

Quality ID #487: Screening for Social Drivers of Health

2023 COLLECTION TYPE: **MIPS CLINICAL QUALITY MEASURES (CQMS)**

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

Measure Submission Type:

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

DENOMINATOR:

Number of patients 18 years and older

DENOMINATOR NOTE: *Signifies that this CPT Category I or HCPCS code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.

Denominator Criteria (Eligible Cases):

Patients aged 18 and older on date of encounter

AND

Patient encounter during the performance period (CPT): 59400, 59510, 59610, 59618, 78012, 78070, 78075, 78102, 78140, 78185, 78195, 78202, 78215, 78261, 78290, 78300, 78305, 78315, 78414, 78428, 78456, 78458, 78579, 78580, 78582, 78597, 78601, 78630, 78699, 78708, 78725, 78740, 78801, 78803, 78999, 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 92002, 92004, 92012, 92014, 92507, 92508, 92521, 92522, 92523, 92524, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92548, 92549, 92550, 92557, 92567, 92568, 92570, 92588, 92625, 92626, 92650*, 92651, 92652, 92653, 96116, 96156, 96158, 97129, 97161, 97162, 97163, 97164, 97802, 97803, 97804, 98960, 98961, 98962, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99236, 99242*, 99243*, 99244*, 99245*, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, 99495, 99496, 99512*, D0120*, D0140*,

D0145*, D0150, D0160*, D0170*, D0180*, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, G0473, G9054

NUMERATOR:

Number of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

NUMERATOR NOTE: The patient is required to have a standardized health-related social needs (HRSN) screening done once per performance period. Documentation that a review of a previous performed standardized HRSN screening during the performance period is acceptable for meeting the numerator criteria.

Examples of standardized HRSN screening tools include but are not limited to:

Accountable Health Communities Health-Related Social Needs Screening Tool ([2017](#))

Accountable Health Communities Health-Related Social Needs Screening Tool ([2021](#))

The Protocol for Responding to and Assessing Patients' Risks and Experiences (PRAPARE) Tool ([2016](#))

WellRx Questionnaire ([2014](#))

American Academy of Family Physicians (AAFP) Screening Tool ([2018](#))

Numerator Options:

Performance Met:

Number of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety (**M1207**)

OR

Performance Not Met:

Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. (**M1208**)

RATIONALE:

An estimated 20 percent of health outcomes are linked to medical care; the remaining 80 percent stem from socioeconomic, environmental and behavioral factors referred to as drivers of health (DOH) (Magnan, 2017). These factors such as homelessness, food insecurity, and exposure to intimate partner violence (IPV)—are linked to poorer health, disproportionately impact communities of color, and have escalated due to COVID-19. Research demonstrates that 66 percent of physician practices are screening for one or more of the 5 DOH domains specified in this measure (Fraze et al., 2019). A 2022 survey by the Physicians Foundation found that 65 percent of U.S. physicians believe that implementing DOH quality measures are important to improve health outcomes and to ensure high-quality and cost-efficient care (Physicians Foundation, 2022). In a cross-sectional analysis of physicians who participated in the first year of the MIPS program, physicians caring for patients with increased social risk had significantly lower MIPS scores compared with other physicians (Khullar et al., 2020). Given MIPS's intent to implement performance-based payment adjustments, not accounting for DOH – which are associated with approximately 38 percent of the geographic variation in per beneficiary Medicare spending (Zhang et al., 2021) – in MIPS is likely confounding these adjustments (Byrd & Chung, 2021).

CLINICAL RECOMMENDATION STATEMENTS:

In COVID-19's wake, food insecurity, housing instability, IPV, and other basic DOH have reached unprecedented levels – and revealed searing racial disparities. In 2021, 17 percent of Black adults and 16 percent of Latino adults reported that their household did not get enough to eat, compared to 6 percent of white adults. Likewise, 28 percent of Black, 18 percent of Latino, and 20 percent of Asian renters are not caught up on rent, compared to 12 percent of white renters (Center for Budget and Policy Priorities, 2021).

Secretary Becerra has pledged “to take a department-wide approach to the advancement of equity, consistent with President Biden’s charge to federal departments and agencies, and this would include examination of ways to address the social determinants of health” (Senate Finance Committee, 2021). In particular, he has noted the importance of collecting more robust DOH data to address the disparities exposed by COVID-19 and leveraging the data and experience from the

CMMI Accountable Health Community (AHC) model, which has screened nearly one million beneficiaries (Senate Health Committee, 2021).

CMS has recognized the importance of making DOH measures standard across programs, identifying the development and implementation of “measures that reflect social and economic determinants” as a key priority and measurement gap to be addressed through Meaningful Measures 2.0 (Centers for Medicare & Medicaid Services, 2022).

A growing set of constituencies have called on CMS to provide leadership in measuring and addressing DOH, citing various rationales for doing so. Healthcare experts have increasingly recognized that equity is unachievable without addressing DOH (Dutton et al., 2021), calling for CMS to require program “participants to uniformly screen for and document drivers of health” and “build DOH measures into MIPS and all APMs” (Navathe et al., 2021). The Health Care Payment Learning & Action Network (LAN) – a group of public and private health care leaders providing thought leadership, strategic direction, and ongoing support to accelerate adoption of APMs – has identified promoting equity and addressing DOH as key facets of APM resiliency (Health Care Payment Learning & Action Network, 2020).

Likewise, physicians and other providers have called on CMS to create standard patient-level DOH measures – beyond socioeconomic status (SES), hierarchical condition category (HCC) score, or duals status – recognizing that these risk factors transcend specific subpopulations (Berkowitz et al., 2017); drive demand for healthcare services (Physicians Foundation, 2020); and escalate physician burnout (Marchis et al., 2019).

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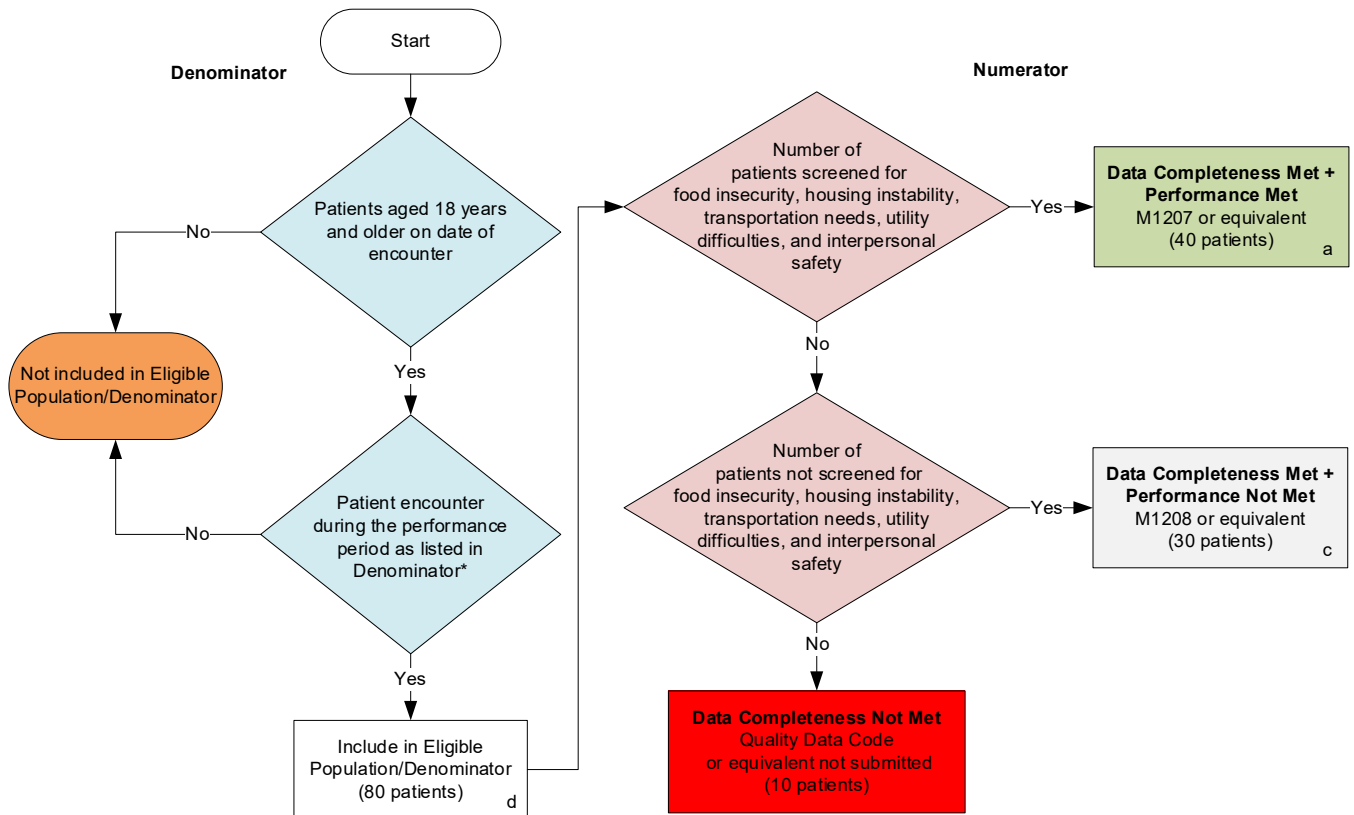
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2023 Clinical Quality Measure Flow for Quality ID #487: Screening for Social Drivers of Health

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



SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met (a=40 patients) + Performance Not Met (c=30 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 patients)}} = \frac{40 \text{ patients}}{70 \text{ patients}} = 57.14\%$$

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

NOTE: Submission Frequency: Patient-Process

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**2023 Clinical Quality Measure Flow Narrative Quality ID #487:
Screening for Social Drivers of Health**

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

1. Start with Denominator
2. Check *Patients 18 years and older on date of encounter*.
 - a. If *Patients 18 years and older on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients 18 years and older on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
 - a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Denominator Population:
 - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
5. Start Numerator
6. Check *Number of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety*:
 - a. If *Number of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety* equals Yes, include in *Data Completeness Met and Performance Met*.
 - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.
 - b. If *Number of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety* equals No, proceed to check *Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety*.
7. Check *Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety*.
 - a. If *Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety* equals Yes, include in *Data Completeness Met and Performance Not Met*.
 - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.
 - b. If *Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties,*

and interpersonal safety equals No, proceed to check Data Completeness Not Met.

8. Check *Data Completeness Not Met*:

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

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population / Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

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

NOTE: Submission Frequency: Patient-Process

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