Rhode Island Accountable Entity Program

Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities:

Quality Measure Specifications Manual

Specifications for Program Years 5 through 7

Rhode Island Executive Office of Health and Human Services (EOHHS)
September 29, 2023

A full revision history can be found at the end of the manual, before Appendix A.

Contents

Revision History

Version	Date	Revisions
1.0	3/1/23	Initial version of quality measure specifications manual.
1.1	5/31/23	• Updated *SDOH Screening* for QPY6 to clarify that there are two options for demonstrating numerator compliance. • Updated *RELD Measure* for QPY6 to remove reference to a diagnosis of secondary diabetes in alignment with CMS measure specification changes. • Relabeled Appendices.
2.1	8/10/23	• Updated to include PY7 specifications for *Patient Engagement with an AE Primary Care Provider*, *SDOH Screening* and *Potentially Avoidable ED Visits*.

Appendix A: Screening for Depression and Follow-up Plan (QPY5)

Steward: Centers for Medicare and Medicaid Services Merit-based Incentive Payment System 2022, Modified by Rhode Island Executive Office of Health and Human Services
As of April 20, 2022

SUMMARY OF CHANGES FOR 2022 (PERFORMANCE YEAR 5)

- Updated the codes to identify patient encounters for the denominator to align with the CMS MIPS 2022 specifications.
- Updated the definition of eligible follow-up plans and the guidance to define "follow-up" to include "referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen."
- Added F32.A to the denominator exclusions.

Description

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

Definitions

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool	A normalized and validated depression screening tool developed for the patient population in which it is being utilized. An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. Examples of screenings tools include but are not limited to those provided in the three rows below.
Adolescent Screening Tools (12-17 Years)	Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2.
Adult Screening Tools (18 Years and Older)	Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale or Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD).

Perinatal Screening Tools	Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale.
Positive Depression Screen	The definition of a positive depression screen varies based on the standardized depression screening tool. See the "Positive Depression Screen Crosswalk" section below for more information on what constitutes a positive depression screen for each tool. Practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.
Follow-up Plan	Documented follow-up for a positive depression screening ***must*** include one or more of the following: • Referral to a referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression Please refer to the "Guidance to Define "Follow-up"" section below for more information on what is an eligible follow-up plan.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	Ages 12 and older
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Event/diagnosis	Patient has at least one eligible encounter during the measurement period. See the "Denominator" section below for a list of eligible encounters.
Exclusions	Patients who have had a diagnosis for depression or a diagnosis of

	bipolar disorder prior to the eligible encounter.
Exceptions	• Patient refuses to participate • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (e.g., certain court appointed cases or delirium)

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[1]

Administrative Specification[2]

Denominator	The eligible population 1. Patients aged ≥12 years on date of encounter AND 2. Patient encounter during the performance period: a. Eligible CPT/HCPCS office visit codes: 59400, 59510, 59610, 59618, 90791–90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161–97163, 97165–97167, 99078, 99202–99205, 99212–99215, 99304–99310, 99315–99316, 99318, 99324–99328, 99334–99337, 99339–99340, 99401–99403, 99483–99484, 99492–

[1] https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[2] Modified from: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2020_Measure_134_MIPSCQM.pdf.

	99493, 99384–99387, 99394–99397, G0101, G0402, G0438–G0439, G0444 b. Eligible telephone visit, e-visit or virtual check-in codes: i. CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ii. Any of the above CPT/HCPCS codes in 1 or 2.a. with the following POS codes: 02 iii. Any of the above CPT/HCPCS codes in 2 or 2.a. with the following modifiers: 95, GT AND NOT 3. Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder: G9717 AND NOT 4. Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) – a. Patients who have been diagnosed with depression - F01.51, F32.A, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345 b. Patients who have been diagnosed with bipolar disorder - F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9 AND NOT 5. Patients with a Documented Reason for not Screening for Depression (Denominator Exception) – One or more of the following conditions are documented during the encounter during the measurement period: a. Patient refuses to participate b. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status c. Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter

	1. Performance Met: Screening for depression is documented as being positive AND a follow-up plan is documented (G8431) OR 2. Performance Met: Screening for depression is documented as negative, a follow-up plan is not required (G8510) OR 3. Denominator Exception: Screening for depression not completed, documented reason (G8433) OR 4. Performance Not Met: Depression screening not documented, reason not given (G8432) OR 5. Performance Not Met: Screening for depression documented as positive, follow-up plan not documented, reason not given (G8511) **Note**: See "Positive Depression Screen Crosswalk" section below for more information on what constitutes a positive depression screen for the purpose of this measure. Practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.

Clinical Specification[3]

Denominator	The eligible population
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter **Note**: See "Positive Depression Screen Crosswalk" section below for more information on what constitutes a positive depression screen for the purpose of this measure. Practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen

[3] Modified from: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Web-Interface-Measures/2020_Measure_PREV12_CMSWebInterface_v4.1.pdf.

	overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.

Positive Depression Screen

The list of standardized depression screening tools included in the measure specifications differ in what they are evaluating. For example, some tools are designed to detect different levels of severity of depression (e.g., the PHQ-9), whereas others do not.

EOHHS has adopted a score of 10+ as an indication of a positive score for the PHQ-9. This is commonly accepted as the cut-point for moderate depression and is identified as a positive depression score by NCQA in its "Depression Screening and Follow-up for Adolescents and Adults" measure.[4] The table below identifies the definition of a positive screen for the other screening tools included in the measure specifications, which is usually the score used to identify moderate depression. The table also indicates if a tool has multiple cut points for a positive score or does not have a clear definition of a positive screen.

As a reminder, practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
Patient Health Questionnaire for Adolescents (PHQ-A)	Adolescent (12-17 years)	A score of 10+ (could be indicative of moderate depression)[5,6]
Beck Depression Inventory-Primary Care Version (BDI-PC)	Adolescent (12-17 years)	A score of 8+ (could be indicative of moderate depression)[7]

[4] National Committee for Quality Assurance (NCQA). "Proposed Changes to Existing Measures for HEDIS MY 2020: Depression Screening and Follow-up Measures." https://www.ncqa.org/wp-content/uploads/2020/02/20200212_18_Depression_Measures.pdf. Accessed April 26, 2021.

[5] This tool is sometimes referred to as the Patient Health Questionnaire Modified for Teens (PHQ-9M). American Academy of Child & Adolescent Psychiatry. "Scoring the PHQ-9 Modified for Teens." https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf. Accessed April 20, 2021.

[6] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.

[7] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
Beck Depression Inventory (BDI or BDI-II)	Adult (18 years and older), Perinatal	A score of 20+ (could be indicative of moderate depression)[8,9]
Computerized Adaptive Diagnostic Screener (CAD-MDD)	Adult (18 years and older)	No clear cutoff for a positive score, as the tool is adaptive and does not have all patients answer the same questions[10]
Computerized Adaptive Testing Depression Inventory (CAT-DI)	Adult (18 years and older)	A score of 66+ (could be indicative of moderate symptoms of depression)[11]
Center for Epidemiologic Studies Depression Scale (CES-D)	Adolescent (12-17 years), Adult (18 years and older), Perinatal	A score of 17+ (could be indicative of clinical depression)[12,13,14]
Cornell Scale for Depression in Dementia (CSDD)	Adult (18 years and older)	A score of 6+ (could be indicative of presence of depressive symptoms)[15,16,17]
Depression Scale (DEPS)	Adult (18 years and older)	A score of 9+ (could be indicative of any level of depression)[18]
Duke Anxiety Depression Scale (DADS)	Adult (18 years and older)	A score of 5+ (could be indicative of anxiety and/or depression symptoms)[19]
Edinburgh Postnatal Depression Scale	Perinatal	A score of 10+ (could be indicative of

[8] The National Child Traumatic Stress Network. "Beck Depression Inventory-Second Edition." https://www.nctsn.org/measures/beck-depression-inventory-second-edition. Accessed April 26, 2021.
[9] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[10] Graham, A.K., Minc, A., Staab, E., Beiser, D.G., Gibbons, R.D., Laiteerapong, N. (2019). "Validation of the Computerized Adaptive Test for Mental Health in Primary Care." *Annals of Family Medicine*, 17(1): 23-30. https://www.annfammed.org/content/annalsfm/17/1/23.full.pdf. Accessed April 20, 2021.
[11] Ibid.
[12] American Psychological Association. (2011). "Center for Epidemiological Studies-Depression." https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/depression-scale. Accessed April 20, 2021.
[13] Boyd, J.H., Weissman, M.M., Thompson, W.G., Myers, J.K. (1982). "Screening for Depression in a Community Sample: Understanding the Discrepancies between Depression Symptom and Diagnostic Scales. *Archives of General Psychiatry*, 39(10)L 1195-1200. https://doi.org/10.1001/archpsyc.1982.04290100059010.
[14] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[15] Alexopoulos, G.S. (2002). "The Cornell Scale for Depression in Dementia: Administration and Scoring Guidelines." *Cornell Institute of Geriatric Psychiatry*. http://www.scalesandmeasures.net/files/files/The%20Cornell%20Scale%20for%20Depression%20in%20Dementia.pdf. Accessed April 26, 2021.
[16] Bienenfeld, D and Stinson, K.N. (December 23, 2018). "Screening Tests for Depression." Medscape. https://emedicine.medscape.com/article/1859039-overview#a1. Accessed April 20, 2021.
[17] Edelstein, B.A., Drozdick, L.W., Ciliberti, C.M. (2010). "Assessment of Depression and Bereavement in Older Adults" in *Handbook of Assessment in Clinical Gerontology*. https://www.sciencedirect.com/science/article/pii/B9780123749611100016. Accessed April 29, 2021.
[18] Poutanen, O., Koivisto, A.M., Kaaria, S., Salokangas, K.R. (2010). "The Validity of the Depression Scale (DEPS) to Assess the Severity of Depression in Primary Care Patients." *Family Practice*, 27(5): 527-534. https://academic.oup.com/fampra/article/27/5/527/717051. Accessed April 20, 2021.
[19] Duke University Medical Center. (2016). "Duke Anxiety-Depression Scale." https://fmch.duke.edu/sites/cfm.duke.edu/files/cfm/Research/HealthMeasures/DukeAD.pdf. Accessed April 20, 2021.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
		possible depression)[20,21]
Geriatric Depression Scale (GDS)	Adult (18 years and older)	A score of 10+ (for the 30-item survey) [could be indicative of mild depression][22,23] A score of 5+ (for the 15-item survey) [could be indicative of depression][24,25] A score of 2+ (for the 5-item scale) [could be indicative of depression][26]
Hamilton Rating Scale for Depression (HAM-D)	Adult (18 years and older)	A score of 20+ (could be indicative of moderately severe depression)[27]
Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)	Adult (18 years and older)	A score of 11+ (could be indicative of moderate depression)[28]
Mood Feeling Questionnaire (MFQ)	Adolescent (12-17 years)	A score of 8+[29] or 11+[30] on the short questionnaire for children (could be indicative of major depression)
Patient Health Questionnaire (PHQ-9)	Adolescent (12-17 years), Adult (18 years and older), Perinatal	A score of 10+ (could be indicative of moderate depression)[31,32]
Pediatric Symptom Checklist (PSC-17)	Adolescent (12-17 years)	The following scores could be indicative of psychological impairment (not solely focused on depression) and suggests the need for further evaluation:

[20] University of California San Francisco School of Medicine Fresno. "Edinburgh Postnatal Depression Scale." https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf. Accessed April 20, 2021.
[21] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[22] Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M., Leirer, V.O. (1983). "Development and Validation of a Geriatric Depression Screening Scale: A Preliminary Report." *Journal of Psychiatric Research*, 17:37-49. https://img.medscape.com/pi/emed/ckb/psychiatry/285911-1335297-1859039-1859094.pdf. Accessed April 26, 2021.
[23] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[24] Anderson, J.E., Michalak, E.E., Lam, R.W. (2002). "Depression in Primary Care: Tools for Screening, Diagnosis and Measuring Response to Treatment." British Columbia Medical Journal, 44(8): 415-419. https://bcmj.org/articles/depression-primary-care-tools-screening-diagnosis-and-measuring-response-treatment. Accessed April 20, 2021.
[25] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[26] Bienenfeld and Stinson.
[27] Bienenfeld and Stinson.
[28] IDS-QIDS. (2021). "Interpretation: Inventory of Depressive Symptomatology (IDS) and Quick Inventory of Depressive Symptomatology (QIDS)." http://ids-qids.org/interpretation.html. Accessed April 26, 2021.
[29] Seattle Children's Hospital. "Short Mood and Feelings Questionnaire." https://www.seattlechildrens.org/globalassets/documents/healthcare-professionals/pal/ratings/smfq-rating-scale.pdf. Accessed April 29, 2021.
[30] University of Washington. "Moods and Feelings Questionnaire." https://depts.washington.edu/uwhatc/PDF/TF-%20CBT/pages/3%20Assessment/Standardized%20Measures/Moods%20and%20Feelings%20Questionnaire%202.08.pdf. Accessed April 28, 2021.
[31] This definition was developed by the AE/MCO Work Group.
[32] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
		A score of 28+ for ages 6-16 A score of 24+ for ages 4-5 A score of 30+ for the PSC-Y for ages 11+[33]
Postpartum Depression Screening Scale	Perinatal	A score of 80+ (indicates that a woman has a high probability of depression)[34]
PRIME MD-PHQ-2	Adolescent (12-17 years), Adult (18 years and older)	A score of 3+ (could be indicative of having depression symptoms, but developer recommends administration of a PHQ-9, GAD-7 or other screening tool to determine whether a mental health condition is present)[35,36]
Zung Self-rating Depression Scale	Perinatal	A score of 60+ (could be indicative of moderate depression)[37]

Guidance to Define "Follow-up"

This section identifies what does and does not classify as an eligible "follow-up plan" for the Screening for Depression and Follow-up Plan measure. It does not provide any clinical guidance on the diagnosis or treatment of depression. For more guidance on that topic, consider referring to sources such as the American Psychological Association[38] and the Institute for Clinical Systems Improvement.[39]

According to the measure specifications, "Documented follow-up for a positive depression screening **must** include one or more of the following:

- Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression"

[33] Bright Futures. "Instructions for Using Pediatric Symptom Checklist." https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf. Accessed April 20, 2021.
[34] Mancini, F., Carlson, C., Albers, L. (2007). "Use of the Postpartum Depression Screening Scale in a Collaborative Obstetric Practice." *Journal of Midwifery & Women's Health*, 52(5): 429-434. https://www.medscape.com/viewarticle/563220. Accessed April 20, 2021.
[35] Pfizer. "Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures." https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf. Accessed April 20, 2021.
[36] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[37] Bienenfeld and Stinson.
[38] American Psychological Association. "Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts." https://www.apa.org/depression-guideline. Accessed April 26, 2021.
[39] Trangle, M., Gursky, J., Haight, R., Hardwig, J., Hinnenkamp, T., Kessler, D., Mack, N. and Myszkowski, M. (2016). "Health Care Guideline: Adult Depression in Primary Care." *Institute for Clinical Systems Improvement*. https://www.icsi.org/wp-content/uploads/2019/01/Depr.pdf. Accessed April 2, 2021.

Please note that additional evaluation or assessment for depression and suicide risk assessment are no longer considered eligible follow-up activities according to CMS as of 2021. The measure assesses the most recent depression screen completed during the eligible encounter or within 14 days prior to the encounter. Therefore, an additional screen performed during the eligible encounter would serve as the most recent screen that, if positive, should have additional follow-up. Should a patient screen positive for depression, a clinician should opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. A suicide risk assessment no longer qualifies as a follow-up plan for the purposes of this measure as the patient could potentially harm themselves, which would be considered an urgent or emergent situation, i.e., an eligible exception outlined in the measure specifications.[40]

Each action that is classified as an eligible "follow-up plan" component is defined further below. Please note that follow-up planning must be provided by a licensed provider or by an ancillary provider working under the general supervision of the licensed provider. The documented follow-up plan must be related to a positive depression screen. For example, "Patient referred for psychiatric evaluation due to positive depression screening."[41]

Referral to a provider for additional evaluation and assessment to formulate a plan for a positive depression screen. This can include, but is not limited to, referral to a psychiatrist, psychologist, social worker, mental health counselor, and/or to a mental health service such as family or group therapy, support group or depression management program.

This can also include a warm hand-off to a behavioral health clinician embedded within the practice.[42]

The referral to a practitioner or program for further evaluation for depression must be made on the date of the eligible encounter for it to be an eligible follow-up action. The patient, however, can make a follow-up appointment with the practitioner or program on a subsequent date.

Pharmacologic interventions. This can include a prescription for antidepressants, including tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs) and atypical antidepressants (e.g., bupropion, mirtazapine, nefazodone, trazodone, etc.)). It can also include a prescription for other

[40] [Email from CMS Practice Improvement and Measures Management Support (PIMMS) Team]. (May 3, 2021).
[41] Oregon Health Authority. (2014). "Depression Screening and Follow-Up Plan Guidance Document." https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Depression-Screening-Guidance-Document.pdf. Accessed April 14, 2021.
[42] Savoy, M. and O'Gurek, D. (2016). "Screening Your Adult Patients for Depression." *Fam Pract Manag,* 23(2): 16-20. https://www.aafp.org/fpm/2016/0300/p16.html. Accessed April 13, 2021.

medications, such as antipsychotics, for the treatment of depression as advised by the practitioner.[43,44,45]

The prescription must be written on the date of the eligible encounter for it to be an eligible follow-up action. The prescription, however, can be filled by the patient on a subsequent date.

Treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect. There may be some instances in which a patient refuses pharmacologic intervention due to the risks associated with antidepressants, even when the provider advises starting treatment.[46]

Other interventions or follow-up for the diagnosis or treatment of depression. This can include behavioral health evaluation,[47] psychotherapy or additional treatment options.

Examples of psychotherapy can include cognitive behavioral therapy (CBT), interpersonal therapy (IPT), dialectical behavior therapy, psychodynamic therapy, psychoanalysis, supportive therapy and more.[48]

Additional treatment options can include enrolling the patient in a collaborative care model to treat and manage depression,[49] acupuncture, or St. John's wort.[50]

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[43] Mulder, R., Hamilton, A., Irwin, L., Boyce, P., Morris, G., Porter, R.J., Malhi, G.S. (October 16, 2018). "Treating Depression with Adjustive Antipsychotics." *Bipolar Disorders*, 20(52), 17-24. https://doi.org/10.1111/bdi.12701.

[44] While not an eligible follow-up activity for the purposes of this measure, a provider could consider having a registered nurse (RN) or pharmacist follow-up with (1) the patient in three to five weeks to assess the effectiveness and side effects of the medication and (2) the prescribing provider to discuss titration of the medication.
[Email from J. Gates]. (April 26, 2021).

[45] If necessary and deemed appropriate, a provider should consider a follow-up assessment with a pharmacist or trained nurse specialist on medication adherence for depression. Such follow-up is typically conducted after an individual has been on a prescription for some time, i.e., would occur on a date other than the eligible encounter, and therefore would not be considered an eligible follow-up activity.
U.S. Preventive Services Task Force. (2016). "Depression in Adults: Screening." https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening#fullrecommendationstart. Accessed April 13, 2021.

[46] Ibid.

[47] Behavioral health evaluation is an eligible follow-up activity if it is performed by a provider other than the provider that conducted the initial positive screen because it would be classified as a "referral to a practitioner or program for further evaluation for depression." It is also an eligible follow-up activity if behavioral health evaluation is used as an intervention to treat depression.
[Email from CMS PIMMS Team]. (May 3, 2021).

[48] Parekh, R., Givon, L. (January 2019). "What Is Psychotherapy?" American Psychiatric Association. https://www.psychiatry.org/patients-families/psychotherapy. Accessed April 26, 2021.

[49] Community Preventive Services Task Force. (2010). "Improving Mental Health and Addressing Mental Illness: Collaborative Care for the Management of Depressive Disorders." https://www.thecommunityguide.org/sites/default/files/assets/Mental-Health-Collaborative-Care.pdf. Accessed April 14, 2021.

[50] Agency for Healthcare Research and Quality. (2015). "Nonpharmacological Versus Pharmacological Treatment for Adult Patients with Major Depressive Disorder." https://pubmed.ncbi.nlm.nih.gov/26764438/. Accessed April 14, 2021.

It can also include a follow-up assessment with a community health worker or medical assistant with a practice-approved checklist.[51]

Continuation of an existing treatment for a behavioral health condition other than depression that can also aid in the treatment of a newly diagnosed case of depression, as described above, is an eligible follow-up action.

For all of the above examples, referrals to or receipt of psychotherapy or other treatment options must be made on the date of the eligible encounter for it to be an eligible follow-up action. The patient, however, can make an appointment with the provider on a subsequent date.

Additional treatment options do **not** include those explicitly excluded in the measure specifications, i.e., additional evaluation or assessment for depression or suicide risk assessment, follow-up conducted by non-licensed provider that is not working under the supervision of a licensed provider, follow-up conducted on a day other than the eligible encounter.

There may be situations in which a patient has a positive screen for depression, but a provider on the basis of their clinical judgment does not implement one of the specified follow-up actions. This is why the target for this measure will never be 100%.

[51] While not an eligible follow-up activity for the purpose of this measure, any concerning findings from the checklist should result in a follow-up assessment by a RN or a visit with a provider within seven days. [Email from J. Gates]. (April 26, 2021).

Appendix B: Screening for Depression and Follow-up Plan (QPY6)

Steward: Centers for Medicare and Medicaid Services Merit-based Incentive Payment System 2023, Modified by Rhode Island Executive Office of Health and Human Services
As of January 26, 2023

SUMMARY OF CHANGES FOR 2023 (PERFORMANCE YEAR 6)

- Updated measure description to indicate a follow-up plan can be documented up to two days after the date of the qualifying encounter.
- Updated the denominator exclusion and exception language to align with the MIPS 2023 specifications to address non-substantive differences.
- Updated the codes used to identify the denominator and denominator exclusions.

Description

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Definitions

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool	A normalized and validated depression screening tool developed for the patient population in which it is being utilized. An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. Examples of screenings tools include but are not limited to those provided in the three rows below.
Adolescent Screening Tools (12-17 Years)	Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2.
Adult Screening Tools (18 Years and Older)	Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale or Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD).

Perinatal Screening Tools	Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale.
Positive Depression Screen	The definition of a positive depression screen varies based on the standardized depression screening tool. See the "Positive Depression Screen Crosswalk" section below for more information on what constitutes a positive depression screen for each tool. Practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.
Follow-up Plan	Documented follow-up for a positive depression screening ***must*** include one or more of the following: • Referral to a referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression Please refer to the "Guidance to Define "Follow-up"" section below for more information on what is an eligible follow-up plan.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	Ages 12 and older
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Event/diagnosis	Patient has at least one eligible encounter during the measurement period. See the "Denominator" section below for a list of eligible encounters.
Exclusions	Patients who have been diagnosed with depression or with bipolar

	disorder.

Exceptions	• Patient refuses to participate
	• Documentation of medical reason for not screening patient for depression
	  ○ Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
	  ○ Cognitive, functional capacity or motivational limitations that may impact the accuracy of results

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[52]

Administrative Specification[53]

Denominator	The eligible population 1. Patients aged ≥12 years on date of encounter AND 2. Patient qualifying encounter during the performance period: a. Eligible CPT/HCPCS office visit codes: 59400, 59510, 59610, 59618, 90791–90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161–97167, 98966-98968, 99078, 99202–99205, 99212–99215, 99304–99310, 99315–99316, 99341, 99324, 99344-99345, 99347–

[52] https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

[53] Modified from MIPS Measure 134 (specifications found here: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2238/2023%20MIPS%20Measure%20Specifications%20and%20Activity%20Descriptions.pdf)..

	99350, 99401–99403, 99424, 99441–99443, 99483–99484, 99491–99493, 99384–99387, 99394–99397, G0101, G0402, G0438–G0439, G0444 b. Eligible telephone visit, e-visit or virtual check-in codes: i. CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ii. Any of the above CPT/HCPCS codes in 1 or 2.a. with the following POS codes: 02 iii. Any of the above CPT/HCPCS codes in 2 or 2.a. with the following modifiers: 95, GT AND NOT 3. Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder: G9717 AND NOT 4. Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) – a. Patients who have been diagnosed with depression - F01.51, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F32.A, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345 i. For historical reference purposes, these ICD-9 codes are also sufficient - 290.13, 290.21, 290.43, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 296.81, 296.82, 298.0, 300.4, 301.12, 309.0, 309.1, 309.28, 311 b. Patients who have been diagnosed with bipolar disorder – F30.2, F30.3, F30.4, F30.8, F30.9, F30.10, F30.11, F30.12, F30.13, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9 i. For historical reference purposes, these ICD-9 codes are also sufficient – 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52,

	296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.81, 296.82, 296.89 AND NOT 5. Patients with a Documented Reason for not Screening for Depression (Denominator Exception) – One or more of the following conditions are documented during the encounter during the measurement period: a. Patient refuses to participate b. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status c. Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter 1. Performance Met: Screening for depression is documented as being positive AND a follow-up plan is documented (G8431) OR 2. Performance Met: Screening for depression is documented as negative, a follow-up plan is not required (G8510) OR 3. Denominator Exception: Screening for depression not completed, documented reason (G8433) OR 4. Performance Not Met: Depression screening not documented, reason not given (G8432) OR 5. Performance Not Met: Screening for depression documented as positive, follow-up plan not documented, reason not given (G8511) **Note**: See "Positive Depression Screen Crosswalk" section below for more information on what constitutes a positive depression screen for the purpose of this measure. Practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered

	numerator non-compliant.

Clinical Specification[54]

Denominator	The eligible population
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter **Note**: See "Positive Depression Screen Crosswalk" section below for more information on what constitutes a positive depression screen for the purpose of this measure. Practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.

Positive Depression Screen

The list of standardized depression screening tools included in the measure specifications differ in what they are evaluating. For example, some tools are designed to detect different levels of severity of depression (e.g., the PHQ-9), whereas others do not.

EOHHS has adopted a score of 10+ as an indication of a positive score for the PHQ-9. This is commonly accepted as the cut-point for moderate depression and is identified as a positive depression score by NCQA in its "Depression Screening and Follow-up for Adolescents and Adults" measure.[55] The table below identifies the definition of a positive screen for the other screening tools included in the measure specifications, which is usually the score used to identify moderate depression. The table also indicates if a tool has multiple cut points for a positive score or does not have a clear definition of a positive screen.

[54] Modified from: https://ecqi.healthit.gov/ecqm/ec/2023/cms002v12.

[55] National Committee for Quality Assurance (NCQA). "Proposed Changes to Existing Measures for HEDIS MY 2020: Depression Screening and Follow-up Measures." https://www.ncqa.org/wp-content/uploads/2020/02/20200212_18_Depression_Measures.pdf. Accessed April 26, 2021.

As a reminder, practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
Patient Health Questionnaire for Adolescents (PHQ-A)	Adolescent (12-17 years)	A score of 10+ (could be indicative of moderate depression)[56,57]
Beck Depression Inventory-Primary Care Version (BDI-PC)	Adolescent (12-17 years)	A score of 8+ (could be indicative of moderate depression)[58]
Beck Depression Inventory (BDI or BDI-II)	Adult (18 years and older), Perinatal	A score of 20+ (could be indicative of moderate depression)[59,60]
Computerized Adaptive Diagnostic Screener (CAD-MDD)	Adult (18 years and older)	No clear cutoff for a positive score, as the tool is adaptive and does not have all patients answer the same questions[61]
Computerized Adaptive Testing Depression Inventory (CAT-DI)	Adult (18 years and older)	A score of 66+ (could be indicative of moderate symptoms of depression)[62]
Center for Epidemiologic Studies Depression Scale (CES-D)	Adolescent (12-17 years), Adult (18 years and older), Perinatal	A score of 17+ (could be indicative of clinical depression)[63,64,65]
Cornell Scale for Depression	Adult (18 years and	A score of 6+ (could be indicative of

[56] This tool is sometimes referred to as the Patient Health Questionnaire Modified for Teens (PHQ-9M). American Academy of Child & Adolescent Psychiatry. "Scoring the PHQ-9 Modified for Teens." https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf. Accessed April 20, 2021.
[57] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[58] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[59] The National Child Traumatic Stress Network. "Beck Depression Inventory-Second Edition." https://www.nctsn.org/measures/beck-depression-inventory-second-edition. Accessed April 26, 2021.
[60] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[61] Graham, A.K., Minc, A., Staab, E., Beiser, D.G., Gibbons, R.D., Laiteerapong, N. (2019). "Validation of the Computerized Adaptive Test for Mental Health in Primary Care." *Annals of Family Medicine*, 17(1): 23-30. https://www.annfammed.org/content/annalsfm/17/1/23.full.pdf. Accessed April 20, 2021.
[62] Ibid.
[63] American Psychological Association. (2011). "Center for Epidemiological Studies-Depression." https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/depression-scale. Accessed April 20, 2021.
[64] Boyd, J.H., Weissman, M.M., Thompson, W.G., Myers, J.K. (1982). "Screening for Depression in a Community Sample: Understanding the Discrepancies between Depression Symptom and Diagnostic Scales. *Archives of General Psychiatry*, 39(10)L 1195-1200. https://doi.org/10.1001/archpsyc.1982.04290100059010.
[65] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
in Dementia (CSDD)	older)	presence of depressive symptoms)[66,67,68]
Depression Scale (DEPS)	Adult (18 years and older)	A score of 9+ (could be indicative of any level of depression)[69]
Duke Anxiety Depression Scale (DADS)	Adult (18 years and older)	A score of 5+ (could be indicative of anxiety and/or depression symptoms)[70]
Edinburgh Postnatal Depression Scale	Perinatal	A score of 10+ (could be indicative of possible depression)[71,72]
Geriatric Depression Scale (GDS)	Adult (18 years and older)	A score of 10+ (for the 30-item survey) [could be indicative of mild depression][73,74] A score of 5+ (for the 15-item survey) [could be indicative of depression][75,76] A score of 2+ (for the 5-item scale) [could be indicative of depression][77]
Hamilton Rating Scale for Depression (HAM-D)	Adult (18 years and older)	A score of 20+ (could be indicative of moderately severe depression)[78]
Quick Inventory of Depressive Symptomatology	Adult (18 years and older)	A score of 11+ (could be indicative of

[66] Alexopoulos, G.S. (2002). "The Cornell Scale for Depression in Dementia: Administration and Scoring Guidelines." *Cornell Institute of Geriatric Psychiatry*. http://www.scalesandmeasures.net/files/files/The%20Cornell%20Scale%20for%20Depression%20in%20Dementia.pdf. Accessed April 26, 2021.

[67] Bienenfeld, D and Stinson, K.N. (December 23, 2018). "Screening Tests for Depression." Medscape. https://emedicine.medscape.com/article/1859039-overview#a1. Accessed April 20, 2021.

[68] Edelstein, B.A., Drozdick, L.W., Ciliberti, C.M. (2010). "Assessment of Depression and Bereavement in Older Adults" in *Handbook of Assessment in Clinical Gerontology*. https://www.sciencedirect.com/science/article/pii/B9780123749611100016. Accessed April 29, 2021.

[69] Poutanen, O., Koivisto, A.M., Kaaria, S., Salokangas, K.R. (2010). "The Validity of the Depression Scale (DEPS) to Assess the Severity of Depression in Primary Care Patients." *Family Practice*, 27(5): 527-534. https://academic.oup.com/fampra/article/27/5/527/717051. Accessed April 20, 2021.

[70] Duke University Medical Center. (2016). "Duke Anxiety-Depression Scale." https://fmch.duke.edu/sites/cfm.duke.edu/files/cfm/Research/HealthMeasures/DukeAD.pdf. Accessed April 20, 2021.

[71] University of California San Francisco School of Medicine Fresno. "Edinburgh Postnatal Depression Scale." https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf. Accessed April 20, 2021.

[72] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.

[73] Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M., Leirer, V.O. (1983). "Development and Validation of a Geriatric Depression Screening Scale: A Preliminary Report." *Journal of Psychiatric Research*, 17:37-49. https://img.medscape.com/pi/emed/ckb/psychiatry/285911-1335297-1859039-1859094.pdf. Accessed April 26, 2021.

[74] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.

[75] Anderson, J.E., Michalak, E.E., Lam, R.W. (2002). "Depression in Primary Care: Tools for Screening, Diagnosis and Measuring Response to Treatment." British Columbia Medical Journal, 44(8): 415-419. https://bcmj.org/articles/depression-primary-care-tools-screening-diagnosis-and-measuring-response-treatment. Accessed April 20, 2021.

[76] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.

[77] Bienenfeld and Stinson.

[78] Bienenfeld and Stinson.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
Self-Report (QID-SR)		moderate depression)[79]
Mood Feeling Questionnaire (MFQ)	Adolescent (12-17 years)	A score of 8+[80] or 11+[81] on the short questionnaire for children (could be indicative of major depression)
Patient Health Questionnaire (PHQ-9)	Adolescent (12-17 years), Adult (18 years and older), Perinatal	A score of 10+ (could be indicative of moderate depression)[82,83]
Pediatric Symptom Checklist (PSC-17)	Adolescent (12-17 years)	The following scores could be indicative of psychological impairment (not solely focused on depression) and suggests the need for further evaluation: A score of 28+ for ages 6-16 A score of 24+ for ages 4-5 A score of 30+ for the PSC-Y for ages 11+[84]
Postpartum Depression Screening Scale	Perinatal	A score of 80+ (indicates that a woman has a high probability of depression)[85]
PRIME MD-PHQ-2	Adolescent (12-17 years), Adult (18 years and older)	A score of 3+ (could be indicative of having depression symptoms, but developer recommends administration of a PHQ-9, GAD-7 or other screening tool to determine whether a mental health condition is present)[86,87]
Zung Self-rating Depression Scale	Perinatal	A score of 60+ (could be indicative of moderate depression)[88]

[79] IDS-QIDS. (2021). "Interpretation: Inventory of Depressive Symptomatology (IDS) and Quick Inventory of Depressive Symptomatology (QIDS)." http://ids-qids.org/interpretation.html. Accessed April 26, 2021.
[80] Seattle Children's Hospital. "Short Mood and Feelings Questionnaire." https://www.seattlechildrens.org/globalassets/documents/healthcare-professionals/pal/ratings/smfq-rating-scale.pdf. Accessed April 29, 2021.
[81] University of Washington. "Moods and Feelings Questionnaire." https://depts.washington.edu/uwhatc/PDF/TF-%20CBT/pages/3%20Assessment/Standardized%20Measures/Moods%20and%20Feelings%20Questionnaire%202.08.pdf. Accessed April 28, 2021.
[82] This definition was developed by the AE/MCO Work Group.
[83] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[84] Bright Futures. "Instructions for Using Pediatric Symptom Checklist." https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf. Accessed April 20, 2021.
[85] Mancini, F., Carlson, C., Albers, L. (2007). "Use of the Postpartum Depression Screening Scale in a Collaborative Obstetric Practice." *Journal of Midwifery & Women's Health*, 52(5): 429-434. https://www.medscape.com/viewarticle/563220. Accessed April 20, 2021.
[86] Pfizer. "Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures." https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf. Accessed April 20, 2021.
[87] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[88] Bienenfeld and Stinson.

Guidance to Define "Follow-up"

This section identifies what does and does not classify as an eligible "follow-up plan" for the Screening for Depression and Follow-up Plan measure. It does not provide any clinical guidance on the diagnosis or treatment of depression. For more guidance on that topic, consider referring to sources such as the American Psychological Association[89] and the Institute for Clinical Systems Improvement.[90]

According to the measure specifications, "Documented follow-up for a positive depression screening **must** include one or more of the following:

- Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression"

Please note that additional evaluation or assessment for depression and suicide risk assessment are no longer considered eligible follow-up activities according to CMS as of 2021. The measure assesses the most recent depression screen completed during the eligible encounter or within 14 days prior to the encounter. Therefore, an additional screen performed during the eligible encounter would serve as the most recent screen that, if positive, should have additional follow-up. Should a patient screen positive for depression, a clinician should opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. A suicide risk assessment no longer qualifies as a follow-up plan for the purposes of this measure as the patient could potentially harm themselves, which would be considered an urgent or emergent situation, i.e., an eligible exception outlined in the measure specifications.[91]

Each action that is classified as an eligible "follow-up plan" component is defined further below. Please note that follow-up planning must be provided by a licensed provider or by an ancillary provider working under the general supervision of the licensed provider. The documented follow-up plan must be related to a positive depression screen. For example, "Patient referred for psychiatric evaluation due to positive depression screening."[92]

Referral to a provider for additional evaluation and assessment to formulate a plan for a positive depression screen. This can include, but is not limited to, referral to a psychiatrist, psychologist, social

[89] American Psychological Association. "Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts." https://www.apa.org/depression-guideline. Accessed April 26, 2021.
[90] Trangle, M., Gursky, J., Haight, R., Hardwig, J., Hinnenkamp, T., Kessler, D., Mack, N. and Myszkowski, M. (2016). "Health Care Guideline: Adult Depression in Primary Care." *Institute for Clinical Systems Improvement*. https://www.icsi.org/wp-content/uploads/2019/01/Depr.pdf. Accessed April 2, 2021.
[91] [Email from CMS Practice Improvement and Measures Management Support (PIMMS) Team]. (May 3, 2021).
[92] Oregon Health Authority. (2014). "Depression Screening and Follow-Up Plan Guidance Document." https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Depression-Screening-Guidance-Document.pdf. Accessed April 14, 2021.

worker, mental health counselor, and/or to a mental health service such as family or group therapy, support group or depression management program.

This can also include a warm hand-off to a behavioral health clinician embedded within the practice.[93]

The referral to a practitioner or program for further evaluation for depression must be made on the date of or up to two days after the date of the qualifying encounter for it to be an eligible follow-up action. The patient, however, can make a follow-up appointment with the practitioner or program on a subsequent date.

Pharmacologic interventions. This can include a prescription for antidepressants, including tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs) and atypical antidepressants (e.g., bupropion, mirtazapine, nefazodone, trazodone, etc.)). It can also include a prescription for other medications, such as antipsychotics, for the treatment of depression as advised by the practitioner.[94,95,96]

The prescription must be written on the date of or up to two days after the date of the qualifying encounter for it to be an eligible follow-up action. The prescription, however, can be filled by the patient on a subsequent date.

Treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect. There may be some instances in which a patient refuses pharmacologic intervention due to the risks associated with antidepressants, even when the provider advises starting treatment.[97]

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[93] Savoy, M. and O'Gurek, D. (2016). "Screening Your Adult Patients for Depression." *Fam Pract Manag,* 23(2): 16-20. https://www.aafp.org/fpm/2016/0300/p16.html. Accessed April 13, 2021.

[94] Mulder, R., Hamilton, A., Irwin, L., Boyce, P., Morris, G., Porter, R.J., Malhi, G.S. (October 16, 2018). "Treating Depression with Adjustive Antipsychotics." *Bipolar Disorders*, 20(52), 17-24. https://doi.org/10.1111/bdi.12701.

[95] While not an eligible follow-up activity for the purposes of this measure, a provider could consider having a registered nurse (RN) or pharmacist follow-up with (1) the patient in three to five weeks to assess the effectiveness and side effects of the medication and (2) the prescribing provider to discuss titration of the medication. [Email from J. Gates]. (April 26, 2021).

[96] If necessary and deemed appropriate, a provider should consider a follow-up assessment with a pharmacist or trained nurse specialist on medication adherence for depression. Such follow-up is typically conducted after an individual has been on a prescription for some time, i.e., would occur on a date other than the eligible encounter, and therefore would not be considered an eligible follow-up activity.
U.S. Preventive Services Task Force. (2016). "Depression in Adults: Screening." https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening#fullrecommendationstart. Accessed April 13, 2021.

[97] Ibid.

Other interventions or follow-up for the diagnosis or treatment of depression. This can include behavioral health evaluation,[98] psychotherapy or additional treatment options.

Examples of psychotherapy can include cognitive behavioral therapy (CBT), interpersonal therapy (IPT), dialectical behavior therapy, psychodynamic therapy, psychoanalysis, supportive therapy and more.[99]

Additional treatment options can include enrolling the patient in a collaborative care model to treat and manage depression,[100] acupuncture, or St. John's wort.[101]

It can also include a follow-up assessment with a community health worker or medical assistant with a practice-approved checklist.[102]

Continuation of an existing treatment for a behavioral health condition other than depression that can also aid in the treatment of a newly diagnosed case of depression, as described above, is an eligible follow-up action.

For all of the above examples, referrals to or receipt of psychotherapy or other treatment options must be made on the date of up to two days after the date of the qualifying encounter for it to be an eligible follow-up action. The patient, however, can make an appointment with the provider on a subsequent date.

Additional treatment options do **not** include those explicitly excluded in the measure specifications, i.e., additional evaluation or assessment for depression or suicide risk assessment, follow-up conducted by non-licensed provider that is not working under the supervision of a licensed provider, follow-up conducted on a day other than the eligible encounter.

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There may be situations in which a patient has a positive screen for depression, but a provider on the basis of their clinical judgment does not implement one of the specified follow-up actions. This is why the target for this measure will never be 100%.

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[98] Behavioral health evaluation is an eligible follow-up activity if it is performed by a provider other than the provider that conducted the initial positive screen because it would be classified as a "referral to a practitioner or program for further evaluation for depression." It is also an eligible follow-up activity if behavioral health evaluation is used as an intervention to treat depression.
[Email from CMS PIMMS Team]. (May 3, 2021).

[99] Parekh, R., Givon, L. (January 2019). "What Is Psychotherapy?" American Psychiatric Association. https://www.psychiatry.org/patients-families/psychotherapy. Accessed April 26, 2021.

[100] Community Preventive Services Task Force. (2010). "Improving Mental Health and Addressing Mental Illness: Collaborative Care for the Management of Depressive Disorders." https://www.thecommunityguide.org/sites/default/files/assets/Mental-Health-Collaborative-Care.pdf. Accessed April 14, 2021.

[101] Agency for Healthcare Research and Quality. (2015). "Nonpharmacological Versus Pharmacological Treatment for Adult Patients with Major Depressive Disorder." https://pubmed.ncbi.nlm.nih.gov/26764438/. Accessed April 14, 2021.

[102] While not an eligible follow-up activity for the purpose of this measure, any concerning findings from the checklist should result in a follow-up assessment by a RN or a visit with a provider within seven days.
[Email from J. Gates]. (April 26, 2021).

Appendix C: Patient Engagement with an AE Primary Care Provider (QPY6 and QPY7)

Steward: Rhode Island Executive Office of Health and Human Services
As of February 2, 2023

SUMMARY OF CHANGES FOR 2023 (PERFORMANCE YEAR 6)

- New measure for 2023.

Description

The percentage of attributed patients who have engaged with any primary care provider employed by or contracted with the member's AE.

Note: EOHHS recognizes that patient engagement with an AE may extend beyond what is captured by this measure (e.g., visits with a care manager, care coordinator, integrated behavioral health specialist, etc.). The intent of this measure, however, is to focus exclusively on visits with an AE primary care provider.

Definitions

Primary Care Provider (PCP)	PCPs are medical doctors, doctors of osteopathy, nurse practitioners, or physician assistants in the following specialties: family and general practice, pediatrics, internal medicine, or geriatrics. PCPs shall also meet the credentialing criteria established by the MCO and approved by EOHHS.[103] Use both the TIN and NPI from the AE provider roster as of the visit date to identify an AE primary care provider.

Eligible Population

Product lines	Medicaid
Stratification	Ages as of December 31 of the measurement year. Report three age-stratified rates and a total rate. • 1-17 years • 18-39 years • 40+ years The total is the sum of the stratifications.
Ages	All ages
Continuous enrollment	The measurement period, as defined using the lookback period
Allowable gap	No more than one gap in enrollment of up to 45 days during each year

[103] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-12/Attachment%20M%20-%20Attribution%20Guidance_PY6_Final.pdf.

	of continuous enrollment with an MCO. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).[104,105,106]
Anchor date	In the AE on December 31 of the measurement year.
Lookback period	24 months for members 18-39 12 months for members 1-17 and 40+
Benefit	Medical
Event/diagnosis	Attribution or re-attribution to the AE for 11 of 12 months of the measurement year.
Exclusions	• Members who were not enrolled for the full measurement year, with the exception of the allowable gap. • Members in hospice care (see "Exclusions" tab in Excel spreadsheet for eligible codes)

Administrative Specifications

Denominator	The eligible population
Numerator 1	One or more ambulatory, preventive or outpatient visits with any primary care provider employed by or contracted with the member's AE as of December 31 of the measurement year during the last twelve months for attributed members under age 18. The visit does not need to be with a member's assigned AE primary care provider. If a PCP contracts with multiple AEs, use the TIN under which the PCP bills to identify the member's AE. See "Numerator 1 2 and 3" tab in the Excel spreadsheet for eligible codes.
Numerator 2	One or more ambulatory, preventive or outpatient visits with any primary care provider employed by or contracted with the member's AE as of December 31 of the measurement year during the last 24 months for attributed members ages 18 to 39. The visit does not need to be with a member's assigned AE primary care provider. If a PCP contracts with multiple AEs, use the TIN under which the PCP bills to identify the member's AE.

[104] NCQA added the Medicaid language after receiving high volumes of questions from Medicaid organizations stating they were unable to determine gaps based on days and could only assess on a monthly basis. The intent of the language is to clarify that, if the organization could only assess enrollment on a monthly basis (e.g., for select populations in RI identified in footnote 2), then a 2-month gap exceeds 45 days and is not allowed.
[105] RIte Care enrollment is verified daily whereas other populations, including expansion adults and adults with disabilities, are verified monthly.
[106] Members 18-39 years can have two allowable gaps and still be included in the denominator as the lookback period for this population is 24 months and not 12 months.

	See “Numerator 1 2 and 3” tab in the Excel spreadsheet for eligible codes.
Numerator 3	One or more ambulatory, preventive or outpatient visits with any primary care provider employed by or contracted with the member’s AE as of December 31 of the measurement year during the last 12 months for attributed members ages 40 and over. The visit does not need to be with a member’s assigned AE primary care provider. If a PCP contracts with multiple AEs, use the TIN under which the PCP bills to identify the member’s AE. See “Numerator 1 2 and 3” tab in the Excel spreadsheet for eligible codes.
Exclusions	None

Excel Spreadsheet with Eligible Codes

Patient
Engagement Measu

Appendix D: SDOH Screening Measure Specifications (QPY5)

Steward: Rhode Island Executive Office of Health and Human Services
As of August 3, 2022

SUMMARY OF CHANGES FOR 2022 (PERFORMANCE YEAR 5)

- No changes.

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[107]

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

Eligible Population

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

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

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

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

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

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[108]

Electronic Data Specifications

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

Denominator	The eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR.

[108] https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

	Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria. AEs can, but not required to, use ICD-10 Z codes to track performance for this measure electronically. An example of two Z codes in use by at least one AE is provided below: • Z04.89 o Definition: Encounter for examination and observations for other specified reasons o Meaning: SDOH screening completed • Z53.8 o Definition: Procedure and treatment not carried out for other reasons o Meaning: SDOH screening offered, but patient refused/declined to complete screen
Unit of measurement	Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record.
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer or a community partner. The screening results must a) be embedded in the EHR, b) be accessible in the EHR as a PDF of the screening results, or c) be accessible from within the EHR without requiring the primary care clinician to leave the EHR to access another electronic location to search for the patient's record and locate and view the screening results. An integrated EHR interface with Unite Us that allows providers to view a patient's screening results meets the documentation requirements. Results for at least one question per required domain must be included for a screen to be considered numerator complaint.
Approved screening tools	For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure.
Required domains	1. Housing insecurity; 2. Food insecurity;

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

Code List

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

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

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

Appendix E: SDOH Screening Measure Specifications (QPY6 and QPY7)

Steward: Rhode Island Executive Office of Health and Human Services
As of May 18, 2023

SUMMARY OF CHANGES FOR 2023 (PERFORMANCE YEAR 6)

- Clarified that there are two options for demonstrating numerator compliance, one of which includes using ICD-10 Z codes.

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[109]

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

Eligible Population

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

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

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

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

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

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[110]

Electronic Data Specifications

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

Denominator	The eligible population
Numerator – Option 1	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement

[110] https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

	year and for whom results are in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria.
Numerator – Option 2	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria. AEs can, but not required to, use ICD-10 Z codes to track performance for this measure electronically. An example of two Z codes in use by at least one AE is provided below: • Z04.89 o Definition: Encounter for examination and observations for other specified reasons o Meaning: SDOH screening completed • Z53.8 o Definition: Procedure and treatment not carried out for other reasons o Meaning: SDOH screening offered, but patient refused/declined to complete screen
Unit of measurement	Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record.
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer or a community partner. The screening results must a) be embedded in the EHR, b) be accessible in the EHR as a PDF of the screening results, or c) be accessible from within the EHR without requiring the primary care clinician to leave the EHR to access another electronic location to search for the patient's record and locate and view the screening

	results. An integrated EHR interface with Unite Us that allows providers to view a patient's screening results meets the documentation requirements. Results for at least one question per required domain must be included for a screen to be considered numerator complaint.
Approved screening tools	For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure.
Required domains	6. Housing insecurity; 7. Food insecurity; 8. Transportation; 9. Interpersonal violence; and 10. Utility assistance. Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Code List

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

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

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

Appendix F: Race, Ethnicity, Language and Disability Status (RELD) Measure (QPY5)

Steward: Rhode Island Executive Office of Health and Human Services (EOHHS)
As of January 13, 2023

SUMMARY OF CHANGES FOR 2022 (PERFORMANCE YEAR 5)

- Updated measure names to align with new NCQA HEDIS measure names.
  - Updated the measure so that AEs report on the AE-specific population rather than their entire Medicaid population.
- Updated information on reporting template and deadline to align with QPY5 reporting dates.
- Added information on how data reported across stratifications should align.
- Specify that FQHC-based AEs should separately reported data for "Unreported" and "Refused to Report" if they have the ability to do so.
- Updated information on where AEs can access disability status data.
- Removed the requirement for AEs to separately report the percentage of patients for which the AE has complete data.

Background

Rhode Island EOHHS is adopting a RELD measure for its Accountable Entity (AE) program for 2022. EOHHS developed this measure in partnership with the AE/MCO Work Group, a stakeholder body of AE and Managed Care Organization (MCO) representatives, and the RELD Measure Work Group, a subgroup of the AE/MCO Work Group. EOHHS prioritized stratification of measures that have evidence of disparities in performance by RELD in Rhode Island and that are required to be stratified for reporting to the National Committee for Quality Assurance (NCQA) and to the Health Resources and Services Administration (HRSA) (for federally qualified health centers (FQHCs)).

The RELD Measure will initially focus on stratifying performance by race, ethnicity, language and disability status (RELD) for measures in the AE Common Measure Slate to encourage AEs to collect REL data (disability status data will come from MCOs) and use RELD data to stratify measure performance. EOHHS aims to include a RELD measure focused on reducing disparities in performance in the future once provider organizations have more robust and more experience with RELD data.

Description

The performance for each of the following measures, stratified by race, ethnicity, language and disability status (RELD):

- Measure #1: *Eye Exam for Patients with Diabetes*
- Measure #2: *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control <8.0%*
- Measure #3: *Controlling High Blood Pressure*
- Measure #4: *Developmental Screening in the First Three Years of Life*

General Guidelines

Organizations Responsible and Data Source Used for Reporting Performance	AEs should use their own EHR-based clinical data, patient age and sex data and REL data, and disability status data obtained from MCOs, to report stratified performance for all measures.
Reporting Template and Deadline	AEs must use the specified reporting template to report performance to EOHHS by August 31 of the year following the measurement year (e.g., AEs must report CY 2022 performance by August 31, 2023). A copy of this Excel reporting template can be obtained through EOHHS' SFTP site.[111]
Overall Parameters for Stratification	AEs should report stratified performance: • for each race, ethnicity, language and disability status stratification category separately (e.g., within race, report measure performance separately for White, Black or African American, etc.; within ethnicity, report measure performance separately for Hispanic/Latino and non-Hispanic/Latino; within language, report measure performance separately for English, Spanish, etc.); • using patient self-reported data gathered by AEs rather than imputing a patient's REL, and • for the AE-specific Medicaid patient population served by the AE provider network meeting each measure's specifications, across health plans. The total numerator and total denominator reported for each RELD stratification category should be the same (e.g., the total numerator reported across all race categories should be equal to the total numerator reported across all ethnicity categories, the total numerator reported across all language categories and the total numerator reported across all disability status categories).
Data Completeness Threshold	There is no RELD data completeness threshold for reporting performance stratified by RELD. Organizations should report on all patients for whom they have RELD data.
Required RELD Reporting Categories	AE can use any framework to collect REL data but should report stratified performance to EOHHS using the following framework. ***For race***: Non-FQHC-based AEs should use the following race categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022: • White • Black • American Indian/Alaska Native • Asian • Native Hawaiian and Other Pacific Islander • Some Other Race

[111] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

	• Two or More Races
	• Declined
	• Unknown
	
	FQHC-based AEs should use the following race categories in use by HRSA for Uniform Data System (UDS) reporting:
	• White
	• Black/African American
	• American Indian/Alaska Native
	• Asian
	• Native Hawaiian
	• Other Pacific Islander
	• More Than One Race
	• Unreported/Refused to Report
	  ○ FQHC-based AEs should separately reported data for "Unreported" and "Refused to Report" if they have the ability to do so.
	
	For ethnicity: Non-FQHC-based AEs should use the following ethnicity categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022:
	• Hispanic/Latino
	• Not Hispanic/Latino
	• Declined
	• Unknown
	
	FQHC-based AEs should use the following ethnicity categories in use by HRSA for UDS reporting:
	• Hispanic/Latino
	• Non-Hispanic/Latino
	• Unreported/Refused to Report
	  ○ FQHC-based AEs should separately reported data for "Unreported" and "Refused to Report" if they have the ability to do so.
	
	Please refer to the "Crosswalk of Race/Ethnicity Reporting Categories" section to see how commonly used frameworks for collecting race and ethnicity data map onto the categories AE should use when reporting stratified performance to EOHHS.
	
	For language: Use the following language categories. Health Level Seven Fast Healthcare Interoperability Resources (HL-7 FHIR) codes used in the US, when available, are included in parentheses.[112] If there is no US-based HL-7 FHIR code available, use the UK-based HL-7 FHIR code denoted with

[112] A full list of HL-7 FHIR common language codes used in the US can be found here: https://www.hl7.org/fhir/valueset-languages.html#definition.

	an asterisk (*).[113] • English (en) • Spanish (es) • Portuguese (pt) • Cape Verdean Creole (N/A – no HL-7 FHIR code available) • Haitian Creole (ht*) • Khmer (km*) • Lao (lo*) • Other • Unknown ***For disability status***: Use the following disability status categories: • Persons with Disabilities[114] • Persons without Disabilities • Unknown Information on disability status will be included in the annual quality reporting file from NHPRI and United. ***Note****: Each of the categories within each race, ethnicity, language, and disability status stratification are mutually exclusive. Therefore, the sum of all stratifications should equal the total population (e.g., the sum of all nine race stratifications should equal the total population).*
Measure Specifications	The RELD Measure specifications can be accessed from the CMS eCQM specifications for Eligible Professionals / Eligible Clinicians for 2022 for Measure #1 – Measure #3.[115] These specifications are designed for reporting by provider organizations. AEs can simply run the specifications as provided by CMS, but stratify performance by race, ethnicity and language. For Measure #4, eCQM specifications are not available. Therefore, the RELD Measure specifications are adapted from CMS' 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.[116]

[113] A full list of HL-7 FHIR common language codes used in the UK can be found here: https://simplifier.net/guide/ukcoredevelopment/codesystemukcore-humanlanguage.

[114] EOHHS defines patients with disabilities as those who belong to the following enrollment categories: children with special healthcare needs (i.e., adoption subsidy, Katie Beckett, SSI <15 years of age, SSI >=15 years of age, substitute care*), substitute/Department of Children, Youth & Families (DCYF) foster care*, and Rhody Health Partners (i.e., intellectual disability (ID), severe and persistent mental illness (SPMI), other disabled ages 21-44, other disabled ages 45+). Categories denoted with an asterisk (*) have enrollment only in NHPRI.

[115] See: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1&globalyearfilter=2021.

[116] See: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html.

Measure #1: Eye Exam for Patients with Diabetes (CMS131v10)[117]

Measure #1 – Description

Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.

Measure #1 – Denominator

Initial Population	Patients 18-75 years of age with diabetes with a visit during the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.
	• Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior
	  ○ OR advanced illness with one inpatient encounter during the measurement period or the year prior
	  ○ OR taking dementia medications during the measurement period or the year prior.
	• Exclude patients receiving palliative care during the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. The sum of the denominators reported across all race categories should equal the denominator statement reported in Rate 1.
Rate 3	The denominator statement, stratified by ethnicity. The sum of the denominators reported across all ethnicity categories should equal the denominator statement reported in Rate 1.
Rate 4	The denominator statement, stratified by language. The sum of the denominators reported across all language categories should equal the denominator statement reported in Rate 1.
Rate 5	The denominator statement, stratified by disability status. The sum of the

[117] Source: CMS 2022 eCQM specifications for Diabetes: Eye Exam. https://ecqi.healthit.gov/ecqm/ep/2022/cms131v10.

	denominators reported across all disability status categories should equal the denominator statement reported in Rate 1.

Measure #1 – Numerator

Numerator Statement	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: • Diabetic with a diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period • Diabetic with no diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period or the year prior to the measurement period
Numerator Exclusions	Not applicable
Guidance	Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included. The eye exam must be performed by an ophthalmologist or optometrist, or there must be evidence that fundus photography results were read by a system that provides an artificial intelligence (AI) interpretation.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race. The sum of the numerators reported across all race categories should equal the numerator statement reported in Rate 1.
Rate 3	The numerator statement, stratified by ethnicity. The sum of the numerators reported across all ethnicity categories should equal the numerator statement reported in Rate 1.
Rate 4	The numerator statement, stratified by language. The sum of the numerators reported across all language categories should equal the numerator statement reported in Rate 1.
Rate 5	The numerator statement, stratified by disability status. The sum of the numerators reported across all disability status categories should equal the numerator statement reported in Rate 1.

Measure #2: Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control <8.0% (CMS122v10)[118]

Measure #2 – Description

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c <8.0% during the measurement year.

Measure #2 – Denominator

Initial Population	Patients 18-75 years of age with diabetes with a visit during the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.
	• Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior
	  ○ OR advanced illness with one inpatient encounter during the measurement period or the year prior
	  ○ OR taking dementia medications during the measurement period or the year prior.
	• Exclude patients receiving palliative care during the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. The sum of the denominators reported across all race categories should equal the denominator statement reported in Rate 1.
Rate 3	The denominator statement, stratified by ethnicity. The sum of the denominators reported across all ethnicity categories should equal the denominator statement reported in Rate 1.
Rate 4	The denominator statement, stratified by language. The sum of the denominators reported across all language categories should equal the denominator statement reported in Rate 1.
Rate 5	The denominator statement, stratified by disability status. The sum of the denominators reported across all disability status categories should equal the denominator statement reported in Rate 1.

[118] Source: Modified from CMS 2022 eCQM specifications for Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%). https://ecqi.healthit.gov/ecqm/ep/2022/cms122v10.

Measure #2 – Numerator

Numerator Statement	Patients whose most recent HbA1c level (performed during the measurement period) is <8.0%.
Numerator Exclusions	Not applicable
Guidance	Patient is numerator compliant if most recent HbA1c level <8%. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance. Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race. The sum of the numerators reported across all race categories should equal the numerator statement reported in Rate 1.
Rate 3	The numerator statement, stratified by ethnicity. The sum of the numerators reported across all ethnicity categories should equal the numerator statement reported in Rate 1.
Rate 4	The numerator statement, stratified by language. The sum of the numerators reported across all language categories should equal the numerator statement reported in Rate 1.
Rate 5	The numerator statement, stratified by disability status. The sum of the numerators reported across all disability status categories should equal the numerator statement reported in Rate 1.

Measure #3: Controlling High Blood Pressure (CMS165v10)[119]

Measure #3 – Description

Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Measure #3 – Denominator

Initial Population	Patients 18-85 years of age who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.
	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.
	• Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior
	  ○ OR advanced illness with one inpatient encounter during the measurement period or the year prior
	  ○ OR taking dementia medications during the measurement period or the year prior.
	• Exclude patients 81 and older with an indication of frailty for any part of the measurement period.
	• Exclude patients receiving palliative care during the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. The sum of the denominators reported across all race categories should equal the denominator statement reported in Rate 1.
Rate 3	The denominator statement, stratified by ethnicity. The sum of the denominators reported across all ethnicity categories should equal the denominator statement reported in Rate 1.

[119] Source: CMS 2022 eCQM specifications. https://ecqi.healthit.gov/ecqm/ep/2022/cms165v910.

Rate 4	The denominator statement, stratified by language. The sum of the denominators reported across all language categories should equal the denominator statement reported in Rate 1.
Rate 5	The denominator statement, stratified by disability status. The sum of the denominators reported across all disability status categories should equal the denominator statement reported in Rate 1.

Measure #3 – Numerator

Numerator Statement	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.
Numerator Exclusions	Not applicable
Guidance	In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record. Do not include BP readings: • Taken during an acute inpatient stay or an ED visit. • Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests. • Taken by the patient using a non-digital device such as a with a manual blood pressure cuff and a stethoscope. If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race. The sum of the numerators reported across all race categories should equal the numerator statement reported in Rate 1.
Rate 3	The numerator statement, stratified by ethnicity. The sum of the numerators reported across all ethnicity categories should equal the numerator statement reported in Rate 1.
Rate 4	The numerator statement, stratified by language. The sum of the numerators

	reported across all language categories should equal the numerator statement reported in Rate 1.
Rate 5	The numerator statement, stratified by disability status. The sum of the numerators reported across all disability status categories should equal the numerator statement reported in Rate 1.

Measure #4: Developmental Screening in the First Three Years of Life[120]

Measure #4 – Description

Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday

Measure #4 – Denominator

Initial Population	Patients 1-3 years of age during the measurement period
Denominator Statement	Equals Initial Population
Denominator Exclusions	None
Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. The sum of the denominators reported across all race categories should equal the denominator statement reported in Rate 1.
Rate 3	The denominator statement, stratified by ethnicity. The sum of the denominators reported across all ethnicity categories should equal the denominator statement reported in Rate 1.
Rate 4	The denominator statement, stratified by language. The sum of the denominators reported across all language categories should equal the denominator statement reported in Rate 1.
Rate 5	The denominator statement, stratified by disability status. The sum of the denominators reported across all disability status categories should equal the denominator statement reported in Rate 1.

Measure #4 – Numerator

Numerator Statement	Patients who had screening for risk of developmental, behavioral and social delays using a standardized, validated tool that was documented in the 12 months preceding or on their first, second and third birthday
Numerator Exclusions	Not applicable
Guidance	Documentation in the medical record must include all of the following: • A note indicating the date on which the test was performed, and • The standardized tool used (see below), and • Evidence of a screening result or screening score

[120] Source: CMS 2021 Medicaid Child Core Set specifications. https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1623809181.

	Tools must meet the following criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional. 2. Established Reliability: Reliability scores of approximately 0.70 or above. 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s). 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above. The following tools meet the above criteria and are included in the Bright Futures Recommendations for Preventive Care, which reference the updated January 2020 American Academy of Pediatrics (AAP) Statement.[121] • Ages and Stages Questionnaire - 3rd Edition (ASQ-3) • Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8 • Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) • Survey of Well-Being in Young Children (SWYC) Note: The 2020 AAP Statement describes the screening tool properties that may be useful for states to consider in designing their policies. Tools included in the 2006 Statement that meet the above criteria but were not listed in the 2020 Statement (as they often are not used by primary care providers in the context of routine well-child care) include the following:[122] • Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months • Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2 • Brigance Screens-II - Birth to 90 months • Child Development Inventory (CDI) - 18 months to age 6 • Infant Development Inventory - Birth to 18 months The tools listed above are not specific recommendations for tools but are examples of tools cited in Bright Futures that meet the above criteria. Tools that do NOT meet the criteria: It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional

[121] Lipkin, Paul H., and Michelle M. Macias. "Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening." Pediatrics, vol. 145, no. 1, January 1, 2020. https://pediatrics.aappublications.org/content/145/1/e20193449.

[122] Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening." Pediatrics, vol. 118, no.1, July 2006, pp. 405-420. https://pediatrics.aappublications.org/content/118/1/405.

	development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race. The sum of the numerators reported across all race categories should equal the numerator statement reported in Rate 1.
Rate 3	The numerator statement, stratified by ethnicity. The sum of the numerators reported across all ethnicity categories should equal the numerator statement reported in Rate 1.
Rate 4	The numerator statement, stratified by language. The sum of the numerators reported across all language categories should equal the numerator statement reported in Rate 1.
Rate 5	The numerator statement, stratified by disability status. The sum of the numerators reported across all disability status categories should equal the numerator statement reported in Rate 1.

Crosswalk of Race/Ethnicity Reporting Categories

Crosswalk of Race/Ethnicity Categories

National Committee for Quality Assurance (NCQA) Categories[123]	Office of Management and Budget (OMB) Categories[124]	Health Resources & Services Administration (HRSA) Uniform Data System (UDS) Categories[125]
White	White	White
Black	Black or African American	Black/African American
American Indian/Alaska Native	American Indian or Alaska Native	American Indian/Alaska Native
Asian	Asian	Asian
Native Hawaiian and Other Pacific Islander	Native Hawaiian and Other Pacific Islander	Native Hawaiian
		Other Pacific Islander
Hispanic/Latino	Hispanic or Latino	Hispanic/Latino
Not Hispanic/Latino	Non-Hispanic or Latino	Non-Hispanic/Latino
Unknown	Unknown	Unreported/Refused to Report
Declined	Asked but No Answer	
Some Other Race	N/A	N/A
Two or More Races	N/A*	More than One Race

*OMB allows individuals to select more than one of the five race categories.

[123] Source: NCQA's Proposed Changes to Existing Measures for HEDIS MY 2022: Introduction of Race and Ethnicity Stratification Into Select HEDIS Measures. https://www.ncqa.org/wp-content/uploads/2021/02/02.-Health-Equity.pdf.

[124] Source: CMS' Inventory of Resources for Standardized Demographic and Language Data Collection. https://www.cms.gov/about-cms/agency-information/omh/downloads/data-collection-resources.pdf.

[125] Source: HRSA's Uniform Data System 2021 Health Center Data Reporting Requirements. https://data.hrsa.gov/tools/data-reporting/program-data/state/LA/table?tableName=7.

Appendix G: Race, Ethnicity, Language and Disability Status (RELD) Measure (QPY6)

Steward: Rhode Island Executive Office of Health and Human Services (EOHHS)
As of May 18, 2023

SUMMARY OF CHANGES FOR 2023 (PERFORMANCE YEAR 6)

- Removed measure background information.
- Updated information on reporting template and deadline to align with QPY6 reporting dates.
- Updated the specifications for *Eye Exam for Patients with Diabetes* to align with CMS131v11 and for *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control <8.0%* to align with CMS122v11, specifically to:
  - Clarify the denominator exclusions.
  - Remove the guidance that says patients with a diagnosis of secondary diabetes due to another condition should not be included.
- Updated the specifications for *Controlling High Blood Pressure* to align with CMS165v11, specifically to:
  - Clarify the denominator exclusions,
  - Remove the guidance that says to do not include BP readings taken on the same day as a diagnostic test or procedure that requires a change in diet or medication or taken by the patient using a non-digital device.
  - Add guidance that says ranges and thresholds do not meet the criteria for the measure.

Description

The performance for each of the following measures, stratified by race, ethnicity, language and disability status (RELD):

- Measure #1: *Eye Exam for Patients with Diabetes*
- Measure #2: *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control <8.0%*
- Measure #3: *Controlling High Blood Pressure*
- Measure #4: *Developmental Screening in the First Three Years of Life*

General Guidelines

Organizations Responsible and Data Source Used for Reporting Performance	AEs should use their own EHR-based clinical data, patient age and sex data and REL data, and disability status data obtained from MCOs, to report stratified performance for all measures.
Reporting Template and Deadline	AEs must use the specified reporting template to report performance to EOHHS by August 31 of the year following the measurement year (e.g., AEs must report CY 2023 performance by August 31, 2024). A copy of this

	Excel reporting template can be obtained through EOHHS' SFTP site.[126]
Overall Parameters for Stratification	AEs should report stratified performance: • for each race, ethnicity, language and disability status stratification category separately (e.g., within race, report measure performance separately for White, Black or African American, etc.; within ethnicity, report measure performance separately for Hispanic/Latino and non-Hispanic/Latino; within language, report measure performance separately for English, Spanish, etc.); • using patient self-reported data gathered by AEs rather than imputing a patient's REL, and • for the AE-specific Medicaid patient population served by the AE provider network meeting each measure's specifications, across health plans. The total numerator and total denominator reported for each RELD stratification category should be the same (e.g., the total numerator reported across all race categories should be equal to the total numerator reported across all ethnicity categories, the total numerator reported across all language categories and the total numerator reported across all disability status categories).
Data Completeness Threshold	There is no RELD data completeness threshold for reporting performance stratified by RELD. Organizations should report on all patients for whom they have RELD data.
Required RELD Reporting Categories	AE can use any framework to collect REL data but should report stratified performance to EOHHS using the following framework. ***For race***: Non-FQHC-based AEs should use the following race categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022: • White • Black • American Indian/Alaska Native • Asian • Native Hawaiian and Other Pacific Islander • Some Other Race • Two or More Races • Declined • Unknown FQHC-based AEs should use the following race categories in use by HRSA for Uniform Data System (UDS) reporting: • White • Black/African American • American Indian/Alaska Native • Asian

[126] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

	• Native Hawaiian
	• Other Pacific Islander
	• More Than One Race
	• Unreported/Refused to Report
	  ○ FQHC-based AEs should separately reported data for "Unreported" and "Refused to Report" if they have the ability to do so.
	
	For ethnicity: Non-FQHC-based AEs should use the following ethnicity categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022:
	• Hispanic/Latino
	• Not Hispanic/Latino
	• Declined
	• Unknown
	
	FQHC-based AEs should use the following ethnicity categories in use by HRSA for UDS reporting:
	• Hispanic/Latino
	• Non-Hispanic/Latino
	• Unreported/Refused to Report
	  ○ FQHC-based AEs should separately reported data for "Unreported" and "Refused to Report" if they have the ability to do so.
	
	Please refer to the "Crosswalk of Race/Ethnicity Reporting Categories" section to see how commonly used frameworks for collecting race and ethnicity data map onto the categories AE should use when reporting stratified performance to EOHHS.
	
	For language: Use the following language categories. Health Level Seven Fast Healthcare Interoperability Resources (HL-7 FHIR) codes used in the US, when available, are included in parentheses.[127] If there is no US-based HL-7 FHIR code available, use the UK-based HL-7 FHIR code denoted with an asterisk (*).[128]
	• English (en)
	• Spanish (es)
	• Portuguese (pt)
	• Cape Verdean Creole (N/A – no HL-7 FHIR code available)
	• Haitian Creole (ht*)
	• Khmer (km*)
	• Lao (lo*)

[127] A full list of HL-7 FHIR common language codes used in the US can be found here: https://www.hl7.org/fhir/valueset-languages.html#definition.
[128] A full list of HL-7 FHIR common language codes used in the UK can be found here: https://simplifier.net/guide/ukcoredevelopment/codesystemukcore-humanlanguage.

	• Other • Unknown ***For disability status***: Use the following disability status categories: • Persons with Disabilities[129] • Persons without Disabilities • Unknown Information on disability status will be included in the annual quality reporting file from NHPRI and United. ***Note****: Each of the categories within each race, ethnicity, language, and disability status stratification are mutually exclusive. Therefore, the sum of all stratifications should equal the total population (e.g., the sum of all nine race stratifications should equal the total population).*
Measure Specifications	The RELD Measure specifications can be accessed from the CMS eCQM specifications for Eligible Professionals / Eligible Clinicians for 2022 for Measure #1 – Measure #3.[130] These specifications are designed for reporting by provider organizations. AEs can simply run the specifications as provided by CMS, but stratify performance by race, ethnicity and language. For Measure #4, eCQM specifications are not available. Therefore, the RELD Measure specifications are adapted from CMS' 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.[131]

[129] EOHHS defines patients with disabilities as those who belong to the following enrollment categories: children with special healthcare needs (i.e., adoption subsidy, Katie Beckett, SSI <15 years of age, SSI >=15 years of age, substitute care*), substitute/Department of Children, Youth & Families (DCYF) foster care*, and Rhody Health Partners (i.e., intellectual disability (ID), severe and persistent mental illness (SPMI), other disabled ages 21-44, other disabled ages 45+). Categories denoted with an asterisk (*) have enrollment only in NHPRI.

[130] See: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1&globalyearfilter=2021.

[131] See: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html.

Measure #1: Eye Exam for Patients with Diabetes (CMS131v11)[132]

Measure #1 – Description

Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.

Measure #1 – Denominator

Initial Population	Patients 18-75 years of age by the end of the measurement period with diabetes with a visit during the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period.
	• Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior
	  ○ OR advanced illness with one inpatient encounter during the measurement period or the year prior
	  ○ OR taking dementia medications during the measurement period or the year prior.
	• Exclude patients receiving palliative care for any part of the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. The sum of the denominators reported across all race categories should equal the denominator statement reported in Rate 1.
Rate 3	The denominator statement, stratified by ethnicity. The sum of the denominators reported across all ethnicity categories should equal the denominator statement reported in Rate 1.

[132] Source: CMS 2022 eCQM specifications for Diabetes: Eye Exam. https://ecqi.healthit.gov/ecqm/ec/2023/cms131v11.

Rate 4	The denominator statement, stratified by language. The sum of the denominators reported across all language categories should equal the denominator statement reported in Rate 1.
Rate 5	The denominator statement, stratified by disability status. The sum of the denominators reported across all disability status categories should equal the denominator statement reported in Rate 1.

Measure #1 – Numerator

Numerator Statement	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: • Diabetic with a diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period • Diabetic with no diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period or the year prior to the measurement period
Numerator Exclusions	Not applicable
Guidance	The eye exam must be performed by an ophthalmologist or optometrist, or there must be evidence that fundus photography results were read by a system that provides an artificial intelligence (AI) interpretation.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race. The sum of the numerators reported across all race categories should equal the numerator statement reported in Rate 1.
Rate 3	The numerator statement, stratified by ethnicity. The sum of the numerators reported across all ethnicity categories should equal the numerator statement reported in Rate 1.
Rate 4	The numerator statement, stratified by language. The sum of the numerators reported across all language categories should equal the numerator statement reported in Rate 1.
Rate 5	The numerator statement, stratified by disability status. The sum of the numerators reported across all disability status categories should equal the numerator statement reported in Rate 1.

Measure #2: Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control <8.0% (CMS122v11)[133]

Measure #2 – Description

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c <8.0% during the measurement year.

Measure #2 – Denominator

Initial Population	Patients 18-75 years of age by the end of the measurement period with diabetes with a visit during the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period.
	• Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior
	  ○ OR advanced illness with one inpatient encounter during the measurement period or the year prior
	  ○ OR taking dementia medications during the measurement period or the year prior.
	• Exclude patients receiving palliative care for any part of the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. The sum of the denominators reported across all race categories should equal the denominator statement reported in Rate 1.
Rate 3	The denominator statement, stratified by ethnicity. The sum of the denominators reported across all ethnicity categories should equal the denominator statement reported in Rate 1.
Rate 4	The denominator statement, stratified by language. The sum of the denominators reported across all language categories should equal the denominator statement

[133] Source: Modified from CMS 2022 eCQM specifications for Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%). https://ecqi.healthit.gov/ecqm/ec/2023/cms122v11.

	reported in Rate 1.
Rate 5	The denominator statement, stratified by disability status. The sum of the denominators reported across all disability status categories should equal the denominator statement reported in Rate 1.

Measure #2 – Numerator

Numerator Statement	Patients whose most recent HbA1c level (performed during the measurement period) is <8.0%.
Numerator Exclusions	Not applicable
Guidance	Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race. The sum of the numerators reported across all race categories should equal the numerator statement reported in Rate 1.
Rate 3	The numerator statement, stratified by ethnicity. The sum of the numerators reported across all ethnicity categories should equal the numerator statement reported in Rate 1.
Rate 4	The numerator statement, stratified by language. The sum of the numerators reported across all language categories should equal the numerator statement reported in Rate 1.
Rate 5	The numerator statement, stratified by disability status. The sum of the numerators reported across all disability status categories should equal the numerator statement reported in Rate 1.

Measure #3: Controlling High Blood Pressure (CMS165v11)[134]

Measure #3 – Description

Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Measure #3 – Denominator

Initial Population	Patients 18-85 years of age by the end of the measurement period who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.
	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period.
	• Exclude patients 66-80 by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior
	  ○ OR advanced illness with one inpatient encounter during the measurement period or the year prior
	  ○ OR taking dementia medications during the measurement period or the year prior.
	• Exclude patients 81 and older by the end of the measurement period with an indication of frailty for any part of the measurement period.
	• Exclude patients receiving palliative care for any part of the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. The sum of the denominators reported across all race categories should equal the denominator statement reported in Rate 1.

[134] Source: CMS 2022 eCQM specifications. https://ecqi.healthit.gov/ecqm/ec/2023/cms165v11.

Rate 3	The denominator statement, stratified by ethnicity. The sum of the denominators reported across all ethnicity categories should equal the denominator statement reported in Rate 1.
Rate 4	The denominator statement, stratified by language. The sum of the denominators reported across all language categories should equal the denominator statement reported in Rate 1.
Rate 5	The denominator statement, stratified by disability status. The sum of the denominators reported across all disability status categories should equal the denominator statement reported in Rate 1.

Measure #3 – Numerator

Numerator Statement	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.
Numerator Exclusions	Not applicable
Guidance	In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record. Do not include BP readings taken during an acute inpatient stay or an ED visit. If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race. The sum of the numerators reported across all race categories should equal the numerator statement reported in Rate 1.
Rate 3	The numerator statement, stratified by ethnicity. The sum of the numerators reported across all ethnicity categories should equal the numerator statement reported in Rate 1.
Rate 4	The numerator statement, stratified by language. The sum of the numerators reported across all language categories should equal the numerator statement reported in Rate 1.

Rate 5	The numerator statement, stratified by disability status. The sum of the numerators reported across all disability status categories should equal the numerator statement reported in Rate 1.

Measure #4: Developmental Screening in the First Three Years of Life[135]

Measure #4 – Description

Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday

Measure #4 – Denominator

Initial Population	Patients 1-3 years of age during the measurement period
Denominator Statement	Equals Initial Population
Denominator Exclusions	None
Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. The sum of the denominators reported across all race categories should equal the denominator statement reported in Rate 1.
Rate 3	The denominator statement, stratified by ethnicity. The sum of the denominators reported across all ethnicity categories should equal the denominator statement reported in Rate 1.
Rate 4	The denominator statement, stratified by language. The sum of the denominators reported across all language categories should equal the denominator statement reported in Rate 1.
Rate 5	The denominator statement, stratified by disability status. The sum of the denominators reported across all disability status categories should equal the denominator statement reported in Rate 1.

Measure #4 – Numerator

Numerator Statement	Patients who had screening for risk of developmental, behavioral and social delays using a standardized, validated tool that was documented in the 12 months preceding or on their first, second and third birthday
Numerator Exclusions	Not applicable
Guidance	Documentation in the medical record must include all of the following: • A note indicating the date on which the test was performed, and • The standardized tool used (see below), and • Evidence of a screening result or screening score

[135] Source: CMS 2022 Medicaid Child Core Set specifications. https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1674779700.

	Tools must meet the following criteria: 5. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional. 6. Established Reliability: Reliability scores of approximately 0.70 or above. 7. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s). 8. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above. The following tools meet the above criteria and are included in the Bright Futures Recommendations for Preventive Care, which reference the updated January 2020 American Academy of Pediatrics (AAP) Statement.[136] • Ages and Stages Questionnaire - 3rd Edition (ASQ-3) • Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8 • Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) • Survey of Well-Being in Young Children (SWYC) Note: The 2020 AAP Statement describes the screening tool properties that may be useful for states to consider in designing their policies. Tools included in the 2006 Statement that meet the above criteria but were not listed in the 2020 Statement (as they often are not used by primary care providers in the context of routine well-child care) include the following:[137] • Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months • Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2 • Brigance Screens-II - Birth to 90 months • Child Development Inventory (CDI) - 18 months to age 6 • Infant Development Inventory - Birth to 18 months The tools listed above are not specific recommendations for tools but are examples of tools cited in Bright Futures that meet the above criteria. Tools that do NOT meet the criteria: It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional

[136] Lipkin, Paul H., and Michelle M. Macias. "Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening." Pediatrics, vol. 145, no. 1, January 1, 2020. https://pediatrics.aappublications.org/content/145/1/e20193449.

[137] Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening." Pediatrics, vol. 118, no.1, July 2006, pp. 405-420. https://pediatrics.aappublications.org/content/118/1/405.

	development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race. The sum of the numerators reported across all race categories should equal the numerator statement reported in Rate 1.
Rate 3	The numerator statement, stratified by ethnicity. The sum of the numerators reported across all ethnicity categories should equal the numerator statement reported in Rate 1.
Rate 4	The numerator statement, stratified by language. The sum of the numerators reported across all language categories should equal the numerator statement reported in Rate 1.
Rate 5	The numerator statement, stratified by disability status. The sum of the numerators reported across all disability status categories should equal the numerator statement reported in Rate 1.

Crosswalk of Race/Ethnicity Reporting Categories

Crosswalk of Race/Ethnicity Categories

National Committee for Quality Assurance (NCQA) Categories[138]	Office of Management and Budget (OMB) Categories[139]	Health Resources & Services Administration (HRSA) Uniform Data System (UDS) Categories[140]
White	White	White
Black	Black or African American	Black/African American
American Indian/Alaska Native	American Indian or Alaska Native	American Indian/Alaska Native
Asian	Asian	Asian
Native Hawaiian and Other Pacific Islander	Native Hawaiian and Other Pacific Islander	Native Hawaiian
		Other Pacific Islander
Hispanic/Latino	Hispanic or Latino	Hispanic/Latino
Not Hispanic/Latino	Non-Hispanic or Latino	Non-Hispanic/Latino
Unknown	Unknown	Unreported/Refused to Report
Declined	Asked but No Answer	
Some Other Race	N/A	N/A
Two or More Races	N/A*	More than One Race

*OMB allows individuals to select more than one of the five race categories.

[138] Source: NCQA's Proposed Changes to Existing Measures for HEDIS MY 2022: Introduction of Race and Ethnicity Stratification Into Select HEDIS Measures. https://www.ncqa.org/wp-content/uploads/2021/02/02.-Health-Equity.pdf.

[139] Source: CMS' Inventory of Resources for Standardized Demographic and Language Data Collection. https://www.cms.gov/about-cms/agency-information/omh/downloads/data-collection-resources.pdf.

[140] Source: HRSA's Uniform Data System 2021 Health Center Data Reporting Requirements. https://data.hrsa.gov/tools/data-reporting/program-data/state/LA/table?tableName=7.

Appendix H: Emergency Department Utilization for Individuals Experiencing Mental Illness (OPY5 and OPY6)

Steward: Oregon Health Authority, December 22, 2020 Specifications, Adapted by Executive Office of Health and Human Services
As of August 3, 2022

SUMMARY OF CHANGES FOR 2023 (PERFORMANCE YEAR 6)

- No changes.

Description

Non-mental health and non-chemical dependency-related ED visits per 1,000 member months of adult members enrolled with an MCO and attributed to an AE who are identified as having experienced mental illness.

Eligible Population

Product lines	Medicaid
Ages	18 years or older as of December 31 of the measurement year
Continuous enrollment	None
Allowable gap	None
Anchor date	N/A
Lookback period	The measurement year and the two years preceding the measurement year (a rolling lookback period for total of 36 months)
Benefit	Medical
Event/diagnosis	Two or more visits with specific mental illness diagnoses. A 'visit' is defined as a unique member and date of service. See "Denominator" tab in Excel spreadsheet for eligible codes.
Exclusions	• Members in hospice care (see "Denominator Exclusions" tab in Excel spreadsheet for eligible codes)

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers.

	Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[141]

Administrative Specifications

Denominator	The eligible population, reported in 1,000 member months[142]
Numerator	Number of emergency department visits from the denominator (members experiencing mental illness), during the enrollment span with the organization within the measurement year. Count each visit to an ED that does not result in an inpatient encounter once; count multiple ED visits on the same date of service as one visit.[143] EOHHS is calculating the measure using the revenue codes associated with visits to the ED. See the "Numerator Option 1" tab in the Excel spreadsheet for eligible codes.[144]
Numerator Exclusions[145]	• ED visits that result in an inpatient stay. • Mental health and chemical dependency services. See "Numerator Exclusions" tab in Excel spreadsheet for eligible codes.

[141] https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

[142] A member should be included in the measure due to a history of qualifying mental illness claims in the 36-month lookback period for the MCO with which they have coverage as of December 31st of the measurement year. Of note, if an MCO does not have 36 months of claims for the member, it should utilize all the claims it has for the member for up to 36 months for the lookback period (e.g., if an MCO only has 24 months of claims for a member, it should utilize all of the 24 months for the lookback period).

[143] When an outpatient, ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the outpatient/ED/observation date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An outpatient, ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

[144] While EOHHS is using "Numerator Option 1" to calculate performance for this measure, MCOs could also calculate the measure using codes associated with procedures that are commonly performed in an ED with an ED place of service code. See the "Numerator Option 2" tab in the Excel spreadsheet for eligible codes.

[145] Apply exclusions at the claim line level. Keep all paid claim lines (i.e., unless the entire claim was denied, the paid lines pass through the algorithm and are picked up for this exclusion).

Excel Spreadsheet

ED Utilization for
Individuals Experien

Appendix I: Potentially Avoidable ED Visits (OPY5, OPY6 and OPY7)

Steward: New York University, Modified by Rhode Island Executive Office of Health and Human Services
As of August 3, 2022

SUMMARY OF CHANGES FOR 2023 (PERFORMANCE YEAR 6)

- No changes.

Numerator

The total sum of the probabilities of 1) preventable/avoidable emergent ED visits, 2) non-emergent ED visits, and 3) emergent ED visits that could have been avoided by regular primary care, using the probabilities supplied by NYU for the primary diagnosis code (ICD-9/10) of each ED visit. Only visits from Medicaid members should be included. There are no age or continuous enrollment exclusions.

Denominator

All ED visits for Medicaid members in the measurement period. There are no age or continuous enrollment exclusions.

Calculated: Preventable ED Visit Rate

The total potentially avoidable ED visits (numerator) divided by all ED visits, stratified by MCO and AE.

Patient/Provider Attribution to AEs

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

	providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[146]

Additional Information

Additional Information on the NYU methodology, including a list of ICD-9/10 codes can be found here: https://wagner.nyu.edu/faculty/billings/nyued-background.

- Validation of an Algorithm for Categorizing the Severity of Hospital Emergency Department Visits: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3881233/.

[146] https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.