# **2024 MIPS Peer-Reviewed Journal Article Requirement Template**

Section 101(c)(1) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals prior to implementing in the Merit-based Incentive Payment System (MIPS). Such measures will be submitted by the Centers for Medicare & Medicaid Services (CMS), to a journal(s), before including any new measure on the MIPS Quality Measures List. The measure submitter shall provide the required information for article submission under the MACRA per the MIPS Annual Call for Quality Measures submission process.

Interested parties submitting measures for consideration through the MIPS Annual Call for Quality Measures must complete the required information by the CMS Annual Call for Measures deadline (8 p.m. ET on May 10, 2024). Some of the information requested below may be listed in specific fields in the CMS Measures Under Consideration (MUC) Entry/Review Information Tool (MERIT); however, to ensure that CMS has all of the necessary information and avoid delays in the evaluation of your submission, please fully complete this form as an attached Word document. The information in MERIT must be consistent with the information below, including the following, but not limited to:

* Addressing Social Needs Electronic Clinical Quality Measure in the Outpatient Setting
* **[Meaningful Measures 2.0 Framework Domain]**

Wellness and Prevention

**Measure Steward:** Centers for Medicare & Medicare Services

**Measure Developer:** Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation

**Description:** The measure calculates thepercentages of patients with a qualifying evaluation and management outpatient visit during the performance period of all ages reflecting whether patients were assessed in four domains of social need: food, housing, transportation, and utilities, and whether the patient received a qualifying follow-up action within the visit for any positive social needs. Qualifying follow-up actions were identified from Gravity Project: adjustment, assistance/assisting, coordination, counseling, education, evaluation of eligibility, provision, and referral.

1. **Statement**

* **Background (Why is this measure important?)**

Assessments for social needs provides an opportunity to improve population health and advance health equity. The measure is aligned with CMS National Quality Strategy goal to address the disparities that underlie our health system, both within and across settings, to ensure equitable access and care for all.1 This measure, which focuses on assessment for social drivers of health, is aligned with main objectives of the CMS Universal Foundation.2 Historical and contemporary discrimination contribute to higher levels of unmet social needs among certain social groups. Systematic assessment and follow-up for unmet social needs may help mitigate some race-based inequities that exist in material hardships.3 There exist opportunities to improve the rates of assessment for social needs. While some hospitals and outpatient facilities currently screen patients for unmet social needs, few comprehensively and universally screen for multiple unmet needs using standardized and validated tools; collect and transfer data electronically using national interoperability standards; set person-centered goals around unmet needs; and provide goal-oriented actions, such as interventions, referrals, and direct supports.4 Measurement using standardized and validated screening instruments that are collected and transmitted using certified electronic health records (EHRs), aims to make care coordination more effective, enable more efficient measurement, reduce administrative burden, and enhance health ecosystem efficiency.

* **Environmental scan (Are there existing measures in this area?).**

The primary objective is to redesign existing measures to improve and transform them into a fully digital electronic clinical quality measure (eCQM), incorporating all payer data. The redesigned Addressing Social Needs (ASN) eCQM will evaluate how hospitals respond to social needs that affect health by calculating percentages of patients with a qualifying evaluation and management outpatient visit during the performance period of all ages reflecting whether patients were assessed in four domains of social need: food, housing, transportation, and utilities, and whether the patient received a qualifying follow-up action within the visit for any positive social needs.

1. **Gap Analysis**

* **Provide evidence for the measure (What are the gaps and opportunities to improve care?).**

Unmet social needs are common among Medicare patients. Over 35 percent of patients screened as part of the CMS Accountable Health Communities program reported at least one unmet social need and were eligible for a referral to community services.5 In recent years there has been growing awareness among policymakers, health plans, providers, and hospitals about the importance of screening for unmet social needs. While screening for unmet social needs is underway in many settings, evidence suggests opportunities for systematic improvements. In 2022, a study reported majority of hospitals (83%) collect social risk data and half (54%) indicate routine collection of social determinants of health (SDOH) data. Routine collection of social risk data varies by hospital characteristics (i.e. urban versus rural, critical access versus non).6 A 2019 study published in JAMA Network Open examined the prevalence of screening for food insecurity, housing instability, utility needs, transportation needs, and interpersonal violence by US physician practices and hospitals, and found that only 25% of hospitals and 16% of physician practices reported screening for all social domains identified in the study.4 Screening varied significantly based on social risk. Hospital screening for transportation insecurity is the most prevalent (74% for hospitals), while screening for utility needs is the least prevalent (36% for hospitals). Preliminary data on screening in health plan settings released by the National Committee for Quality Assurance (NCQA) found overall low rates of screening with performance rates being highest for food (12.6%), followed by transportation (3.5%) and then housing (3.3%). The majority, but not all, of those with a positive screen requested and received an intervention, with highest rates for food (75.1%) followed by transportation (68.5%) and housing (24.3%).7 Less information is available specifically for the Medicare population. Over 35% of patients screened as part of the CMS Accountable Health Communities program reported at least one unmet social need and were eligible for a referral to community services.8

There is paucity of information regarding potential disparities in screening or intervention rates. A study examining prevalence of social risk at six- and 12-month look-back periods did not find significant differences between timepoints, suggesting annual assessments are reliable. Yearly assessments for social needs in outpatient settings may reduce patient survey fatigue and system burden.9 Some evidence suggests the need for greater screening in lower income settings. For example, one study reported social needs screening rates were higher among disproportionate share hospitals.10 There is also evidence that suggests access to support services, such as community-based interventions, may be less available in high need communities, raising concern about potential disparities.11 From an operational perspective, there are also concerns about resource requirements associated with this measure for hospitals; for example, hospitals with high social needs population will require much more intervention than hospitals with low social needs. There may be a need to mitigate by developing a measure scoring system that considers the differences in social needs across populations. While health systems increasingly collect SDOH data, integration into the EHR remains a challenge. This is likely due to standardized SDOH LOINC (screening) and SNOMED CT (intervention) codes not being fully implemented in most facilities. A study found 80% of respondents used a standardized coding system (i.e. ICD-10-CM diagnosis codes, CPT codes, SNOMED-CT, or LOINC), to code SDOH data elements, yet a gap remains for accurate and consistent application of these codes to capture of SDOH data.12 Environmental scan of the literature reveals increasing documentation of social needs assessments but follow up actions are less commonly found in a standardized format within EHRs**.**10-12

* **Expected outcome (patient care/patient health improvements, cost savings).**

The 2019 National Academies of Science, Engineering and Medicine (NASEM) Report Integrating Social Care into the Delivery of Health Care identified better awareness for the unmet social needs of defined patients and populations an important strategy for improving health and social outcomes.13 While the growing literature base suggests positive impacts of social care interventions, conclusive evidence on effectiveness of social interventions to improve health and moderate costs remains limited across many domains.14-15 Thus, while it is likely there will be some immediate opportunities to reduce material hardship (i.e., moderate the symptoms of food insecurity) and potentially improve chronic disease outcomes, at this stage it is challenging to draw general conclusions around the potential efficacy of such interventions on population health and cost outcomes.16

* **Recommendation for the measure (Is it based on a study, consensus opinion, USPSTF recommendation etc.?).**

Driven by the extensive evidence on the role of SDOH on health outcomes and health equity, identifying and addressing social needs is a national clinical priority. This is evidenced by the guidelines of multiple US professional organizations. Both the American Academy of Family Physicians and American Academy of Pediatrics detail professional requirements to address SDOH in policy and practice statements. Both professional orgs specific a requirement to address SDOH directly for patients and through broader social policy toward the goal of health equity.17-19

The American College of Obstetricians and Gynecologists detail a need to address SDOH to improve patient centeredness and assist the goal of reducing inequities in reproductive health care.20

The American Diabetes Association included the importance of addressing SDOH in its updated Standards of Care for Diabetes.21

In a broad review of professional medical association statements, it was found that across the AAP, AAFP, APA, AMA, ACP, ACC, ACOG, ACEP there were consistent statements on the importance of screening and intervening on SDOH to improve health outcomes and address health inequities.22

USPSTF recommendation: American Diabetes Association provided the evidence-grading system for clinical practice recommendations. (2021). Improving Care and Promoting Health in Populations: Standards of Medical Care in Diabetes—2021. Diabetes Care, 44(Supplement 1), S7–S14. <https://doi.org/10.2337/dc21-S001>

1. **Reliability/Validity**

* **What testing has been performed at the level of implementation? (MIPS requires full measure testing at the individual clinician level (and may also need to be tested at the group level) for MIPS Clinical Quality Measures (CQMs) and Electronic Clinical Quality Measures (eCQMs) collection types. Administrative claims measures tested at the group level require a reliability threshold to be implemented at the group level.)**

**Please provide testing results including the N value, Bonnie test case results, correlation coefficient and any other pertinent information or values to be considered.**

* + **Reliability Testing Results at the accountable entity level**
    - Not yet complete, expected August 2024
  + **Face Validity Testing Results, Clinician Sites**

We systematically assessed the face validity of the measure score as an indicator of quality by soliciting the TEP members agreement with the following statement: The OUTPATIENT Addressing Social Needs Electronic Clinical Quality Measure could differentiate good from poor quality care among providers (or accountable entities),

Results of the TEP rating of agreement with the validity statement were as follows: A total of 14 TEP members responded. The scale was as follows: *strongly agree, agree, neutral disagree, strongly disagree.* There were 2 votes for strongly agree (14.3%), 3 votes for agree (21.4%),7 votes for neutral (50%), 0 votes for disagree (0%), and 2 votes for strongly disagree (14.3%).

Face validity: 85.7% of TEP members either agreed or were neutral that the ASN eCQM measure could differentiate good from poor quality care. Members who voted in agreement noted the activities captured by the measure align with definition of good care, members who voted in neutrality noted uncertainty of how the measure would determine quality of care by capturing percentage of patients screened and percentage of follow up for positive screenings.

The 14.3% of TEP members who voted disagree or strongly disagree noted the following reasons for disagreement:

* + 1. They were unclear how the numerator and denominator are defined.
    2. It was noted the numerator was too broad, while the denominator only counts specific visit types, potentially skewing results.
    3. Patient satisfaction, particularly regarding follow up on positive assessments, might not accurately reflect provider performance since many solutions rely on community resources outside of a provider’s control.
    4. They were concerned about the measure's timing, noting the timeframe for follow-up is unrealistically short and not necessarily aligned with the provision of effective interventions.
    5. Feasibility of the measure was a concern, particularly in terms of data capture within EHR systems.
    6. They were concerned results do not reflect why a lack of follow-up occurred, which might be the result of limited resources available at the community level, which providers should not be held accountable for.

Due to the currently available data in ecosystem, we were unable to conduct the face validity vote on the final performance measure with the TEP prior to MUC submission. We have entered results in which the TEP voted on measure importance based off the fully specified measure and testing plan. We intend to provide face validity results on the final performance measure in August 2024.

* + **Empiric Validity Testing Results at the accountable entity level**
    - Not yet complete, expected August 2024

* + **Data Element/Patient Encounter Level Testing**
    - Not yet complete, expected August 2024
  + **Exclusion Frequency** 
    - Not yet complete, expected August 2024
  + **What were the minimum sample sizes used for reliability results?** 
    - Not yet complete, expected August 2024
  + **Other Information**
* **Is it risk adjusted?** 
  + No, the measure is not risk adjusted.
* **What benchmarking information is available?** 
  + None at this time
* **Collection Type: Specify the data collection type.**
  + ALL data elements are in defined fields in electronic sources
* **Specify measure stage of development.**
  + Testing stage
* For Patient Reported Outcome Performance Measures:
  + The survey or tool has been tested and doesn’t require modifications based on results?
  + Patient/encounter level testing for each critical data element doesn’t require changes to the tool base on the results?

1. **Endorsement**

* **Provide the Consensus-Based Entity (CBE) (i.e., Partnership for Quality Measures (PQM)) endorsement status (and CBE ID) and/or other endorsing body. If the measure is only endorsed for paper records, please note endorsement for only the data source being submitted.**

The measure has not been submitted for CBE Endorsement yet.

1. **Summary**

* **Alignment with CMS Meaningful Measures Initiative or MACRA (if applicable).**

This measure aligns with CMS Meaningful Measures Initiative interrelated goals by improving and transforming existing measures into fully a digital format to standardize social needs data collection and enhance data analytics. The measure is calculated using data from electronic health records. Successful completion of the measure requires that eligible clinical settings encode information on screening, diagnoses, and follow-ups into structured data elements in accordance with the United States Core Data for Interoperability (USCDI), a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange. The ASN eCQM measure will be FHIR-based to exchange clinical information through application programing interfaces (APIs). The primary mission of the ASN eCQM measure is to address social determinants of health (SDOH) for progress toward health equity.

* **Relevance to MIPS or other CMS programs.**

This measure builds upon the Quality ID #487: Screening for Social Drivers of Health mea This measure builds upon the Quality ID #487: Screening for Social Drivers of Health measure. The ASN eCQM expands this measure population to all ages and limits the social needs categories to housing, food, utilities, and transportation. Additionally, it measures the rate of patients who receive a follow-up action if screened positive in each domain screened.

The measure #498: Connection to Community Service Provider captures percentage of patient who had contact with a Community Service Provider (CSP) for at least one of their HRSNs within 60 days after screening. The ASN eCQM limits the social needs categories to housing, food, utilities, and transportation and allows for multiple types of follow-up/intervention to occur. Additionally, the follow-up must be completed during the visit and documented within two days.

Additionally, the measure population and timing for documentation of assessment and intervention are based upon those utilized in the MIPS Measure #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan. The ASN eCQM expands this measure population to all ages and limits the social needs categories to housing, food, utilities, and transportation. Additionally, it measures the rate of patients who receive a follow-up action if screened positive in each domain screened.

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* **Rationale: Use of measure for inclusion in program (specialty society, regional collaborative, other).**

Based on the evidence, this measure supports a national clinic priority. The measure requires eligible clinical settings encode information on screening, diagnoses, and follow-ups into structured data elements in accordance with the United States Core Data for Interoperability (USCDI), for nationwide interoperable health information exchange to support requirements capable of addressing SDOH in policy and practice.

The ASN eCQM expands measure population to all ages and limits the social needs categories to housing, food, utilities, and transportation. Additionally, it measures the rate of patients who receive a follow-up action if screened positive in each domain screened. The measure requires that eligible clinical settings encode information on screening, diagnoses, and follow-ups into structured data elements in accordance with the United States Core Data for Interoperability (USCDI), a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange. The ASN eCQM measure will be FHIR-based to exchange clinical information through application programing interfaces (APIs). The primary mission of the ASN eCQM measure is to address social determinants of health (SDOH) for progress toward health equity. In a broad review of professional medical association statements, it was found that across the AAP, AAFP, APA, AMA, ACP, ACC, ACOG, ACEP there were consistent statements on the importance of screening and intervening on SDOH to improve health outcomes and address health inequities

* **Public reporting (if applicable).** 
  + N/A
* **Preferable relevant peer-reviewed journal for publication.**

Journal of the American Medical Association

* **Rationale as to how the measure correlates to existing cost measures and improvement activities, as applicable and feasible.** 
  + This measure builds on existing SDOH measures to include accountability for following up on patients’ social needs.

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