers would be required to submit validated race and ethnicity data for the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure. In the 2024 ratings year, QHP issuers would be allowed to report the stratification using their own directly collected member data for race and ethnicity as outlined in the HEDIS® measure specifications. Additionally, plans would be able to supplement directly collected data with indirect race and ethnicity data (i.e., assigned or imputed from secondary data sources such as assignment by surname analysis and geocoding). Plans would not be required to use a specific method for imputation when reporting stratified race and ethnicity data using indirect data sources and would not be required to use direct data sources until the 2025 ratings year, at the earliest.

The draft measure technical specifications for the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure are included in Appendix F.[31]

4.4 Expanding Electronic Clinical Data System Reporting

In the Final 2022 Call Letter for the QRS and QHP Enrollee Survey, CMS finalized the introduction of optional ECDS reporting alongside hybrid or administrative reporting for four measures in the QRS measure set: *Colorectal Cancer Screening*, *Breast Cancer Screening*, *Immunization for Adolescents (Combination 2)*, and *Childhood Immunization Status (Combination 10)*.[32] ECDS is a reporting standard for health plans collecting and submitting quality measures that defines data sources and the types of structured data acceptable for use for a measure.[33]

Beginning with the 2024 ratings year, CMS proposes to introduce optional ECDS reporting to the *Cervical Cancer Screening* measure, as well as to transition the *Breast Cancer Screening* measure to ECDS-only reporting. As detailed above in sections 4.2.2, 4.2.3 and 4.2.4, CMS also proposes to add

[30] See the Final 2022 Call Letter for the QRS and QHP Enrollee Survey for more information: https://www.cms.gov/files/document/final-2022-call-letter-qrs-qhp-enrollee-survey.pdf

[31] The *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure technical specifications included in Appendix F are subject to change and may differ from those published in the 2024 QRS Measure Technical Specifications to align with changes made by the measure steward.

[32] See the Final 2022 Call Letter for the QRS and QHP Enrollee Survey for more information: https://www.cms.gov/files/document/final-2022-call-letter-qrs-qhp-enrollee-survey.pdf.

[33] Resources to support ECDS reporting can be found on NCQA's ECDS webpage, in particular under the section called 'Resources and Publications': https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/

three new measures – the *Adult Immunization Status* (AIS-E) measure, the *Social Need Screening and Intervention* (SNS-E) measure, and the *Depression Screening and Follow-Up for Adolescents and Adults* (DSF-E) measure – beginning with the 2024 ratings year that would also be subject to ECDS-only reporting.[34]

4.4.1 Transitioning the *Breast Cancer Screening* Measure to ECDS-only Reporting

Beginning with the 2023 measurement year (i.e., 2024 ratings year), the measure steward (i.e., NCQA) is retiring the *Breast Cancer Screening* measure reported via the Administrative Method and transitioning to the *Breast Cancer Screening* (BCS-E) measure that is reported via the ECDS method only.

CMS proposes transition of the *Breast Cancer Screening* measure to the *Breast Cancer Screening* (BCS-E) measure beginning with the 2024 ratings year in alignment with NCQA's retirement of the measure reported via the Administrative Method. If this transition is finalized as proposed, QHP issuers would be required to submit the *Breast Cancer Screening* (BCS-E) measure as a part of data submissions for the 2024 ratings year.

CMS is also collecting interested party feedback on whether to include this measure in scoring for the 2024 ratings year or to remove the measure from scoring for one year, so the *Breast Cancer Screening* (BCS-E) measure would not be included in scoring until the 2025 ratings year, at the earliest.[35] Retaining the measure in scoring would align with other CMS quality reporting program approaches (e.g., Medicare Part C and D Star Ratings Program) for incorporating required ECDS reporting. Additionally, retention of the measure in scoring would allow for inclusion of this important clinical topic in QRS scores and ratings and result in better continuity when comparing QRS scores and rating over time. However, CMS recognizes a transition in the reporting method may result in high missingness in measure data during the first year as issuers may need additional time to implement the processes and infrastructure to report this measure via the ECDS method. .

CMS will continue to collect the *Breast Cancer Screening* measure and use it for scoring in the 2023 ratings year.

4.4.2 Adding Optional ECDS Reporting for Additional Measures

Beginning with the 2023 measurement year (i.e., 2024 ratings year), CMS proposes to expand optional ECDS reporting for the *Cervical Cancer Screening* measure alongside the Hybrid and Administrative Methods to align with the measure steward's (i.e. NCQA) timeline for incorporating ECDS.[36] If finalized as proposed, the *Cervical Cancer Screening* measure would be the fifth measure in the QRS measure set that allows issuers to use the ECDS reporting method.[37]

[34] If finalized as proposed, CMS would begin collecting data for these three new measures for the 2024 ratings year, but scoring for the measures would not begin until the 2025 ratings year.
[35] For NCQA's comparison of performance results generated from measure data reporting using the ECDS method in comparison to traditional reporting methods (i.e., Hybrid or Administrative), see the *Special Report: Results for Measures Leveraging Electronic Clinical Data for HEDIS®*, available at: Special-Report-Nov-2022-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf (ncqa.org)
[36] See supra note 33.
[37] As detailed in section 4.1.1, CMS proposes to transition the *Breast Cancer Screening* measure to ECDS-only reporting beginning with the 2024 ratings year. As such, there would be four measures in the 2024 QRS measure set that offered

4.5 Additional Collection of Stratified Race and Ethnicity Data to Advance Health Equity

In the Final 2022 Call Letter for the QRS and QHP Enrollee Survey, CMS finalized the requirement for QHP issuers to submit validated race and ethnicity data for five measures in the QRS measure set beginning with the 2022 measurement year (i.e., 2023 ratings year).[38] Beginning with the 2023 measurement year (i.e., 2024 ratings year), CMS is proposing to expand required collection and reporting of stratified race and ethnicity data for the following five measures: *Breast Cancer Screening*, *Immunizations for Adolescents*, *Well-Child Visits in the First 30 Months of Life*, *Initiation and Engagement of Substance Use Disorder Treatment*, and *Asthma Medication Ratio* to continue CMS' commitment to advancing health equity and exploration of ways to analyze health equity and disparities among the Exchange population through the reporting of stratified measure data. If finalized, this refinement would be included as a part of the *2024 QRS Measure Technical Specifications* in alignment with the measure steward's (i.e., NCQA) refinements to these HEDIS® measures.[39]

Exhibit 7 contains the measures for which CMS finalized the requirement for QHP issuers to submit validated race and ethnicity data in the Final 2022 Call Letter for the QRS and QHP Enrollee Survey, as well as the measures proposed for inclusion of race and ethnicity data collection via the Draft 2023 Call Letter for the QRS and QHP Enrollee Survey.

Exhibit 7. Measures Proposed and Finalized for Race and Ethnicity Stratification

Implementation Status	Measure
Finalized beginning with the 2022 measurement year	Child and Adolescent Well-Care Visits
	Colorectal Cancer Screening
	Controlling High Blood Pressure
	Hemoglobin A1c (HbA1c) Control for Patient With Diabetes: HbA1c control (<8.0%)
	Prenatal and Postpartum Care
Proposed for implementation beginning with the 2023 measurement year	Asthma Medication Ratio
	Breast Cancer Screening[40]
	Immunization for Adolescents
	Initiation and Engagement of Substance Use Disorder Treatment
	Well-Child Visits in the First 30 Months of Life
	HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)[41]

optional ECDS reporting [i.e., *Colorectal Cancer Screening*, *Cervical Cancer Screening*, *Immunization for Adolescents (Combination 2)*, and *Childhood Immunization Status (Combination 10)]*.

[38] See the Final 2022 Call Letter for the QRS and QHP Enrollee Survey for more information: https://www.cms.gov/files/document/final-2022-call-letter-qrs-qhp-enrollee-survey.pdf

[39] This is consistent with NCQA's approach and timeline for stratification of select HEDIS® measures. For more information, see: https://www.ncqa.org/about-ncqa/health-equity/data-and-measurement/

[40] As detailed in section 4.1.1, CMS is also proposing to transition the *Breast Cancer Screening* measure to ECDS-only reporting beginning with the 2024 ratings year and is collecting feedback on whether to include the *Breast Cancer Screening* (BCS-E) measure in scoring during either the 2024 ratings year or the 2025 ratings year, at the earliest.

[41] If the transition from the *HbA1c Control for Patient with Diabetes: HbA1c control (<8.0%)* measure to the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure is finalized as proposed in section 4.3, QHP issuers will be required to comply with the race and ethnicity reporting requirements outlined in section 4.3 for reporting *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure data.

CMS intends to continue to follow a phased-in approach for implementing stratifications to race and ethnicity measure data that QHP issuers are required to submit as part of the QRS. In the 2023 measurement year, QHP issuers would be allowed to report the stratification using their own directly collected member data for race and ethnicity as outlined in the HEDIS® measure specifications. Additionally, plans would be able to supplement directly collected data with indirect race and ethnicity data (i.e., assigned or imputed from secondary data sources such as assignment by surname analysis and geocoding). Plans would not be required to use a specific method for imputation when reporting stratified race and ethnicity data using indirect data sources and would not be required to use direct data sources until the 2024 measurement year, at the earliest.

Additionally, as communicated via the Final 2022 Call Letter for the QRS and QHP Enrollee Survey CMS will allow QHP issuers to continue to follow this phase-in approach for the 2023 measurement year for those measures that for which race and ethnicity data stratification reporting requirements were finalized (i.e., *Child and Adolescent Well-Care Visits, Colorectal Cancer Screening, Controlling High Blood Pressure*).[42]

CMS is committed to advancing health equity, and the proposal to expand the requirement to report stratified race and ethnicity data for the identified additional five measures is a further initial step to facilitate analysis of this data at a more granular level for the Exchange population. At this time, CMS does not anticipate display of stratified race and ethnicity data during the 2024 ratings year.

5. Potential QRS and QHP Enrollee Survey Revisions for Future Years

CMS is also soliciting comments on potential modifications to the QRS and QHP Enrollee Survey for future years (e.g., the 2024 ratings year and beyond). Topics under consideration and evaluation for potential revisions in future years include, but are not limited to:

- Potential refinements to the Benchmark Ratio approach scoring methodology,
- Changes to the QRS measure set, and
- Revisions to the QHP Enrollee Survey Questionnaire.

CMS anticipates including these proposed refinements in future Draft Call Letters, through the rulemaking process, or through the information collection request process per the PRA requirements (as appropriate). CMS is soliciting general comments at this time to help inform the development of potential future proposals.

5.1 Determining a Minimum Number of Reporting Units Required to Establish a Measure Benchmarks

CMS implemented the Benchmark Ratio approach scoring methodology beginning with the 2021 measurement year (i.e., 2022 ratings year).[43] The Benchmark Ratio approach consists of two distinct parts:

1) The calculation of measure-specific performance targets (i.e., measure benchmarks); and

[42] See the Final 2022 Call Letter for the QRS and QHP Enrollee Survey for more information: https://www.cms.gov/files/document/final-2022-call-letter-qrs-qhp-enrollee-survey.pdf

[43] For more information regarding the Benchmark Ratio approach, see the Quality Rating System and Qualified Health Plan Enrollee Survey Technical Guidance for 2022, available at: https://www.cms.gov/files/document/2022-qrs-and-qhp-enrollee-survey-technical-guidance.pdf

2) The calculation of measure scores using the measure benchmark.

Currently, measure benchmarks are comprised of the highest performing reporting units representing ≥10 percent of the eligible enrollee population. CMS experience during initial testing of the Benchmark Ratio approach and during the first year this approach was implemented found there could be instances where one or two reporting units may define the benchmark calculation for a given measure if those respective reporting units contain a large eligible enrollee population and are the highest performers.

In an effort to confirm the most fair and representative measure benchmarks in each ratings year, CMS is collecting feedback on further exploration of determining a minimum number of reporting units required to define a measure benchmark and on what analyses, approaches, and factors should be considered to refine the measure benchmark composition (e.g., minimum number of reporting units, diversity of reporting units). For example, CMS could evaluate the impact on the measure benchmark itself (e.g., value of benchmark and corresponding percentile), the eligible enrollee population percentage represented by the benchmark, and the measure scores.

CMS may implement this refinement beginning with the 2023 measurement year (i.e., 2024 ratings year) if CMS determines this change is of less significance. Significance of the change would be determined by impact to the benchmarks, and thus the impact on the subsequent scores and ratings as well as the continuation to produce sound and meaningful results.[44]

5.2 Adding the *Enrollment by Product Line* Measure

Beginning with the 2024 measurement year (i.e., 2025 ratings year), CMS proposes to add the *Enrollment by Product Line* measure to the QRS measure set. The *Enrollment by Product Line* measure is a non-clinical measure that includes health plan descriptive information, requiring only plan enrollment/eligibility data.

Beginning with 2024 measurement year HEDIS® reporting, NCQA will require all Medicaid, commercial, and Medicare submissions to include *Enrollment by Product Line* reporting in their HEDIS® submission file through the Interactive Data Submission System (IDSS).[45] Collecting enrollment data for the Exchange product line as part of the QRS measure set aligns with the measure steward's new requirement and would provide added value to CMS and QRS interested parties, because enrollment data can be used to help verify the validity of the measure data by providing additional information to auditors and other data users.

CMS is therefore soliciting comments on whether interested parties support the addition of the *Enrollment by Product Line* measure beginning with the 2024 measurement year to establish enrollment thresholds by product line and facilitate eligible population benchmarking.

[44] For information on the timeline for incorporating refinements into the QRS program (including the approach for significant and non-significant changes), see the Final 2016 Call Letter for the QRS and QHP Enrollee Survey and the Final 2018 Call Letter for the QRS and QHP Enrollee Survey, available at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/aca-mqi/downloads/mqi-downloads.

[45] Currently all Medicare Advantage Organizations are also required to report *Enrollment by Product Line* data.

The draft measure technical specifications for the *Enrollment by Product Line* measure are included in Appendix G.[46]

5.3 Revising the QHP Enrollee Survey Questionnaire

The QHP Enrollee Survey is designed to help CMS and consumers understand enrollees' experience with their health plan and care. The data received are an important part of QHP issuers' quality improvement activities and for informing efforts to advance health equity. CMS annually reviews feedback on the value and usability of the QHP Enrollee Survey from interested parties through public comment and the QHP Enrollee Survey Technical Expert Panel (TEP). CMS also analyzes QHP Enrollee Survey results, including question response rates and reliability. CMS has received public comments via previous Call Letters, as well as QHP issuer focus groups expressing concerns about the length of the QHP Enrollee Survey and the impact on response rates. CMS welcomes additional public comment on potential questions for removal to assist the agency as it continues to consider potential revisions to the survey questionnaire.

CMS is committed to advancing health equity. As such, CMS is exploring adding questions to the survey regarding sexual orientation and gender identity (SOGI). CMS welcomes feedback about the collection SOGI data using the QHP Enrollee Survey and if these data are currently collected by issuers using other methods.

CMS will comply with the PRA as applicable for implementing changes to the QHP Enrollee Survey, currently authorized under OMB number 0938-1221.

6. Reminders and Announcements for the 2023 Ratings Year

This section includes announcements and reminders of updates to the QRS and QHP Enrollee Survey for the 2023 ratings year that have been discussed in prior Call Letters or the QRS and QHP Enrollee Survey Technical Guidance for 2023.

6.1 Temporary Rule to Limit Star Rating Declines

In the Final 2022 Call Letter, CMS finalized the retention of the temporary rule to limit star rating declines for the 2022 ratings year.[47] As such, this temporary rule will not apply for the 2023 ratings year. This temporary methodology refinement was implemented to mitigate the impact of the COVID-19 public health emergency on QRS ratings. Its discontinuation also aligns with the Biden-Harris Administration's recently announced decision to end the COVID-19 public health emergency on May 11, 2023.[48]

[46] The *Enrollment by Product Line* measure technical specifications included in Appendix G are subject to change and may differ from those published in the 2024 QRS Measure Technical Specifications to align with changes made by the measure steward.
[47] See supra note 42.
[48] https://www.whitehouse.gov/wp-content/uploads/2023/01/SAP-H.R.-382-H.J.-Res.-7.pdf.

6.2 Cut Point Methodology Refinements

Beginning with the 2023 ratings years, CMS is replacing the clustering cut point methodology with a static cut point approach, using 60, 70, 80, 90 threshold values at both the summary indicator and global levels of the hierarchy as indicated in the Final 2022 Call Letter.[49] For more information please refer to the QRS and QHP Enrollee Survey Technical Guidance for 2023.[50]

6.3 Adding and Modifying QHP Enrollee Survey Questions to Support Analysis of Health Equity and Disparities

As proposed in the Draft 2022 Call Letter for the QRS and QHP Enrollee Survey and finalized via the Final 2022 Call Letter for the QRS and QHP Enrollee Survey,[51] CMS intends to revise the race question and expand the responses for the ethnicity question. The changes would align with the 2011 HHS Data Collection Standards, which were established based on a requirement in Section 4302 of the Patient Protection and Affordable Care Act (ACA). Adding expanded race categories and ethnicity response options to the QHP Enrollee Survey would facilitate analysis of health equity and disparities amongst subpopulations that would not be feasible without this level of granularity. These changes would also provide insight and awareness for QHP issuers into the quality of care and satisfaction among members of different demographics enrolled in each health plan, thereby, allowing issuers to advance health equity. CMS will seek further public comment on these new data categories through a Federal Register Notice published as part of the Paperwork Reduction Act clearance process and anticipates publishing such a Notice in advance of implementation of the 2024 QHP Enrollee Survey.

[49] See supra note 42.
[50] See the QRS and QHP Enrollee Survey Technical Guidance for 2023 for more information: https://www.cms.gov/files/document/2023-qrs-qhp-enrollee-survey-technical-guidance.pdf
[51] See supra note 42.

Appendix A. QRS Hierarchy

The QRS measures are organized into a hierarchal structure that serves as a foundation of the QRS rating methodology (the QRS hierarchy). The measures are grouped into summary indicators to form a single global rating.[52]

Exhibit 8 illustrates the proposed ratings year 2024 QRS hierarchy, which is the organization of measures into summary indicators and ultimately, a single global rating. Measures denoted with a strikethrough (–), if removed as proposed, would not be collected for the 2024 ratings year. Measures denoted with an asterisk (*) and in bold font, are measures proposed for addition to the measure set and if finalized as proposed, would be collected, but not included in 2024 QRS scoring. Measures that require ECDS reporting are indicated by a "-E" in parentheses following the measure name. Measures not currently endorsed by the National Quality Forum (NQF) are noted as ¥.

Exhibit 8. Proposed 2024 QRS Hierarchy

QRS Summary Indicator	Measure Title	NQF ID (¥ indicates not currently endorsed)
Clinical Quality Management	Asthma Medication Ratio	1800
	Antidepressant Medication Management	0105
	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up)	0576
	Depression Screening and Follow – Up for Adolescents and Adults (DSF-E)*	0418 ¥
	Initiation and Engagement of Substance Use Disorder Treatment	0004
	Controlling High Blood Pressure	0018
	Proportion of Days Covered (RAS Antagonists)	0541
	Proportion of Days Covered (Statins)	0541
	Eye Exam for Patient with Diabetes	0055
	~~Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c control (<8.0%)~~	~~0575~~
	Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c poor control (>9.0%)*	0059
	Proportion of Days Covered (Diabetes All Class)	0541
	Kidney Health Evaluation for Patients with Diabetes	N/A[53]
	International Normalized Ratio Monitoring for Individuals on Warfarin	0555
	Annual Monitoring for Persons on Long-term Opioid Therapy	3541
	Plan All-Cause Readmissions	1768 ¥

[52] In communicating total measure counts, the totals presented here represent the perspective of the scoring methodology, rather than the perspective of the measure steward. If counting based the perspective of the scoring methodology, there are 39 measures that are collected and used in scoring (rather than 36). The difference of three measures in this count comes from two factors. First, Prenatal and Postpartum Care is split into two distinct measures for the QRS hierarchy: *Timeliness of Prenatal Care* and *Postpartum Care*. Similarly, Proportion of Days Covered (NQF #0541) is split into three distinct measures: *Diabetes All Class, Renin Angiotensin System (RAS) Antagonists*, and *Statins.*

[53] The measure steward, NCQA, anticipates seeking NQF endorsement for the *Kidney Health Evaluation for Patients with Diabetes* measure at a later date.

QRS Summary Indicator	Measure Title	NQF ID (¥ indicates not currently endorsed)
	Breast Cancer Screening (BCS-E)	2372
	Cervical Cancer Screening	0032
	Colorectal Cancer Screening	0034
	Prenatal and Postpartum Care (Postpartum Care)	1517 ¥
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	1517 ¥
	Chlamydia Screening in Women	0033
	~~Flu Vaccinations for Adults Ages 18-64~~	~~0039~~
	Adult Immunization Status (AIS-E)*	3620
	Medical Assistance with Smoking and Tobacco Use Cessation	0027 ¥
	~~Annual Dental Visit~~	~~1388 ¥~~
	Oral Evaluation, Dental Services*	2517
	Social Need Screening and Intervention (SNS-E)*	N/A
	Childhood Immunization Status (Combination 10)	0038
	Immunizations for Adolescents (Combination 2)	1407
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024
	Well-Child Visits in the First 30 Months of Life	1392
	Child and Adolescent Well-Care Visits	N/A
Enrollee Experience	Access to Care	0006
	Care Coordination	0006
	Rating of All Health Care	0006
	Rating of Personal Doctor	0006
	Rating of Specialist	0006
Plan Efficiency, Affordability, & Management	~~Appropriate Testing for Pharyngitis~~	~~0002 ¥~~
	Appropriate Treatment for Upper Respiratory Infection	0069
	Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	0058
	Use of Imaging Studies for Low Back Pain	0052 ¥
	Access to Information	0007 ¥
	Plan Administration	0006
	Rating of Health Plan	0006

Appendix B. *Oral Evaluation, Dental Services* Measure Technical Specification

*Oral Evaluation, Dental Services (OED)**

Description

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

Eligible Population

Product line	Medicaid.
Ages	Under 21 years as of December 31 of the measurement year. Report four age stratifications and a total rate: • 0–2 years. • 3–5 years. • 6–14 years. • 15–20 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	180 days during the measurement year.
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	None.
Required exclusions	Exclude members who meet either of the following criteria: • Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*. • Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

Administrative Specification

Denominator	The eligible population.

Numerator[54]* A comprehensive or periodic oral evaluation (Oral Evaluation Value Set) with a dental provider (NUCC Provider Taxonomy Value Set) during the measurement year.

Data Elements for Reporting

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

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

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

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

*Use of the CDT codes by NCQA, including inclusion in HEDIS, is contingent on NCQA and the ADA/DQA entering into an appropriate license agreement.

Appendix C. *Adult Immunization Status* (AIS-E) Measure Technical Specification

*Adult Immunization Status (AIS-E)**

***Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO).**

Description	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
Measurement period	January 1–December 31.
Clinical recommendation statement	The Advisory Committee on Immunization Practices recommends annual influenza vaccination; and tetanus, diphtheria and acellular pertussis (Tdap) and/or tetanus and diphtheria (Td) vaccine; herpes zoster vaccine; and pneumococcal vaccination for adults at various ages.
Citations	Murthy, N., Wodi, A.P., Bernstein, H., McNally, V., Cineas, S., Ault, K. 2022. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years and Older—United States, 2022." MMWR Morb Mortal Wkly Rep 71:229–233. DOI: http://dx.doi.org/10.15585/mmwr.mm7107a1
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Influenza. – Product line: ▪ Exchange. – Age (as of the start of the measurement period, for each product line): ▪ 19–65 years. ▪ 66 years and older. – Race (for each product line): ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ 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.
- Td/Tdap.
    - Product line:
        - Exchange.
    - Age (as of the start of the measurement period, for each product line):
        - 19–65 years.
        - 66 years and older.
    - Race (for each product line):
        - Race—White.
        - Race—Black or African American.
        - Race—American Indian or Alaska Native.
        - Race—Asian.
        - Race—Native Hawaiian or Other Pacific Islander.
        - 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.
- Zoster.
    - Product line:
        - Exchange.
    - Age (as of the start of the measurement period, for each product line):
        - 50–65 years.
        - 66 years and older.
    - Race (for each product line):
        - Race—White.
        - Race—Black or African American.
        - Race—American Indian or Alaska Native.
        - Race—Asian.
        - Race—Native Hawaiian or Other Pacific Islander.
        - 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. • Pneumococcal. – Product line: ▪ Exchange. – Age (as of the start of the measurement period, for each product line): ▪ 66 years and older. – Race (for each product line): ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ 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	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 15* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Requirements:** All measure rates are specified based on clinical guideline recommendations for the age group included in the rate.

	Reporting: Product line stratifications are not included in the measure calculation logic and need to be programmed manually.
Definitions	
Participation **Participation period**	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. The measurement period.
Initial population	**Initial population 1** Members 19 years and older at the start of the measurement period who also meet the criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Members 50 years and older at the start of the measurement period who also meet the criteria for participation. **Initial population 4** Members 66 years and older at the start of the measurement period who also meet the criteria for participation.
Exclusions	**Exclusions 1** Members in hospice or using hospice services any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 4** Same as exclusions 1.
Denominator	**Denominator 1** The initial population 1, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** The initial population 3, minus exclusions. **Denominator 4** The initial population 4, minus exclusions.

Numerator	**Numerator 1—Immunization Status: Influenza** • Members who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period, ***or*** • Members with anaphylaxis due to the influenza vaccine any time before or during the measurement period. **Numerator 2—Immunization Status: Td/Tdap** • Members who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period, ***or*** • Members with a history of at least one of the following contraindications any time before or during the measurement period: – Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine. – Encephalitis due to the diphtheria, tetanus or pertussis vaccine. **Numerator 3—Immunization Status: Zoster** • Members who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, any time on or after the member's 50th birthday and before or during the measurement period, ***or*** • Members with anaphylaxis due to the herpes zoster vaccine any time before or during the measurement period. **Numerator 4—Immunization Status: Pneumococcal** • Members who were administered at least one dose of an adult pneumococcal vaccine on or after the member's 19th birthday and before or during the measurement period, ***or*** • Members with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period.

Data criteria (element level)

Value Sets:

- **AISE_HEDIS_MY2023-2.0.0**
  - Adult Influenza Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1913)
  - Adult Influenza Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1914)
  - Adult Pneumococcal Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2405)
  - Adult Pneumococcal Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2406)
  - Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2240)
  - Anaphylaxis Due to Herpes Zoster Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2379)
  - Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2241)
  - Herpes Zoster Live Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1915)
  - Herpes Zoster Live Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1917)
  - Herpes Zoster Recombinant Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1916)
  - Herpes Zoster Recombinant Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1918)
  - Influenza Virus LAIV Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1974)
  - Influenza Virus LAIV Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1973)
  - Td Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1923)
  - Td Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1924)
  - Tdap Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1791)
  - Tdap Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1792)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_Stratification-1.0.0**
  - American Indian or Alaska Native Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2365)
  - Asian Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2366)
  - Black or African American Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2367)

- Hispanic or Latino Detailed Ethnicity (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2368)
- Native Hawaiian or Other Pacific Islander Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2369)
- White Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2370)

Direct reference codes and codesystems:

- **AISE_HEDIS_MY2023-2.0.0**
  - codesystem "SNOMEDCT": 'http://snomed.info/sct/731000124108'
  - code "Anaphylaxis caused by vaccine product containing Influenza virus antigen (disorder)": '471361000124100' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine product containing Influenza virus antigen (disorder)'
  - code "Anaphylaxis caused by vaccine product containing Streptococcus pneumoniae antigen (disorder)": '471141000124102' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine product containing Streptococcus pneumoniae antigen (disorder)'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "NullFlavor": 'http://terminology.hl7.org/CodeSystem/v3-NullFlavor'
  - codesystem "RaceAndEthnicityCDC": 'https://www.hl7.org/fhir/us/core/CodeSystem-cdcrec'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "American Indian or Alaska Native": '1002-5' from "RaceAndEthnicityCDC" display 'American Indian or Alaska Native'
  - code "Asian": '2028-9' from "RaceAndEthnicityCDC" display 'Asian'
  - code "Asked but no answer": 'ASKU' from "NullFlavor" display 'Asked but no answer'
  - code "Black or African American": '2054-5' from "RaceAndEthnicityCDC" display 'Black or African American'
  - code "Hispanic or Latino": '2135-2' from "RaceAndEthnicityCDC" display 'Hispanic or Latino'
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "Native Hawaiian or Other Pacific Islander": '2076-8' from "RaceAndEthnicityCDC" display 'Native Hawaiian or Other Pacific Islander'
  - code "Non Hispanic or Latino": '2186-5' from "RaceAndEthnicityCDC" display 'Non Hispanic or Latino'
  - code "Other": 'OTH' from "NullFlavor" display 'Other'
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"
  - code "Unknown": 'UNK' from "NullFlavor" display 'Unknown'
  - code "White": '2106-3' from "RaceAndEthnicityCDC" display 'White'

Data Elements for Reporting

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

Table AIS-E-A:-4 Data Elements for Adult Immunization Status

Metric	Age	Data Element	Reporting Instructions
Influenza	19-65	InitialPopulation	For each Metric and Stratification
TdTdap	66+	ExclusionsByEHR	For each Metric and Stratification
	Total	ExclusionsByCaseManagement	For each Metric and Stratification
		ExclusionsByHIERegistry	For each Metric and Stratification
Zoster	50-65	ExclusionsByAdmin	For each Metric and Stratification
	66+	Exclusions	(Sum over SSoRs)
	Total	Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
Pneumococcal	66+	NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Table AIS-E-B-4: Data Elements for Adult Immunization Status: Stratifications by Race

Metric
Influenza
TdTdap
Zoster
Pneumococcal

Race	Source	Data Element	Reporting Instructions
White	Direct	InitialPopulation	For each Metric and Stratification
BlackOrAfricanAmerican	Indirect	Exclusions	For each Metric and Stratification
AmericanIndianOrAlaskaNative	Total	Denominator	For each Metric and Stratification
Asian		Numerator	For each Metric and Stratification
NativeHawaiianOrOtherPacificIslander		Rate	(Percent)
SomeOtherRace			
TwoOrMoreRaces			
AskedButNoAnswer*			
Unknown**			

Table AIS-E-C-4: Data Elements for Adult Immunization Status: Stratifications by Ethnicity

Metric
Influenza
TdTdap
Zoster
Pneumococcal

Ethnicity	Source	Data Element	Reporting Instructions
HispanicOrLatino	Direct	InitialPopulation	For each Metric and Stratification
NotHispanicOrLatino	Indirect	Exclusions	For each Metric and Stratification
AskedButNoAnswer*	Total	Denominator	For each Metric and Stratification
Unknown**		Numerator	For each Metric and Stratification
		Rate	(Percent)

*AskedButNoAnswer is only reported for Source='Direct.'
**Unknown is only reported for Source='Indirect.'

Appendix D. *Social Need Screening and Intervention* (SNS-E) Measure Technical Specification

Social Need Screening and Intervention (SNS-E)

Description	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. • *Food Screening.* The percentage of members who were screened for food insecurity. • *Food Intervention.* The percentage of members who received a corresponding intervention within 1 month of screening positive for food insecurity. • *Housing Screening.* The percentage of members who were screened for housing instability, homelessness or housing inadequacy. • *Housing Intervention.* The percentage of members who received a corresponding intervention within 1 month of screening positive for housing instability, homelessness or housing inadequacy. • *Transportation Screening.* The percentage of members who were screened for transportation insecurity. • *Transportation Intervention.* The percentage of members who received a corresponding intervention within 1 month of screening positive for transportation insecurity.
Measurement period	January 1–December 31.
Clinical recommendation statement	**American Academy of Family Physicians:** The AAFP urges health insurers and payors to provide appropriate payment to support health care practices to identify, monitor, assess, and address SDoH. **American Academy of Pediatrics:** The AAP recommends surveillance for risk factors related to social determinants of health during all patient encounters. **American Diabetes Association:** Assess food insecurity, housing insecurity/homelessness, financial barriers and social capital/social community support to inform treatment decisions, with referral to appropriate local community resources.
Citations	American Academy of Family Physicians. 2019. “Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position Paper).” https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html

	American Academy of Pediatrics. 2016. "Poverty and Child Health in the United States." https://pediatrics.aappublications.org/content/137/4/e20160339#sec-12 American Diabetes Association. 2022. "Standards of Medical Care in Diabetes-2022." Diabetes Care 45(Suppl 1): S4–7. DOI:10.2337/dc22-Srev The Gravity Project. "Terminology Workstream Dashboard." The Gravity Project Confluence, n.d. https://confluence.hl7.org/display/GRAV/Terminology+Workstream+Dashboard
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Food Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period, for each product line): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Food Intervention. – Product line: ▪ Exchange. – Age (as of the start of the measurement period, for each product line): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Housing Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period, for each product line): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Housing Intervention. – Product line: ▪ Exchange. – Age (as of the start of the measurement period, for each product line): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Transportation Screening.

	– Product line: ▪ Exchange. – Age (as of the start of the measurement period, for each product line): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Transportation Intervention. – Product line: ▪ Exchange. – Age (as of the start of the measurement period, for each product line): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 15* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Reporting:** The total is the sum of the age stratifications. Product line stratifications are not included in the measure calculation logic and need to be programmed manually.
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.
Food insecurity	Uncertain, limited or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways.
Housing instability	Currently consistently housed but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction.

Homelessness

Currently living in an environment that is not meant for permanent human habitation (e.g., cars, parks, sidewalks, abandoned buildings, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.

Housing inadequacy

Housing does not meet habitability standards.

Transportation insecurity

Uncertain, limited or no access to safe, reliable, accessible, affordable and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being or livelihood.

Food insecurity instruments

Eligible screening instruments with thresholds for positive findings include:

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel®[1]	95251-5	LA33-6
Hunger Vital Sign™[1] (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)®[1]	95400-8	LA33-6
	95399-2	LA33-6
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Housing instability, homelessness and housing inadequacy screening instruments

Eligible screening instruments with thresholds for positive findings include:

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
Children's Health Watch Housing Stability Vital Signs™1	98976-4	LA33-6
	98977-2	≥3
	98978-0	LA33-6
Health Leads Screening Panel®1	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93033-9	LA33-6
	71802-3	LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2

Transportation insecurity screening instruments

Eligible screening instruments with thresholds for positive findings include:

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes

	Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
	American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
	Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
	Health Leads Screening Panel®1	99553-0	LA33-6
	Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93030-5	LA30133-5 LA30134-3
	PROMIS®1	92358-1	LA30024-6 LA30026-1 LA30027-9
	WellRx Questionnaire	93671-6	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Interventions

An intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period.

- A positive food insecurity screen finding must be met by a food insecurity intervention.
- A positive housing instability or homelessness screen finding must be met by a housing instability or homelessness intervention.
- A positive housing inadequacy screen finding must be met by a housing inadequacy intervention.
- A positive transportation insecurity screen finding must be met by a transportation insecurity intervention.

Intervention may include any of the following intervention categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral.

Initial population

Initial population 1
Members of any age enrolled at the start of the measurement period who also meet criteria for participation.

Initial population 2
Same as the initial population 1.

Initial population 3
Same as the initial population 1.

Initial population 4
Same as the initial population 1.

	Initial population 5 Same as the initial population 1. **Initial population 6** Same as the initial population 1.
Exclusions	**Exclusions 1** • Members in hospice or using hospice services any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 4** Same as exclusions 1. **Exclusions 5** Same as exclusions 1. **Exclusions 6** Same as exclusions 1.
Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** All members in numerator 1 with a positive food insecurity screen finding between January 1 and December 1 of the measurement period. **Denominator 3** Same as denominator 1. **Denominator 4** All members in numerator 3 with a positive housing instability, homelessness or housing inadequacy screen finding between January 1 and December 1 of the measurement period. **Denominator 5** Same as denominator 1. **Denominator 6** All members in numerator 5 with a positive transportation insecurity screen finding between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1—Food Screening** Members in denominator 1 with a documented result for food insecurity screening performed between January 1 and December 1 of the measurement period.

	Numerator 2—Food Intervention Members in denominator 2 receiving a food insecurity intervention on or up to 30 days after the date of the first positive food insecurity screen (31 days total). **Numerator 3—Housing Screening** Members in denominator 3 with a documented result for housing instability, homelessness or housing inadequacy screening performed between January 1 and December 1 of the measurement period. **Numerator 4—Housing Intervention** Members in denominator 4 receiving an intervention corresponding to the type of housing need identified on or up to 30 days after the date of the first positive housing screen (31 days total). **Numerator 5—Transportation Screening** Members in denominator 5 with a documented result for transportation insecurity screening performed between January 1 and December 1 of the measurement period. **Numerator 6—Transportation Intervention** Members in denominator 6 receiving a transportation insecurity intervention on or up to 30 days after the date of the first positive transportation screen (31 days total).
Data criteria (element level)	
Value Sets: • **NCQA_Hospice-2.0.0** – Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761) – Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762) • **SNSE_HEDIS_MY2023-1.0.0** – Food Insecurity Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2262) – Homelessness Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2410) – Housing Instability Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2412) – Inadequate Housing Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2411) – Transportation Insecurity Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2264) ***Direct reference codes and codesystems:*** • **NCQA_Terminology-2.0.0** – codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode' – code "managed care policy": 'MCPOL' from "ActCode" – code "retiree health program": 'RETIRE' from "ActCode" – code "subsidized health program": 'SUBSIDIZ' from "ActCode"	

- **SNSE_HEDIS_MY2023-1.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Access to transportation/mobility status [CUBS]": '89569-8' from "LOINC" display 'Access to transportation/mobility status [CUBS]'
  - code "Always has enough food for family Caregiver": '96434-6' from "LOINC" display 'Always has enough food for family Caregiver'
  - code "Are you homeless or worried that you might be in the future [WellRx]": '93669-0' from "LOINC" display 'Are you homeless or worried that you might be in the future [WellRx]'
  - code "Are you worried about losing your housing [PRAPARE]": '93033-9' from "LOINC" display 'Are you worried about losing your housing [PRAPARE]'
  - code "At risk": 'LA19952-3' from "LOINC" display 'At risk'
  - code "At risk of becoming homeless Caregiver": '96441-1' from "LOINC" display 'At risk of becoming homeless Caregiver'
  - code "Behind on rent or mortgage in past 12 months": '98976-4' from "LOINC" display 'Behind on rent or mortgage in past 12 months'
  - code "Bug infestation": 'LA32691-0' from "LOINC" display 'Bug infestation'
  - code "Current level of confidence I can use public transportation [PROMIS]": '92358-1' from "LOINC" display 'Current level of confidence I can use public transportation [PROMIS]'
  - code "Delayed medical care due to distance or lack of transportation": '99594-4' from "LOINC" display 'Delayed medical care due to distance or lack of transportation'
  - code "Did you or others you live with eat smaller meals or skip meals because you didn't have money for food in the past 2 months [WellRx]": '93668-2' from "LOINC" display 'Did you or others you live with eat smaller meals or skip meals because you didnt have money for food in the past 2 months'
  - code "Do you have trouble finding or paying for transportation [WellRx]": '93671-6' from "LOINC" display 'Do you have trouble finding or paying for transportation [WellRx]'
  - code "Food": 'LA30125-1' from "LOINC" display 'Food'
  - code "Food insecurity risk [HVS]": '88124-3' from "LOINC" display 'Food insecurity risk [HVS]'
  - code "Food security status [U.S. FSS]": '95264-8' from "LOINC" display 'Food security status [U.S. FSS]'
  - code "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living": '93030-5' from "LOINC" display 'Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living'
  - code "Have you or any family members you live with been unable to get any of the following when it was really needed in past 1 year [PRAPARE]": '93031-3' from "LOINC" display 'Have you or any family members you live with been unable to get any of the following when it was really needed in past 1 year [PRAPARE]'
  - code "Homeless in past 12 months": '98978-0' from "LOINC" display 'Homeless in past 12 months'
  - code "Housing status": '71802-3' from "LOINC" display 'Housing status'
  - code "I am a little confident": 'LA30026-1' from "LOINC" display 'I am a little confident'
  - code "I am not at all confident": 'LA30024-6' from "LOINC" display 'I am not at all confident'
  - code "I am somewhat confident": 'LA30027-9' from "LOINC" display 'I am somewhat confident'

- code "I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)": 'LA31995-6' from "LOINC" display 'I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)'
- code "I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)": 'LA30190-5' from "LOINC" display 'I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)'
- code "I have a place to live today, but I am worried about losing it in the future": 'LA31994-9' from "LOINC" display 'I have a place to live today, but I am worried about losing it in the future'
- code "I have no access to transportation, public or private; may have car that is inoperable": 'LA29234-4' from "LOINC" display 'I have no access to transportation, public or private; may have car that is inoperable'
- code "In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food [U.S. FSS]": '95251-5' from "LOINC" display 'In the last 12 months, did you ever eat less than you felt you should because there wasnt enough money for food [U.S. FSS]'
- code "Inadequate heat": 'LA32694-4' from "LOINC" display 'Inadequate heat'
- code "Lack of heat": 'LA31998-0' from "LOINC" display 'Lack of heat'
- code "Lead paint or pipes": 'LA31997-2' from "LOINC" display 'Lead paint or pipes'
- code "Lead paint/pipes": 'LA32693-6' from "LOINC" display 'Lead paint/pipes'
- code "Low food security": 'LA30985-8' from "LOINC" display 'Low food security'
- code "Mold": 'LA28580-1' from "LOINC" display 'Mold'
- code "My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured": 'LA29232-8' from "LOINC" display 'My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured'
- code "My transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.": 'LA29233-6' from "LOINC" display 'My transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.'
- code "No": 'LA32-8' from "LOINC" display 'No'
- code "No or non-working smoke detectors": 'LA32696-9' from "LOINC" display 'No or non-working smoke detectors'
- code "Non-functioning oven/stove": 'LA32695-1' from "LOINC" display 'Non-functioning oven/stove'
- code "Number of residential moves in past 12 months": '98977-2' from "LOINC" display 'Number of residential moves in past 12 months'
- code "Often true": 'LA28397-0' from "LOINC" display 'Often true'
- code "Oven or stove not working": 'LA31999-8' from "LOINC" display 'Oven or stove not working'
- code "Pests such as bugs, ants, or mice": 'LA31996-4' from "LOINC" display 'Pests such as bugs, ants, or mice'
- code "Problems with place where you live": '96778-6' from "LOINC" display 'Problems with place where you live'
- code "Smoke detectors missing or not working": 'LA32000-4' from "LOINC" display 'Smoke detectors missing or not working'
- code "Sometimes true": 'LA6729-3' from "LOINC" display 'Sometimes true'

- code "Very low food security": 'LA30986-6' from "LOINC" display 'Very low food security'
- code "Water leaks": 'LA32001-2' from "LOINC" display 'Water leaks'
- code "Went without health care due to lack of transportation in last 12 months": '99553-0' from "LOINC" display 'Went without health care due to lack of transportation in last 12 months'
- code "Within the past 12 months the food we bought just didn't last and we didn't have money to get more [U.S. FSS]": '88123-5' from "LOINC" display 'Within the past 12 months the food we bought just didnt last and we didnt have money to get more [U.S. FSS]'
- code "Within the past 12 months the food we bought just didn't last and we didn't have money to get more Caregiver [U.S. FSS]": '95399-2' from "LOINC" display 'In the last 12 months, did the food you bought just not last and you didnt have money to get more?'
- code "Within the past 12 months we worried whether our food would run out before we got money to buy more [U.S. FSS]": '88122-7' from "LOINC" display 'Within the past 12 months we worried whether our food would run out before we got money to buy more [U.S. FSS]'
- code "Within the past 12 months we worried whether our food would run out before we got money to buy more Caregiver [U.S. FSS]": '95400-8' from "LOINC" display 'Within the past 12 months we worried whether our food would run out before we got money to buy more Caregiver [U.S. FSS]'
- code "Worried about housing stability in next 2 months": '99550-6' from "LOINC" display 'Worried about housing stability in next 2 months'
- code "Yes": 'LA33-6' from "LOINC" display 'Yes'
- code "Yes, it has kept me from medical appointments or from getting my medications": 'LA30133-5' from "LOINC" display 'Yes, it has kept me from medical appointments or from getting my medications'
- code "Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need": 'LA30134-3' from "LOINC" display 'Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need'

Data Elements for Reporting

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

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

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

**These metrics share an initial population. Repeat the initial population, denominator and exclusions data elements for all three screening metrics.*

Appendix E. *Depression Screening and Follow-Up for Adolescents and Adults* Measure Technical Specification

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)*

***Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS).**

Description	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (B recommendation) The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)
Citations	U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6. U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.
Characteristics	
Scoring **Type**	Proportion. Process.
Stratification	• Depression Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period, for each product line): ▪ 12–17 years (for commercial and Medicaid only). ▪ 18–64 years. ▪ 65 years and older. • Follow-Up on Positive Screen.

<table>
<tr><td></td><td>– Product line:
▪ Exchange.
– Age (as of the start of the measurement period, for each product line):
▪ 12–17 years (for commercial and Medicaid only).
▪ 18–64 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 participation period.

When identifying members in hospice, the requirements described in General Guideline 15 for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.

Requirements:
• This measure requires the use of an age-appropriate screening instrument. The member’s age is used to select the appropriate depression screening instrument.
• Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated.

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

Product line stratifications are not included in the measure calculation logic and need to be programmed manually.</td></tr>
<tr><td colspan="2">Definitions</td></tr>
<tr><td>Participation</td><td>The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the participation period.</td></tr>
<tr><td>Participation period</td><td>The measurement period.</td></tr>
<tr><td>Depression screening instrument</td><td>A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:
<table><tr><th>Instruments for Adolescents (≤17 years)</th><th>Positive Finding</th></tr></table></td></tr>
</table>

Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10
PROMIS Depression	Total score (T Score) ≥60

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.

Instruments for Adults (18+ years)	**Positive Finding**
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Beck Depression Inventory (BDI-II)	Total score ≥20
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total score ≥30
Geriatric Depression Scale Short Form (GDS)[1]	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10

Instruments for Adults (18+ years)	**Positive Finding**
My Mood Monitor (M-3)®	Total score ≥5
PROMIS Depression	Total score (T Score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	Total score ≥31

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.

Initial population

Initial population 1
Members 12 years of age and older at the start of the measurement period who also meet criteria for participation.

	Initial population 2 Same as the initial population 1.
Exclusions	**Exclusions 1** • Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period. • Members with depression that starts during the year prior to the measurement period. • Members in hospice or using hospice services any time during the measurement period. **Exclusions 2** Same as exclusions 1.
Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** All members from numerator 1 with a positive depression screen finding between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1—Depression Screening** Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period. **Numerator 2—Follow-Up on Positive Screen** Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. • A behavioral health encounter, including assessment, therapy, collaborative care or medication management. • A dispensed antidepressant medication. ***OR*** • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. ***Note:*** *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*
Data criteria (element level)	

Value Sets:

- **DSFE_HEDIS_MY2023-2.0.0**
  - Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1044)
  - Depression (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1390)
  - Other Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1399)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_Screening-1.0.0**
  - Antidepressant Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1503)
  - Behavioral Health Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1383)
  - Depression Case Management Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1389)
  - Depression or Other Behavioral Health Condition (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1501)
  - Follow Up Visit (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1385)
  - Symptoms of Depression (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2392)

Direct reference codes and codesystems:

- **DSFE_HEDIS_MY2023-2.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Beck Depression Inventory Fast Screen total score [BDI]": '89208-3' from "LOINC" display 'Beck Depression Inventory Fast Screen total score [BDI]'
  - code "Beck Depression Inventory II total score [BDI]": '89209-1' from "LOINC" display 'Beck Depression Inventory II total score [BDI]'
  - code "Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]": '89205-9' from "LOINC" display 'Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]'
  - code "Edinburgh Postnatal Depression Scale [EPDS]": '71354-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'
  - code "Final score [DUKE-AD]": '90853-3' from "LOINC" display 'Final score [DUKE-AD]'
  - code "Geriatric depression scale (GDS) short version total": '48545-8' from "LOINC" display 'Geriatric depression scale (GDS) short version total'
  - code "Geriatric depression scale (GDS) total": '48544-1' from "LOINC" display 'Geriatric depression scale (GDS) total'
  - code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
  - code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'

  - code "PROMIS-29 Depression score T-score": '71965-8' from "LOINC" display 'PROMIS-29 Depression score T-score'
  - code "Total score [CUDOS]": '90221-3' from "LOINC" display 'Total score [CUDOS]'
  - code "Total score [M3]": '71777-7' from "LOINC" display 'Total score [M3]'
- **NCQA_Screening-1.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Exercise counseling": 'Z71.82' from "ICD-10-CM" display 'Exercise counseling'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"

Data Elements for Reporting

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

Table DSF-E-1/2: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults

Metric	Age	Data Element	Reporting Instructions
Screening	12-17	InitialPopulation	For each Metric and Stratification
FollowUp	18-64	ExclusionsByEHR	For each Metric and Stratification
	65+	ExclusionsByCaseManagement	For each Metric and Stratification
	Total	ExclusionsByHIERegistry	For each Metric and Stratification
		ExclusionsByAdmin	For each Metric and Stratification
		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)

Table DSF-E-3: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults

Metric	Age	Data Element	Reporting Instructions
Screening	18-64	InitialPopulation	For each Metric and Stratification
FollowUp	65+	ExclusionsByEHR	For each Metric and Stratification

	Total	ExclusionsByCaseManagement	For each Metric and Stratification
		ExclusionsByHIERegistry	For each Metric and Stratification
		ExclusionsByAdmin	For each Metric and Stratification
		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)

Appendix F. *HbA1c Control for Patient with Diabetes: HbA1c Poor Control (>9.0%)* Measure Technical Specification

Hemoglobin A1c Control for Patients With Diabetes (HBD)

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c Poor Control (>9.0%).

Note: *Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.*

Eligible Population

Product lines

Exchange.

Stratification

For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:

- *Race:*
  - White.
  - Black or African American.
  - American Indian or Alaska Native.
  - Asian.
  - Native Hawaiian or Other Pacific Islander.
  - Some Other Race.
  - Two or More Races.
  - Asked but No Answer.
  - Unknown.
  - Total.
- *Ethnicity:*
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked but No Answer.
  - Unknown.
  - Total.

Note: *Stratifications are mutually exclusive and the sum of all categories in each stratification is the total population.*

Ages

18–75 years as of December 31 of the measurement year.

Continuous enrollment

The measurement year.

Allowable gap

No more than one gap in enrollment of up to 45 days during the measurement year. 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.

Event/diagnosis There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. 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. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes 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.
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.
     - Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription	
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol

Description	Prescription		
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide	• Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding Farxiga®)	• Ertugliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Required exclusions

Exclude members who meet any of the following criteria:

- Members who did not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.*

- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.

Exclusions Exclude members who meet any of the following criteria:

Note: *Supplemental and medical record data may not be used for these exclusions.*

- 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** of the following frailty and advanced illness criteria to be excluded:
  1. 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.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
     - Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
     - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness 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.
     - A dispensed dementia medication (Dementia Medications List).

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine

Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Administrative Specification

Denominator The eligible population.

Numerator

HbA1c Poor Control >9% Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Greater Than 9.0 Value Set	Compliant

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the Hemoglobin A1c Control for Patients With Diabetes (HBD), Eye Exam for Patients With Diabetes (EED) and Blood Pressure Control for Patients With Diabetes (BPD) measures may use the same sample for all three measures. If the same sample is used for the three diabetes measures, the organization must first take the inverse of the HbA1c poor control >9.0% rate (100 minus the HbA1c poor control rate) before reducing the sample.

Organizations may reduce the sample size based on the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate of all HBD indicators and EED and BPD measures.

If separate samples are used for the HBD, EED and BPD measures, organizations may reduce the sample based on the product line-specific current measurement year's administrative rate or the prior year's audited, product line-specific rate for the measure.

Refer to the *Guidelines for Calculations and Sampling* for information on reducing sample size.

Numerator

HbA1c Poor Control >9% The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through laboratory data or medical record review.

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Note

- *If a combination of administrative, supplemental or hybrid data are used, the most recent HbA1c result must be used, regardless of data source.*

Data Elements for Reporting

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

Table HBD-A-4: Data Elements for Hemoglobin A1c Control for Patients With Diabetes

Metric	Data Element	Reporting Instructions	A
PoorHbA1cControl	CollectionMethod	Report once	✓
	EligiblePopulation*	Report once	✓
	ExclusionAdminRequired*	Report once	✓
	NumeratorByAdminElig	Report once	
	CYAR	(Percent)	
	MinReqSampleSize	Report once	
	OversampleRate	Report once	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Report once	
	ExclusionEmployeeOrDep	Report once	
	OversampleRecsAdded	Report once	
	Denominator	Report once	
	NumeratorByAdmin	Report once	✓
	NumeratorByMedicalRecords	Report once	
	NumeratorBySupplemental	Report once	✓
	Rate	(Percent)	✓

Table HBD-B-4: Data Elements for Hemoglobin A1c Control for Patients With Diabetes: Stratifications by Race

Metric
PoorHbA1cControl

Race	Source	Data Element	Reporting Instructions	A
White	Direct	CollectionMethod	Repeat per Stratification	✓
BlackOrAfricanAmerican	Indirect	EligiblePopulation*	For each Stratification	✓
AmericanIndianOrAlaskaNative	Total	Denominator	For each Stratification	
Asian		Numerator	For each Stratification	✓
NativeHawaiianOrOtherPacificIslander		Rate	(Percent)	✓
SomeOtherRace				
TwoOrMoreRaces				
AskedButNoAnswer**				
Unknown***				

Table HBD-C-4: Data Elements for Hemoglobin A1c Control for Patients With Diabetes: Stratifications by Ethnicity

Metric
PoorHbA1cControl

Ethnicity	Source	Data Element	Reporting Instructions	A
HispanicOrLatino	Direct	CollectionMethod	Repeat per Stratification	✓
NotHispanicOrLatino	Indirect	EligiblePopulation*	For each Stratification	✓
AskedButNoAnswer**	Total	Denominator	For each Stratification	
Unknown***		Numerator	For each Stratification	✓
		Rate	(Percent)	✓

*Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the Administrative Method.
**AskedButNoAnswer is only reported for Source='Direct.'
***Unknown is only reported for Source='Indirect.'

Appendix G. *Enrollment by Product Line* (ENP) Measure Technical Specification

Enrollment by Product Line (ENP)

Description

The total number of members enrolled in the product line, stratified by age.

Calculations

Product lines Report the following tables for each applicable product line, stratified by age:

- Table ENP-4 Exchange.

Member months For each product line, report all member months for the measurement year. IDSS will convert these to member years. Refer to *Specific Instructions for Utilization Tables* for more information.

Table ENP-4: Data Elements for Enrollment by Product Line

Metric	Age	Data Element	Reporting Instructions
Enrollment	LessThan1	MemberMonths	For each Stratification
	1-4	Rate	(Member Years)
	5-9		
	10-14		
	15-17		
	18-19		
	20-24		
	25-29		
	30-34		
	35-39		
	40-44		
	45-49		
	50-54		
	55-59		
	60-64		
	65-69		
	70-74		
	75-79		
	80-84		
	85-89		
	90+		
	Unknown		
	Total		