Quality ID #498: Connection to Community Service Provider

2025 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percent of patients 18 years or older who screen positive for one or more of the following health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least one of their HRSNs within 60 days after screening.

INSTRUCTIONS:
This measure is to be submitted a minimum of once per performance period for patients seen during the performance period. This measure is intended to reflect the quality of services provided for patients who are screened for HRSNs. 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: Include only patients that have been seen during the denominator identification period of November 1st of the previous performance period through October 31st of the current performance period. This will allow the evaluation of at least 60 days after the denominator eligible encounter within the performance period.

NOTE: Patient encounters for this measure conducted via telehealth (including but not limited to encounters coded with GQ, GT, POS 02, POS 10) are allowable. Please note that effective January 1, 2025, while a measure may be denoted as telehealth eligible, specific denominator codes within the encounter may no longer be eligible due to changes outlined in the CY 2024 PFS Final Rule List of Medicare Telehealth Services.

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

DENOMINATOR:
Patients aged 18 years or older who screened positive for at least one of the five HRSN domains (food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety) during the measurement period

Definitions:
Community Service Provider (CSP) – Defined as any independent, for-profit, non-profit, state, territorial, or local agency capable of addressing core or supplemental health-related social needs. The clinician's own organization may be considered a CSP for the purposes of the measure (e.g., a clinic with an in-house food pantry or co-located housing resources).

Denominator Identification Period – The period in which eligible patients can have a denominator eligible encounter. The "denominator identification period" occurs from November 1st of the previous performance period thru October 31st of the current performance period. This will allow for a full 12-month period for denominator eligibility determination.

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

Denominator Criteria (Eligible Cases):
Patients aged 18 years or older
AND
Patient encounter during the denominator identification period (CPT or HCPCS): 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, 92622, 92625, 92626, 92650*, 92651, 92652, 92653, 96116, 96156, 96158, 97129, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 99202, 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, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99421, 99422, 99423, 99429*, 99495, 99496, 99512*, D0120, D0140, D0145, D0150, D0160, D0170, D0180, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0108, G0136, G0270, G0271, G0402, G0438, G0439, G0447, G0473, G9054
AND
Patients who screened positive for at least 1 of the 5 HRSNs: M1320
AND NOT
DENOMINATOR EXCLUSION:
Patients who are counseled on connection with a CSP and explicitly opt out: M1317

NUMERATOR:
Patients who had contact with a CSP for at least one of their HRSNs within 60 days after screening

Definition:
Contact – For the purpose of reporting this measure, defined as engagement with CSP for the purpose of addressing at least one HRSN, either as reported by patient or acknowledged from CSP.

NUMERATOR NOTE: Electronic health record and non-electronic clinical data, as well as patient reported data and electronic data received from CSP may be used to determine whether contact was made with a CSP.

Numerator Options:
Performance Met: Patients who had documented contact with a CSP for at least one of their screened positive HRSNs within 60 days after screening (M1319)

OR

Performance Not Met:	Patients who did not have documented contact with a CSP for at least one of their screened positive HRSNs within 60 days after screening OR documentation that there was no contact with a CSP (M1318)

RATIONALE:

In its 2022 Strategic plan, CMS placed screening for and acting on health-related social needs as a key goal underpinning its strategic health equity pillar [1]. In particular, HHS Secretary Becerra has noted the importance of collecting more robust DOH data to address the disparities [2,3] exposed by COVID-19 and leveraging the data and experience from the CMMI Accountable Health Community (AHC) model, which has screened over one million beneficiaries [4]. CMS has also 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 [5].

Healthcare experts have increasingly recognized that equity is unachievable without addressing Social Drivers of Health (SDOH) [6], calling for CMS to require program "participants to uniformly screen for and document drivers of health" and "build [S]DOH measures into MIPS and all APMs" [7]. Likewise, physicians and other providers have called on CMS to create standard patient-level SDOH measures – beyond socioeconomic status (SES), hierarchical condition category (HCC) score, or dual-eligible status – recognizing that these risk factors transcend specific subpopulations [8]; associate with poorer health outcomes [9]; drive demand for healthcare services [10]; escalate physician burnout [11]; and penalize physicians caring for those patients via worse Merit-based Incentive Payment System (MIPS) scores [12, 13].

Along with existing SDOH screening measures, understanding the nature and frequency of patient connection to community resources provides valuable insight into efforts to address SDOH across sectors and in communities. This measure leverages data and experience from OCHIN's nationwide network of Community Health Centers, who as of January 2023 had documented over 1.6 million SDOH screens in the EHR, as well as CMMI's 5+ years of data and experience with the Accountable Health Communities (AHC) program [14, 15], which measured screening, referral, and navigation across over 1.1 million beneficiaries.

References

1. Centers for Medicare & Medicaid Services. CMS Strategic Plan Pillar: Health Equity. 2022. https://www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf. Accessed September 2022.
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CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF provides a "B" recommendation that recommends that clinicians screen for Intimate Partner Violence (one of the HRSNs included in the denominator of the proposed measure) in women of reproductive age and provide or refer women who screen positive to ongoing support services [1]. They cite adequate evidence that available screening instruments can identify IPV in women, and that screening for IPV in women of reproductive age and providing or referring women who screen positive to ongoing support services has a moderate net benefit.

In addition to this individual measure, USPSTF has also released a technical brief on screening and interventions for social risk factors [2] which notes that social risk factors are mentioned in two-thirds of USPSTF recommendation statements, and six other professional medical organizations explicitly promote clinician engagement in social risk screening and referrals. The report also highlights the lack of unintended consequences encountered during implementation of social risk screening and intervention in studies reporting these outcomes, despite any perceived barriers.

References

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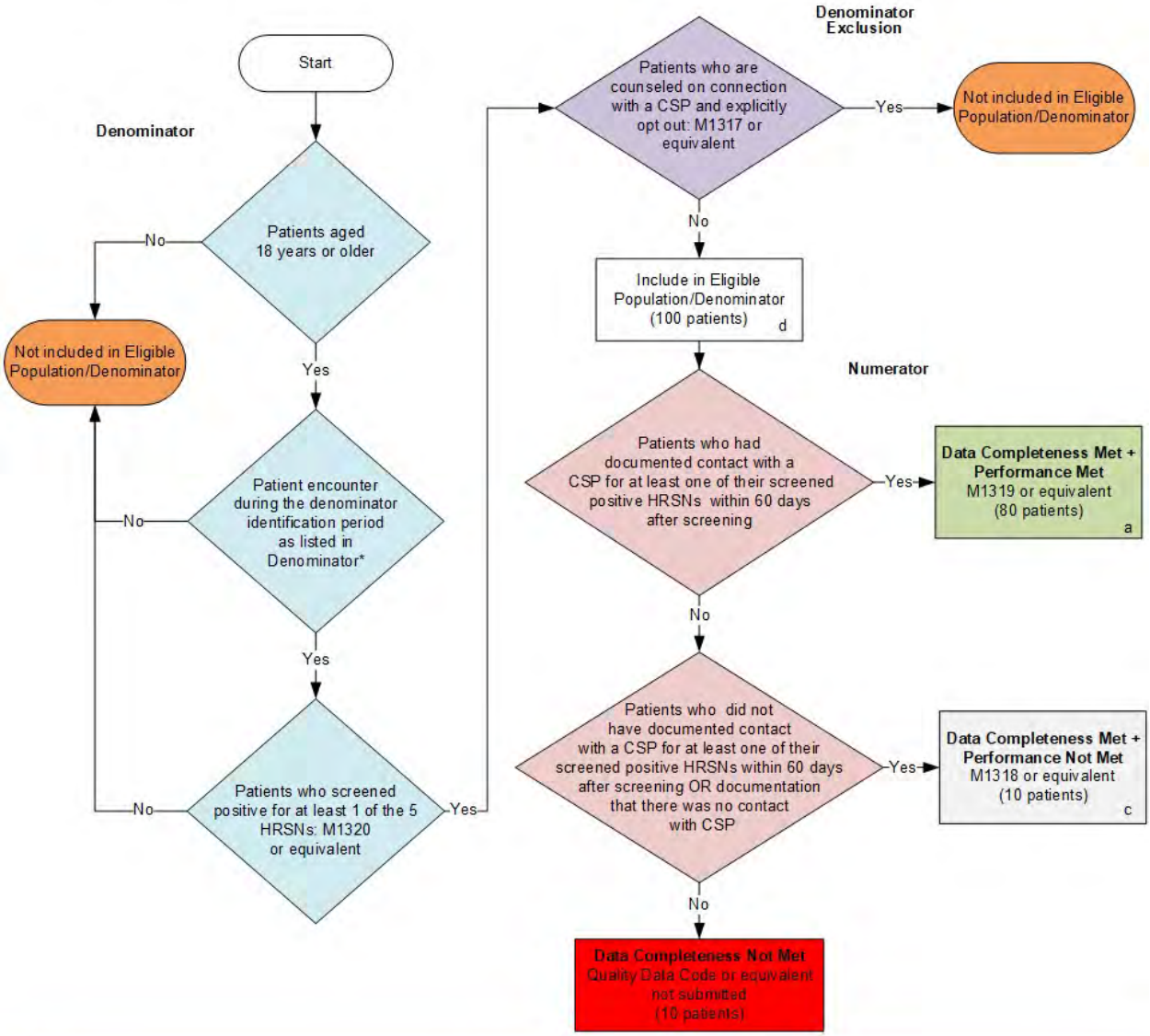
2025 Clinical Quality Measure Flow for Quality ID #498: Connection to Community Service Provider

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



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a=80 patients) + Performance Not Met (c=10 patients) = 90 patients = **90.00%**
Eligible Population / Denominator (d=100 patients) = 100 patients

Performance Rate=
Performance Met (a=80 patients) = 80 patients = **88.89%**
Data Completeness Numerator (90 patients) = 90 patients

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

2025 Clinical Quality Measure Flow Narrative for Quality ID #498: Connection to Community Service Provider

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

1. Start with Denominator

2. Check *Patients aged 18 years or older:*

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

    b. If *Patients aged 18 years or older* equals Yes, proceed to check *Patient encounter during the denominator identification period as listed in Denominator*.*

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

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

    b. If *Patient encounter during the denominator identification period as listed in Denominator** equals Yes, proceed to check *Patients who screened positive for at least 1 of the 5 HRSNs.*

4. Check *Patients who screened positive for at least 1 of the 5 HRSNs:*

    a. If *Patients who screened positive for at least 1 of the 5 HRSNs* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients who screened positive for at least 1 of the 5 HRSNs* equals Yes, proceed to check *Patients who are counseled on connection with a CSP and explicitly opt out.*

5. Check *Patients who are counseled on connection with a CSP and explicitly opt out*:

    a. If *Patients who are counseled on connection with a CSP and explicitly opt out* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.

    b. If *Patients who are counseled on connection with a CSP and explicitly opt out* equals No, include in *Eligible Population/Denominator*.

6. Denominator Population:

    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 100 patients in the Sample Calculation.

7. Start Numerator

8. Check *Patients who had documented contact with a CSP for at least one of their screened positive HRSNs within 60 days after screening:*

    a. If *Patients who had documented contact with a CSP for at least one of their screened positive HRSNs within 60 days after screening* 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 80 patients in the Sample Calculation.

b. If *Patients who had documented contact with a CSP for at least one of their screened positive HRSNs within 60 days after screening* equals No, proceed to check *Patients who did not have documented contact with a CSP for at least one of their screened positive HRSNs within 60 days after screening OR documentation that there was no contact with CSP.*

9. Check *Patients who did not have documented contact with a CSP for at least one of their screened positive HRSNs within 60 days after screening OR documentation that there was no contact with CSP*:

    a. If *Patients who did not have documented contact with a CSP for at least one of their screened positive HRSNs within 60 days after screening OR documentation that there was no contact with CSP* 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 10 patients in the Sample Calculation.

    b. If *Patients who did not have documented contact with a CSP for at least one of their screened positive HRSNs within 60 days after screening OR documentation that there was no contact with CSP* equals No, proceed to check *Data Completeness Not Met*.

10. *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 80 patients) plus Performance Not Met (c equals 10 patients) divided by Eligible Population/Denominator (d equals 100 patients). All equals 90 patients divided by 100 patients. All equals 90.00 percent.

Performance Rate equals Performance Met (a equals 80 patients) divided by Data Completeness Numerator (90 patients). All equals 80 patients divided by 90 patients. All equals 88.89 percent.

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

measure. NOTE: Submission Frequency: Patient Periodic

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.