

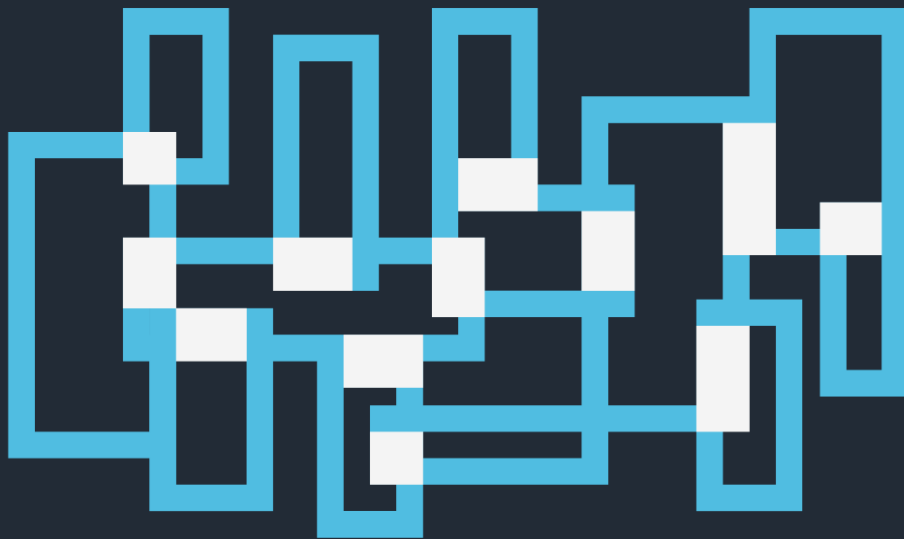
MILLIMAN REPORT

# 2025 Milliman Qualified Entity Report

Detailed Methodology

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## About the Qualified Entity Program

The Qualified Entity (QE) Program of the Centers for Medicare and Medicaid Services (CMS) enables organizations approved as QEs to receive Medicare claims data under Parts A, B, and D for use in evaluating provider performance. As a QE receiving Medicare data for all 50 states and the District of Columbia, Milliman is required to combine the Medicare data with claims data from other sources to create public reports that evaluate provider performance in all geographic regions. Milliman's public report does not identify specific providers. To maintain QE status, QEs must publish a report at least annually after receiving the Medicare data. For more information about the Qualified Entity Program, see <https://www.qemedicaredata.org>.

## Overview

Milliman has developed an interactive tool that allows users to explore healthcare system quality measure performance in the context of social determinants of health (SDoH) characteristics such as socioeconomic status and healthcare provider supply, where variation in quality measure performance is not attributable to differences in disease burden.<sup>a</sup>

As a certified QE, Milliman has created a combined dataset composed of claims data from 2018 through 2022 for over 50 million Medicare fee-for-service (FFS) beneficiaries, referred to as Medicare beneficiaries throughout this report, and over 100 million commercially insured members.<sup>1</sup> The interactive tool displays results calculated from this combined dataset for multiple quality measures that represent provider performance. For geographic regions, the measures show average performance by providers during the period immediately following inpatient admissions and emergency department (ED) visits, when health risk is elevated. Services following discharge are major contributors to overall healthcare costs, and performance below benchmarks on these measures may reflect shortcomings in the provision of high-quality care during the acute care encounter itself, the follow-up period post-discharge, or more generally in ongoing health management over time in the community. Examining variation in provider quality measure performance in different geographic areas highlights potential gaps in care that may represent opportunities to improve quality and reduce healthcare costs.

To supplement the claims-based quality measure results, the interactive tool displays key SDoH characteristics for geographic areas in order to present a more comprehensive, contextual view that may highlight opportunities to reduce health disparities observed in healthcare system performance. The SDoH characteristics reported in the interactive tool represent all beneficiaries living in the area (not limited to the Medicare beneficiaries and commercially insured members in the combined claims data).

Included in the Milliman Qualified Entity Report is the **Milliman Health Disparity Risk Index (MHDRI)**. This index aggregates multiple SDoH factors that are associated with health disparities into a single value. The MHDRI allows users to explore quality measure performance in the context of a weighted aggregation of SDoH factors that represents community-level health disparity risk, rather than in the context of individual SDoH factors.

<sup>a</sup> Risk adjustment was applied to select measures where population health has an expected impact on quality measure performance. See Figure 4: Quality Measures for additional details.

The interactive tool presents two primary map-based views:

- **Metrics by Geography:** This view allows users to view results for a single metric on a map of the United States—either an SDoH characteristic or a quality measure result. Depending on the geographic area selected on the map, the SDoH characteristics and quality measure results for the area selected and a relevant comparison population are displayed in a table below the map.
- **Geographic Comparison:** This view allows users to compare SDoH characteristics and quality measure results between a collection of small geographic areas in one U.S. census division and a collection of small areas in another census division. Users may select a range of values for select SDoH characteristics and the map and summaries update to reflect the collection of small areas that meet those criteria.

For detailed instructions on how to use the interactive tool, refer to the [Report User Guide](#).

## SDoH characteristics

Milliman reviewed potential data sources that include variables that represent a variety of SDoH characteristics that have been associated with health disparities, collectively referred to as SDoH characteristics. SDoH characteristics are “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”<sup>2</sup> Examples of such characteristics represented by specific variables include socioeconomic (income, education, employment, etc.), demographic (age, sex, ethnicity, etc.), urban/rural location, and provider density. Of those candidate characteristics where the relevant variables have sufficient geographic granularity in the data sources to support mapping, the following datasets were identified as national, robust, widely recognized as reputable, and reasonably recent sources of information for select SDoH characteristics as displayed in Figure 1. Note that all SDoH characteristics represent all individuals living in the area (not limited to Medicare beneficiaries and commercially insured members in the combined data).

**FIGURE 1: SDOH CHARACTERISTICS**

SDOH CHARACTERISTICS	DATA SOURCE, SPONSOR	LEVEL OF GEOGRAPHIC GRANULARITY
<b>Socioeconomic status</b>	Social Deprivation Index (SDI), Robert Graham Center <sup>3</sup>	ZCTA; County FIPS
<b>Race and ethnicity</b>	American Community Survey (ACS), U.S. Census Bureau <sup>4</sup>	ZCTA
<b>Urban/rural location</b>	Rural-Urban Commuting Area (RUCA) Codes, U.S. Department of Agriculture <sup>5</sup>	ZCTA
<b>Facility density</b>	Provider of Services File, Centers for Medicare and Medicaid Services (CMS) <sup>6</sup>	ZCTA; reported at the County FIPS level
<b>Clinician density</b>	Area Health Resources Files, Health Resources and Services Administration (HRSA) <sup>7</sup>	County FIPS

The level of geographic granularity refers to the smallest geographic area for which the data is available. ZIP Code tabulation areas (ZCTAs) are generalized area representations of United States Postal Service (USPS) ZIP Code service areas. ZCTA is a trademark of the U.S. Census Bureau and ZIP Code is a trademark of USPS. In most instances, the ZCTA code is the same as the ZIP Code for an area.<sup>8</sup> Facility density is reported at the county Federal Information Processing System (FIPS) level to better represent the boundary with which beneficiaries and members seek and receive care.

The following SDoH characteristics displayed in the tool were generated from the original data sources in one of three ways:

### 1. Drawn directly from the original data source

- Socioeconomic status
- Race and ethnicity

## 2. Derived using numerical data from the original data source and grouped into categorical data

- a. Urban/rural location

## 3. Derived using data from the original data source and reported on a per capita basis for the geographic region

- a. Facility density
- b. Clinician density

Milliman also includes the health insurance coverage distribution in the report to assist with interpretation of the quality measure results in the context of other SDoH characteristics.<sup>9</sup> For example, if the user has selected an area with a majority Medicaid population, the quality measure results displayed will not entirely align with the SDoH characteristics displayed because the interactive tool only includes claims and enrollment data from Medicare FFS beneficiaries (excluding members of Medicare Advantage plans) and a sample of commercially insured members. The uninsured population and populations with other insurance coverage (such as Medicaid) are not represented in the claims-based quality measure results. The insurance coverage distribution was derived directly from the original data source (American Community Survey) and grouped into the following categories: Medicare, commercial, Medicaid, other insurance, uninsured. In addition, because the socioeconomic status and race and ethnicity variables were collected from a sample of the U.S. population rather than the whole population, summaries for these variables reflect estimates rather than exact values for each level of geography.

Please see the [SDoH Characteristics](#) section of the [Appendix](#) for additional details.

## Milliman Health Disparity Risk Index

The Milliman Health Disparity Risk Index (MHDRI) is a composite index that aggregates multiple SDoH characteristics that are associated with health disparities into a single value. The MHDRI allows users to explore quality measure performance in the context of a collection of SDoH characteristics, instead of separately exploring quality measure performance in the context of individual SDoH characteristics.

### VARIABLE SELECTION

Milliman identified the following SDoH characteristics shown to be associated with health disparities in the published literature:

- Race and ethnicity<sup>10,11</sup>
- Socioeconomic status (income level, education, and occupation)<sup>12</sup>
- Food insecurity<sup>13</sup>
- Safe housing<sup>14,15,16</sup>
- Language<sup>17</sup>
- Immigrant status<sup>18</sup>
- Family structure<sup>19</sup>
- Transportation access<sup>20</sup>
- Internet access<sup>21</sup>
- Living in a rural area<sup>22</sup>
- Climate risk<sup>23,24,25</sup>

To support development of the composite index, Milliman identified several data sources that contain variables relevant to the SDoH characteristics identified in the list above. Data sources that were appropriate for use in the composite index development needed to meet the following data integrity criteria:

- Nationally representative
- Publicly available

- Available at the appropriate level of geographic granularity (i.e., ZCTA [preferred] or county level)
- Relatively recent to align with the combined dataset years

Of the data sources identified, Milliman proceeded with four data sources that (1) included variables relevant to the SDoH characteristics associated with health disparities and (2) met all data integrity criteria listed above. The final variables displayed in Figure 2 are available at the ZCTA level, except for Food Insecurity, which is available only at the county level.

**FIGURE 2: MHDRI VARIABLES AND DATA SOURCES**

SDOH CHARACTERISTIC	VARIABLE NAME	DATA SOURCE	2022 ZCTA FACTOR LOADING	2022 COUNTY FACTOR LOADING
<b>Living in a Rural Area</b>	Primary Rural-Urban Commuting Area (RUCA)	RUCA Codes, U.S. Department of Agriculture	-	-
<b>Food Insecurity</b>	Percent of Population with Food Insecurity	Map the Meal Gap Data, Feeding America <sup>26</sup>	-	0.483
<b>Race and Ethnicity</b>	Percent of Population Black	American Community Survey (ACS), U.S. Census Bureau	0.396	0.460
<b>Race and Ethnicity</b>	Percent of Population Hispanic		0.750	0.655
<b>Race and Ethnicity</b>	Percent of Population white		-0.897	-0.866
<b>Race and Ethnicity</b>	Percent of Population Other Race		-	-
<b>Income Level</b>	Percent of Population Less than 100% of the Federal Poverty Level (FPL)		0.430	0.620
<b>Family Structure</b>	Percent of Single Parent Families with Dependents < 18 Years		0.428	0.628
<b>Education</b>	Percent of Population 25 Years or More With < 12 Years of Education		0.533	0.662
<b>Occupation</b>	Percent of Population Unemployed		0.276	0.562
<b>Transportation Access</b>	Percent of Households with No Vehicle		0.431	0.434
<b>Safe Housing: Renter-Occupied</b>	Percent of Households Living in Renter-Occupied Housing Units		0.612	0.626
<b>Safe Housing: Crowded Housing</b>	Percent of Households Living in Crowded Housing Units	Federal Emergency Management Agency (FEMA)	0.433	-
<b>Language</b>	Percent of Population Speaks Only English		-0.840	-0.698
<b>Immigrant Status</b>	Percent of Population Foreign-Born		0.718	0.551
<b>Internet Access</b>	Percent of Households with Broadband Internet Subscription (i.e., high-speed Internet access)		-	-
<b>Climate Risk</b>	Composite index quantifying the risk of the potential for negative impacts as a result of a natural hazard			

## MHDRI DEVELOPMENT

Milliman's development process used a linear combination of several of the 17 observed variables listed in [Figure 2](#) in order to form a single value using factor analysis. This process was carried out at both the ZCTA and county levels of geography. The factor analysis used to develop the MHDRI is a rigorous statistical technique that reduces multiple variables into a smaller set of factors, which are ultimately consolidated into a single value (the underlying factor). The underlying factor represents the unobserved latent variable(s) that quantifies the correlation between the observed variables. SAS software was used to perform the factor analysis on our variable data.<sup>27</sup>

Before performing the factor analysis, population counts at each level of geography were winsorized at the 80th percentile, which means that the population count was set to the 80th percentile population count for ZCTAs and counties with a population count above the 80th percentile. Given that the factor analysis uses a population-weighted

approach when developing the factor loadings (a value that represents the correlation between observed variables and the underlying factor), this technique dampens the impact that high-population geographies have on the factor loadings. Any variables that had a factor loading less than the chosen significance threshold of 0.4 on 2021 data were removed from the model.<sup>28,29,30</sup> The larger the factor loading value was for a particular variable, the higher the correlation was between that variable and the underlying factor.

For a given geography, each variable's value was multiplied by its respective variable weight, and all remaining variables were summed together to obtain one value for the geography to generate the aggregate score. Before multiplying each variable value by its respective variable weight, each variable was standardized such that they were all on a common scale. Standardizing all variables to a common scale helps to reduce the impact of variables with large variances from being overly influential to the model due to the variables having different scales and units of measurement. The aggregate score was then standardized to be on a scale from 0 to 100. This standardized score is referred to as the MHDRI score. Figure 2 displays all variables considered, their data sources, and their 2022 factor loadings, as applicable. To maintain continuity in the meaning of the MHDRI score across years, we recalibrate MHDRI variables (i.e., reassess variable significance in the factor analysis) every three years, where both 2018 and 2021 were recalibration years. Variables and factor loadings from the 2018 and 2021 factor analysis are available in the Appendix. Variables without weights were dropped from the model based on the chosen significance threshold.

### MHDRI score interpretation

A lower MHDRI score (closer to 0) suggests that the average population in the area is at a lower risk of health disparities, and a higher MHDRI score (closer to 100) suggests that the average population in the area is at a higher risk of health disparities. Researchers define a health disparity as “largely preventable health differences that adversely affect populations who experience greater challenges to optimal health and are closely linked with intergenerational social, economic, and/or environmental disadvantages.”<sup>51</sup> The MHDRI should not be used to draw conclusions regarding individual beneficiary or member risk.

## Assignment of beneficiaries and members to a geographic area

The interactive maps display results for quality measures of provider performance and SDoH characteristics at the following levels of geography in descending level of granularity: nation, census division, state, county, and ZCTA.

Figure 3 shows a summary of the high-level steps to assign all beneficiaries and members in the combined dataset to a geographic location.

FIGURE 3: ANALYSIS STEPS



**Step 1:** Assign Each Beneficiary and Member to a Geographic Area



**Step 2:** Identify SDoH Characteristics of a Geographic Area



**Step 3:** Link Geographic Area SDoH Characteristics to Beneficiaries and Members Assigned to the Same Geographic Area



**Step 4:** Evaluate and Report Quality Measure Performance for All Beneficiaries and Members Assigned to the Same Geographic Area

## STEP 1: ASSIGN EACH BENEFICIARY AND MEMBER TO A GEOGRAPHIC AREA

To assess providers' quality performance at each level of geography, each beneficiary and member from the combined data was attributed to a geographic area using their location of residence. Most beneficiaries and members (60%-70%) were attributed to a single ZIP Code. When physical address and residence ZIP Code were unavailable (this only occurred for commercially insured members), members were attributed to their county code, if available. If the county code was unavailable, members were only attributed to their state code.

Quality measure results are reported at each level of geography using cross-walks from beneficiary and member residence (either ZIP Code, county code, or state code) to the various geographic levels reported.

## STEP 2: IDENTIFY SDOH CHARACTERISTICS OF A GEOGRAPHIC AREA

Using the data sources displayed in [Figure 1 above](#), the SDOH characteristics were summarized at the most granular level of geography. Milliman also developed a composite index that aggregates multiple SDOH characteristics into a single value for each level of geography. See the [Milliman Health Disparity Risk Index](#) section for more information.

## STEP 3: LINK GEOGRAPHIC AREA SDOH CHARACTERISTICS TO BENEFICIARIES AND MEMBERS ASSIGNED TO THE SAME GEOGRAPHIC AREA

Using the beneficiary-level and member-level geographic area assignment from Step 1 and the SDOH geographic area attribution from Step 2, each beneficiary and member of the combined data was linked to the SDOH characteristics of their geographic area of residence.

## STEP 4: EVALUATE AND REPORT QUALITY MEASURE PERFORMANCE FOR ALL BENEFICIARIES AND MEMBERS ASSIGNED TO THE SAME GEOGRAPHIC AREA

For each of the quality measures, the measure specifications (as defined by the measure steward) were followed and results are summarized at all available levels of geography.

# Quality measures

## QUALITY MEASURE OVERVIEW

The Milliman QE Report includes annual results for available reporting years from the combined data for the quality measures displayed in Figure 4 at all levels of geography.

FIGURE 4: QUALITY MEASURES

NAME	STEWARD, SPECIFICATIONS***	REPORTING YEARS	DESCRIPTION
<b>Risk-Adjusted Return to Hospital*</b>			
<b>Plan All-Cause Readmissions (PCR)</b>	National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS) <sup>31</sup>	2019, 2020, 2021	For beneficiaries and members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure is reported as a risk-adjusted rate of unplanned acute readmissions per 1,000 discharges among eligible members in the sample population.
<b>Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)</b>	CMS, Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report <sup>32</sup>	2019, July -December 2020, 2021  <i>January-June 2020 is excluded from 2020 reporting per the measure specifications.</i>	The measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for acute myocardial infarction (AMI). Excess days include post-discharge ED visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. This measure is reported as a risk-adjusted rate of excess days per 100 discharges.



NAME	STEWARD, SPECIFICATIONS***	REPORTING YEARS	DESCRIPTION
<b>EDAC After Hospitalization for Heart Failure (HF)</b>	CMS, Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report <sup>33</sup>	2019, July -December 2020, 2021  <i>January-June 2020 is excluded from 2020 reporting per the measure specifications.</i>	The measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for heart failure (HF). Excess days include post-discharge ED visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. This measure is reported as a risk-adjusted rate of excess days per 100 discharges.
<b>EDAC After Hospitalization for Pneumonia (PNA)</b>	CMS, Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report <sup>34</sup>	2019, July -December 2020, 2021  <i>January-June 2020 is excluded from 2020 reporting per the measure specifications.</i>	The measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for pneumonia. Excess days include post-discharge ED visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. This measure is reported as a risk-adjusted rate of excess days per 100 discharges.
<b>Follow-Up Visit**</b>			
<b>Timely Follow-Up After Acute Exacerbations for Chronic Conditions</b>	IMPAQ International, Timely Follow-up After Acute Exacerbations of Chronic Conditions <sup>35</sup>	2018, 2019, 2020, 2021	Percentage of hospital visits (ED visit, observation stay, or inpatient stay) for beneficiaries and members 18 years of age and older for one of the following six chronic conditions: hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes mellitus (type 1 or type 2), and who received a follow-up visit within the timeframe recommended by clinical practice guidelines in a nonemergency outpatient setting.
<b>Timely Follow-Up After Acute Exacerbations for Chronic Conditions</b>	CMS, Timely Follow-up After Acute Exacerbations of Chronic Conditions <sup>36</sup>	2022	Percentage of hospital visits (ED visit, observation stay, or inpatient stay) for beneficiaries and members 18 years of age and older for one of the following six chronic conditions (with eight categories) of interest (coronary artery disease [CAD] {high or low acuity}, hypertension {high or medium acuity}, heart failure [HF], diabetes, asthma, and chronic obstructive pulmonary disease [COPD] and who received a follow-up visit within the timeframe recommended by clinical practice guidelines in a nonemergency outpatient setting.
<b>Follow-Up Visit Within 7 Days of Emergency Department Visit for Adults with Multiple High-Risk Chronic Conditions (FMC)</b>	NCQA, HEDIS <sup>37</sup>	2019, 2020, 2021  <i>2018 is not available due to 12-month enrollment requirement.</i>	Percentage of ED visits for beneficiaries and members 18 years of age and older who have multiple high-risk chronic conditions and who had a follow-up service within seven days of an ED visit.
<b>Medication Management**</b>			
<b>Pharmacotherapy Management of COPD Exacerbation (PCE)</b>	NCQA, HEDIS <sup>38</sup>	2018, 2019, 2020, 2021	The percentage of COPD exacerbations for beneficiaries and members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: <ol style="list-style-type: none"> <li>1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.</li> <li>2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.</li> </ol>

NAME	STEWARD, SPECIFICATIONS***	REPORTING YEARS	DESCRIPTION
<b>Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)</b>	NCQA, HEDIS <sup>39</sup>	2019, 2020, 2021	The percentage of beneficiaries and members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

\* Lower values indicate better provider performance.

\*\* Higher values indicate better provider performance.

\*\*\* See Appendix for applicable measure specification by year.

## QUALITY MEASURE TECHNICAL CLARIFICATIONS

For select measures, the specifications did not include full operational definitions of all required elements for use with all Medicare beneficiaries and commercially insured members in the combined data. When this occurred, Milliman established definitions to fill gaps, as needed, based upon literature review and prior claims analysis experience. Figure 5 contains the definitions used for each applicable measure.

**FIGURE 5: DEFINITIONS FOR ELEMENTS NOT IDENTIFIABLE FOR CERTAIN MEMBERS BY MEASURE SPECIFICATIONS**

MISSING ELEMENT	MISSING ELEMENT AND MILLIMAN DEFINITION	MEASURE
<b>Inpatient Hospitalizations</b>	Inpatient hospitalizations are not defined in the measure specifications for commercially insured members. Therefore, inpatient hospitalizations for commercially insured members are defined using revenue codes. Refer to the <a href="#">definitions for elements not identified in measure specifications</a> section of the <a href="#">Appendix</a> for a list of codes used to identify inpatient hospitalizations.	
<b>Acute Care Hospitals</b>	Acute care hospitals are not defined in the measure specifications for use for commercially insured members. Therefore, based on the CMS Certification number (CCN) acute care hospitals are defined as facilities with a CCN that meets one of the following criteria: <ul style="list-style-type: none"> <li>Nonfederal short-term acute care hospitals are identified as inpatient claims where the third digit of the CCN is a "0."</li> <li>Children's hospitals are identified as inpatient claims where the third and fourth digits of the CCN are "33."</li> <li>Transplant centers are identified as inpatient claims where the third and fourth digits of the CCN are "98."</li> <li>Critical access hospitals are identified as inpatient claims where the third and fourth digits of the CCN are "13."</li> <li>Veterans Affairs hospitals are identified as inpatient claims where the fifth digit of the CCN is "V."</li> </ul>	EDAC After Hospitalization for AMI, EDAC After Hospitalization for HF, EDAC After Hospitalization for PNA
<b>Date of Death</b>	Date of death is not available in the combined data for commercially insured members. Therefore, where date of death is required to confirm that commercially insured members did not die during the measure lookout period, the absence of ongoing enrollment is used as a proxy for death. If there is no evidence of enrollment in the calendar month following discharge, death is assumed and the member's encounter is excluded from the denominator.	
<b>Skilled Nursing Facility (SNF), Non-Acute Hospital Care, Hospice</b>	SNF, non-acute hospital care, and hospice are not defined in the IMPAQ International measure specifications. Therefore, these services are defined using revenue codes, Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes for Medicare beneficiaries and commercially insured members. Refer to the <a href="#">definitions for elements not identified in measure specifications</a> section of the <a href="#">Appendix</a> for a list of codes used to identify SNF, non-acute hospital care, and hospice services.	Timely Follow-Up After Acute Exacerbations for Chronic Conditions

## CREDIBILITY AND PAYER-MIX ADJUSTMENT

Milliman established credibility thresholds and applied a payer-mix adjustment (Medicare, commercial) to account for differences in typical age and healthcare utilization across these different populations. This adjustment allows provider performance to be reasonably evaluated and understood across populations residing in different geographic areas. The payer-mix adjustment is applied to the Timely Follow-Up After Acute Exacerbations for Chronic Conditions measure. ZCTAs with a population less than 200 were deemed non-credible and excluded from reporting at the ZCTA level in the interactive tool. These ZCTAs appear blank in the interactive tool when the map displays boundaries at the ZCTA level, and SDoH characteristics and quality measure results are not populated. Note that no additional adjustment (beyond the risk adjustment that applies to certain measures) was made for differences in health status across different areas.

For ZCTAs with a population greater than 200, an additional payer-mix credibility threshold (applied separately to each covered population) of 30 denominator encounters for Medicare beneficiaries and 30 denominator encounters for commercially insured members was applied for the Timely Follow-Up After Acute Exacerbations for Chronic Conditions quality measure. For all other measures, a credibility threshold of 30 denominator encounters in aggregate across both populations was applied. Given that the combined data includes 100% of Medicare beneficiaries and a population sample of commercially insured members across all 50 states and Washington, D.C., the quality measure results were adjusted for differences in payer mix by applying a weighted average of national denominator counts of beneficiaries and members in the combined data to each payer-specific rate. The payer-mix adjustment is applied when national denominator counts for each population exceeds 20% of the combined data across both populations. This allows for comparison of results across geographic areas. For example, if the user selects a single county, the quality measure rate displayed is the weighted average of the national distribution of Medicare beneficiaries and commercially insured members in the combined data and the Medicare-specific and commercial-specific results for that county. If the ZCTA population is greater than 200 but the payer-mix credibility threshold for each covered population is not met, only the SDoH characteristics are displayed in the report and quality measure results are not populated. Note that the ZCTA level of geography is only available when a minimum of five ZCTAs meet the credibility threshold for the selected measure.

## Data refresh cadence

As a QE, Milliman receives 100% Medicare FFS claims and enrollment data on an annual basis. This interactive tool will be updated annually each summer.

## Caveats and limitations

The interactive tool was developed using three key resources—claims and enrollment data, external data, and quality measure specifications from various measure stewards—each of which has limitations. The most significant limitations not already mentioned throughout the report are described below.

- SDoH characteristics are not generally captured for both the Medicare beneficiaries and commercially insured members in the health insurance claims and enrollment information that makes up the combined data. Medicare data includes the Beneficiary Race Code, but this information is not available in the data source for commercially insured members. The ICD-10-CM Official Guidelines for Coding and Reporting include SDoH-related Z codes, ranging from Z55 to Z65. While reporting of these diagnosis codes on claims is encouraged, reporting has historically not been comprehensive, and a number of the diagnosis codes are new, so they were not available during the time period of analysis for this report (2018-2022). Therefore, in order to allow users to explore provider performance in the context of SDoH characteristics, Milliman linked beneficiaries and members in the combined data to SDoH characteristics based on their geographic area of residence. However, the SDoH characteristics of a geographic area reported in the interactive tool do not directly represent the specific beneficiaries and members included in the combined data used to generate quality measure results, though there is likely some level of overlap (varying by measure and geography). Other people living in the geographic area include individuals not represented in either the Medicare beneficiaries or the sample of the commercially insured members in the combined data (i.e., uninsured, covered by other payers or health benefit programs such as Medicaid or Medicare Advantage, commercially insured members

not included in the combined data). Therefore, it is possible that the beneficiaries and members in the combined data residing in a geographic area do not have the same SDoH characteristics as the total population that resides in that area. Most beneficiaries and members in the combined data (60%-70%) were attributed to a single ZIP Code; however, when ZIP Code was unavailable, commercially insured members were attributed to their county or state code. For beneficiaries and members attributed to a geographic area by their ZIP Code, Milliman assumes that their SDoH characteristics resemble those of the average person residing in the corresponding ZCTA. For commercially insured members attributed to a geographic area by their county code, Milliman assumes that their SDoH characteristics resemble those of the average person residing in that county. Given that counties are larger than ZCTAs, there may be larger variance between members' individual characteristics and the overall characteristics of the total population that live in the geographic area. This variance differs across geographies and impacts the validity of any potential relationship observed between quality measure results and SDoH characteristics.

- The MHDRI may not be an appropriate measure of the risk of health disparities for all geographic areas because of the differences in resources and infrastructure across neighborhoods. For example, a ZCTA in a major metropolitan city may have a high MHDRI score because most residents are renters and do not have access to a vehicle. These characteristics are known to be associated with health disparities. However, for larger cities with a high cost of living and widely used public transportation systems, renting and having no access to a vehicle may not be indicative of an increased risk in health disparities.
- The quality measure results are calculated based on claims paid by health insurance payers. There is variability in billing, coding, and claim-filing practices across providers and geographic areas that may impact the observed healthcare system performance.
- Beneficiaries and members attributed by ZIP Code are included in all levels of geography. Members attributed by county code are not included in the ZCTA level of reporting due to their lack of a ZIP Code. Members attributed by state code are not included in the ZCTA or county levels of reporting. Therefore, the summary of quality measure results reported for all ZCTAs within a county or state may not equal quality measure results reported for the county or state.
- For certain quality measures, measure specifications lacked detail for defining key elements for all individuals included in the combined data. Milliman established specifications to fill gaps, as needed, based upon literature review and prior claims analysis experience. However, Milliman's results for these quality measures may vary from other published sources due to methodological differences in filling the gaps. Refer to [Figure 5 in the quality measure technical clarifications](#) section above for more information.
- The U.S. Census Bureau establishes ZCTA geographic boundary files, which are updated on a decennial basis to account for shifts in population or boundary names.<sup>40</sup> The interactive tool includes geographic boundaries from the 2010 Census for reporting years 2018-2021 and the 2020 Census for reporting year 2022. Due to the frequent updates to the mapping of ZIP codes to ZCTAs that occur between the 10 years with the decennial census, there may be areas within the 50 states and District of Columbia that are not represented. In addition, the SDoH characteristics and quality measure results displayed may not entirely represent the area shown on the map for a county or ZCTA with boundaries that changed between 2010 and the reporting years (2018-2021) or between 2020 and reporting year 2022.
- Percentile distributions were established for the Geographic Comparison view provided in the interactive tool using results for individual ZCTAs to develop the distribution. To reduce the impact of outliers skewing the distribution, ZCTAs with a denominator encounter count less than 100 were deemed non-credible for the purposes of developing a percentile distribution and excluded from the creation of the percentile distribution.
- The results included in this report are based on historical data. Emerging and future results will differ from historical results.

- Milliman’s interactive tool was developed to allow [KH1]users to explore healthcare system performance in the context of the SDoH characteristics for a geographic area. As explained herein, the SDoH characteristics for a geographic area do not directly represent the specific beneficiaries and members included in the combined data. All information displayed in the interactive tool, including the MHDRI, was developed for geographic areas, and should not be used to draw conclusions regarding individual member risk. Any interpretations, conclusions, and/or opinions reached as a result of the information displayed in the interactive tool do not constitute the findings, policies, or recommendations of Milliman.
- Milliman does not intend to benefit or create a legal duty to any third-party user of its work product.
- Milliman has developed certain models to estimate the values included in this report. The intents of the models were to estimate the results for multiple quality measures and to develop a composite index using SDoH characteristics. Milliman has reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).
- In developing this interactive tool, Milliman relied on data maintained by third parties such as the ACS. Milliman has not audited or verified this data or the combined data for accuracy or completeness. If the underlying information is inaccurate or incomplete, the content of our report may likewise be inaccurate or incomplete.
- To maximize the number of credible geographies, five-year estimates for the ACS variables were used in the interactive tool. While quality measures are calculated for each calendar year, the ACS estimates do not represent a specific point in time during the five-year collection period, but rather a pooling of the data collected during the entire period.<sup>41</sup> Therefore, year-over-year comparisons should not be made for data obtained from the ACS.
- Any user of this interactive tool should possess a certain level of expertise in areas relevant to this analysis to appreciate the significance of the limitations and the impact of these limitations on the results. The user should also be advised by their own qualified professionals competent to properly interpret the material.
- The information displayed in the interactive tool may not be appropriate for all uses. If users leverage information from the interactive tool for purposes beyond the Milliman website, Milliman requests that the information be distributed with a reference to Milliman’s QE Report.

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- |                    |                       |                    |
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## Appendix

### SDOH CHARACTERISTICS

#### Social Deprivation Index

The Social Deprivation Index (SDI), representing socioeconomic status, is reported as a numeric percentile value from zero to 100, where zero is the least deprived and 100 is the most deprived. SDI is available at multiple levels of geography including the ZCTA level. The SDI scores for reporting years 2018 to 2021 are taken directly from the original data source, the Robert Graham Center.<sup>42</sup> The SDI is not included for reporting year 2022. For more information on the SDI, refer to the Robert Graham Center website, <https://www.graham-center.org/maps-data-tools/social-deprivation-index.html>.

#### Race and ethnicity

Race and ethnicity is reported as the percentage of people who are non-Hispanic Black, non-Hispanic white, Hispanic, or Other Race or Ethnicity, defined by the variables in Figure 6 sourced from the ACS's Table B03002: Hispanic or Latino Origin by Race.<sup>43</sup> Race and ethnicity is available at the ZCTA level.

**FIGURE 6: RACE AND ETHNICITY VARIABLE MAPPING**

TABLE_FIELD NAME	VARIABLE NAME	MAPPING
<b>B03002_001E</b>	Estimate total	Total Population
<b>B03002_003E</b>	Estimate total Not Hispanic or Latino White alone	Non-Hispanic white
<b>B03002_004E</b>	Estimate total Not Hispanic or Latino Black or African American alone	Non-Hispanic Black
<b>B03002_012E</b>	Estimate total Hispanic or Latino	Hispanic

The Non-Hispanic white, Non-Hispanic Black, and Hispanic fields are populated using B03002\_003E, B03002\_004E, and B03002\_012E, respectively. The Other Race or Ethnicity field is defined as the population that does not map to Non-Hispanic white, Non-Hispanic Black, or Hispanic. The Other Race or Ethnicity field encapsulates all non-Hispanic races. The ACS describes these fields as American Indian, Alaska Native, Asian, Native Hawaiian, Other Pacific Islander, other races, and two or more races. Historically Marginalized Racial and Ethnic Groups are defined as the populations that map to Non-Hispanic Black, Hispanic, and Other Race or Ethnicity.

#### Facility Density

Facility Density represents the number of facilities per 100,000 individuals within a given geographic area. The facility count was sourced from the CMS Provider of Services file, available at the ZIP Code level, and subsequently mapped to ZCTA.<sup>44</sup> For more information on provider count, refer to the CMS website, <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-hospital-non-hospital-facilities>.

The facility types included in the facility count were identified by one of the following criteria:

1. A valid CMS Certification number (CCN) in the PRVDR\_NUM field, determined by having a value length of six digits
2. A PRVDR\_CTGRY\_CD (Provider Category Code) value of 1, which corresponds to hospitals
  - AND a PGM\_TRMNTN\_CD (Termination Code) not equal to 1, which corresponds to voluntary closures
  - AND a PRVDR\_NUM (CCN) with the last four digits within the following ranges:
    - 0001 and 0879, corresponding with short-term facilities
    - 1300 and 1399, corresponding with critical access facilities
    - 3300 and 3399, corresponding with children's hospitals
    - 9800 and 9899, corresponding with transplant centers

The total population of the given geographic area was sourced from the ACS's Table B03002: Hispanic or Latino Origin by Race, B03002\_001E Estimate Total.<sup>45</sup> This total population is at the ZCTA level.



Facility density for a given county is calculated as follows:

$$\text{Facility Density per 100,000} = \frac{\text{Sum of facility count in the county}}{\text{Sum of ZCTA population in the county}} \times 100,000$$

### Clinician Density

Clinician Density represents the number of clinicians per 100,000 individuals within a given geographic area. The clinician count was sourced from HRSA's Area Health Resources Files and is available at the county level.<sup>46</sup> For more information on clinician count, refer to the HRSA website, <https://data.hrsa.gov/topics/health-workforce/ahrf>. Note that clinician density information is not available for the state of Connecticut in 2022 due to changes in county assignments that are not reflected in the Area Health Resources Files.

The clinician types included in the clinician count were identified using the fields listed in Figure 7 from each annual file, where YY denotes the final two digits of the corresponding data year for 2018-2020.

**FIGURE 7: AREA HEALTH RESOURCES FILES CLINICIAN DENSITY FIELDS**

FIELD NAME (2018-2020)	FIELD NAME (2021-2022)	DESCRIPTION
<b>F00002</b>	fips_st_cnty	FIPS St & City Code
<b>F12129-YY</b>	md_nf_fed_activ_YY	Total Active M.D.s Non-Federal & Federal
<b>F13882-YY</b>	do_nf_fed_activ_YY	Total Active D.O.s Non-Federal & Federal
<b>F14641-YY</b>	pa_npi_YY	Physician Assistants w/NPI
<b>F14646-YY</b>	aprn_npi_YY	Advanced Practice Registered Nurse w/NPI
<b>F14642-YY</b>	np_npi_YY	Nurse Practitioners w/NPI
<b>F14643-YY</b>	clin_nurse_spec_npi_YY	Clinical Nurse Specialist w/NPI
<b>F14644-YY</b>	crna_npi_YY	Certified Registered Nurse Anesthetists w/NPI
<b>F14645-YY</b>	apn_midwvs_npi_YY	Advanced Practitioner Nurse Midwives w/NPI

The total population of the given geographic area was sourced from the ACS's Table B03002: Hispanic or Latino Origin by Race, B03002\_001E Estimate Total.<sup>47</sup> This total population is at the ZCTA level.

Clinician density for a given county is calculated as follows:

$$\text{Clinician Density per 100,000} = \frac{\text{Sum of Clinician Count in the County}}{\text{Sum of ZCTA population in the County}} \times 100,000$$

### Urban/Rural Location

Urban/Rural Location is populated for 2018 to 2021 using a categorization of the primary rural-urban commuting area (RUCA) code, sourced from the U.S. Department of Agriculture.<sup>48</sup> The RUCA code is not included for reporting year 2022. Figure 8 displays the mapping of each primary RUCA code to one of four categories: Metropolitan, Micropolitan, Small Town, or Rural. The categorization is assigned based upon the population weighted average. For more information on RUCA codes, refer to the U.S. Department of Agriculture website, <https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx>.

**FIGURE 8: PRIMARY RUCA VARIABLE MAPPING**

PRIMARY RUCA CODES	DESCRIPTION	MAPPING
<b>1</b>	Metropolitan area core: Primary flow within an urbanized area (UA)	Metropolitan
<b>2</b>	Metropolitan area high commuting: Primary flow 30% or more to a UA	Metropolitan
<b>3</b>	Metropolitan area low commuting: Primary flow 10% to 30% to a UA	Metropolitan
<b>4</b>	Micropolitan area core: Primary flow within an urban cluster of 10,000 to 49,999 (large UC)	Micropolitan
<b>5</b>	Micropolitan high commuting: Primary flow 30% or more to a large UC	Micropolitan

PRIMARY RUCA CODES	DESCRIPTION	MAPPING
6	Micropolitan low commuting: Primary flow 10% to 30% to a large UC	Micropolitan
7	Small town core: Primary flow within an urban cluster of 2,500 to 9,999 (small UC)	Small Town
8	Small town high commuting: Primary flow 30% or more to a small UC	Small Town
9	Small town low commuting: Primary flow 10% to 30% to a small UC	Small Town
10	Rural areas: Primary flow to a tract outside a UA or UC	Rural
99	Not coded: Census tract has zero population and no rural-urban identifier information	N/A

## Insurance Coverage

Insurance Coverage is reported as the percentage of people with one of the following sources of health insurance coverage: Commercial, Medicare, Medicaid, Other Insurance, or Uninsured. Variable estimates were sourced from the ACS's Table B27010: Types of Health Insurance Coverage by Age.<sup>49</sup> Fields indicating Medicare coverage in combination with other insurance coverage were mapped to Medicare because not enough information is known in order to discern the primary payer. For more information on health insurance coverage estimates, refer to the ACS website, <https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html>.

**FIGURE 9: INSURANCE COVERAGE VARIABLE MAPPING**

TABLE_FIELD NAME	VARIABLE NAME	MAPPING
B27010_001E	Estimate total	Total Population
B27010_004E	Estimate total under 19 years with one type of health insurance coverage with employer-based health insurance only	Commercial
B27010_011E	Estimate total under 19 years with two or more types of health insurance coverage with employer-based and direct-purchase coverage	Commercial
B27010_020E	Estimate total 19 to 34 years with one type of health insurance coverage with employer-based health insurance only	Commercial
B27010_027E	Estimate total 19 to 34 years with two or more types of health insurance coverage with employer-based and direct-purchase coverage	Commercial
B27010_036E	Estimate total 35 to 64 years with one type of health insurance coverage with employer-based health insurance only	Commercial
B27010_043E	Estimate total 35 to 64 years with two or more types of health insurance coverage with employer-based and direct-purchase coverage	Commercial
B27010_053E	Estimate total 65 years and over with one type of health insurance coverage with employer-based health insurance only	Commercial
B27010_059E	Estimate total 65 years and over with two or more types of health insurance coverage with employer-based and direct-purchase coverage	Commercial
B27010_007E	Estimate total under 19 years with one type of health insurance coverage with Medicaid/means-tested public coverage only	Medicaid
B27010_023E	Estimate total 19 to 34 years with one type of health insurance coverage with Medicaid/means-tested public coverage only	Medicaid
B27010_039E	Estimate total 35 to 64 years with one type of health insurance coverage with Medicaid/means-tested public coverage only	Medicaid
B27010_006E	Estimate total under 19 years with one type of health insurance coverage with Medicare coverage only	Medicare
B27010_012E	Estimate total under 19 years With two or more types of health insurance coverage with employer-based and Medicare coverage	Medicare
B27010_013E	Estimate total under 19 years with two or more types of health insurance coverage with Medicare and Medicaid/means-tested public coverage	Medicare
B27010_022E	Estimate total 19 to 34 years with one type of health insurance coverage with Medicare coverage only	Medicare
B27010_028E	Estimate total 19 to 34 years with two or more types of health insurance coverage with employer-based and Medicare coverage	Medicare
B27010_029E	Estimate total 19 to 34 years with two or more types of health insurance coverage with Medicare and Medicaid/means-tested public coverage	Medicare
B27010_038E	Estimate total 35 to 64 years with one type of health insurance coverage with Medicare coverage only	Medicare



TABLE_FIELD NAME	VARIABLE NAME	MAPPING
B27010_044E	Estimate total 35 to 64 years with two or more types of health insurance coverage with employer-based and Medicare coverage	Medicare
B27010_045E	Estimate total 35 to 64 years with two or more types of health insurance coverage with direct-purchase and Medicare coverage	Medicare
B27010_046E	Estimate total 35 to 64 years with two or more types of health insurance coverage with Medicare and Medicaid/means-tested public coverage	Medicare
B27010_055E	Estimate total 65 years and over with one type of health insurance coverage with Medicare coverage only	Medicare
B27010_060E	Estimate total 65 years and over with two or more types of health insurance coverage with employer-based and Medicare coverage	Medicare
B27010_061E	Estimate total 65 years and over with two or more types of health insurance coverage with direct-purchase and Medicare coverage	Medicare
B27010_062E	Estimate total 65 years and over with two or more types of health insurance coverage with Medicare and Medicaid/means-tested public coverage	Medicare
B27010_005E	Estimate total Under 19 years with one type of health insurance coverage with direct-purchase health insurance only	Other Insurance
B27010_008E	Estimate total Under 19 years with one type of health insurance coverage with TRICARE/military health coverage only	Other Insurance
B27010_009E	Estimate total under 19 years with one type of health insurance coverage with VA healthcare only	Other Insurance
B27010_014E	Estimate total under 19 years with two or more types of health insurance coverage other private only combinations	Other Insurance
B27010_015E	Estimate total under 19 years with two or more types of health insurance coverage other public only combinations	Other Insurance
B27010_016E	Estimate total under 19 years with two or more types of health insurance coverage other coverage combinations	Other Insurance
B27010_021E	Estimate total 19 to 34 years with one type of health insurance coverage with direct-purchase health insurance only	Other Insurance
B27010_024E	Estimate total 19 to 34 years with one type of health insurance coverage with TRICARE/military health coverage only	Other Insurance
B27010_025E	Estimate total 19 to 34 years with one type of health insurance coverage with VA healthcare only	Other Insurance
B27010_030E	Estimate total 19 to 34 years with two or more types of health insurance coverage other private only combinations	Other Insurance
B27010_031E	Estimate total 19 to 34 years with two or more types of health insurance coverage other public only combinations	Other Insurance
B27010_032E	Estimate total 19 to 34 years with two or more types of health insurance coverage other coverage combinations	Other Insurance
B27010_037E	Estimate total 35 to 64 years with one type of health insurance coverage with direct-purchase health insurance only	Other Insurance
B27010_040E	Estimate total 35 to 64 years with one type of health insurance coverage with TRICARE/military health coverage only	Other Insurance
B27010_041E	Estimate total 35 to 64 years with one type of health insurance coverage with VA healthcare only	Other Insurance
B27010_047E	Estimate total 35 to 64 years with two or more types of health insurance coverage other private only combinations	Other Insurance
B27010_048E	Estimate total 35 to 64 years with two or more types of health insurance coverage other public only combinations	Other Insurance
B27010_049E	Estimate total 35 to 64 years with two or more types of health insurance coverage other coverage combinations	Other Insurance
B27010_054E	Estimate total 65 years and over with one type of health insurance coverage with direct-purchase health insurance only	Other Insurance
B27010_056E	Estimate total 65 years and over with one type of health insurance coverage with TRICARE/military health coverage only	Other Insurance
B27010_057E	Estimate total 65 years and over with one type of health insurance coverage with VA healthcare only	Other Insurance
B27010_058E	Estimate total 65 years and over with two or more types of health insurance coverage	Other Insurance
B27010_063E	Estimate total 65 years and over with two or more types of health insurance coverage other private only combinations	Other Insurance

TABLE_FIELD NAME	VARIABLE NAME	MAPPING
<b>B27010_064E</b>	Estimate total 65 years and over with two or more types of health insurance coverage other public only combinations	Other Insurance
<b>B27010_065E</b>	Estimate total 65 years and over with two or more types of health insurance coverage other coverage combinations	Other Insurance
<b>B27010_017E</b>	Estimate total under 19 years with no health insurance coverage	Uninsured
<b>B27010_033E</b>	Estimate total 19 to 34 years with no health insurance coverage	Uninsured
<b>B27010_050E</b>	Estimate total 35 to 64 years with no health insurance coverage	Uninsured
<b>B27010_066E</b>	Estimate total 65 years and over with no health insurance coverage	Uninsured

## DEFINITIONS FOR ELEMENTS NOT IDENTIFIED IN MEASURE SPECIFICATIONS

### Inpatient Hospitalizations

Figure 10 includes revenue codes used to identify Inpatient Hospitalizations for the commercially insured members for the following measures: Excess Days in Acute Care (EDAC) After Hospitalization for AMI, EDAC After Hospitalization for HF, and EDAC After Hospitalization for PNA.

**FIGURE 10: INPATIENT REVENUE CODES**

CODE TYPE	CODE	DESCRIPTION
UBREV	0100	ALL INCLUSIVE RATE-ALL-INCLUSIVE ROOM AND BOARD PLUS ANCILLARY
UBREV	0101	ALL INCLUSIVE RATE-ALL-INCLUSIVE ROOM AND BOARD
UBREV	0110	ROOM & BOARD-PRIVATE (ONE BED)-GENERAL CLASSIFICATION
UBREV	0111	ROOM & BOARD-PRIVATE (ONE BED)-MEDICAL/SURGICAL/GYN
UBREV	0112	ROOM & BOARD-PRIVATE (ONE BED)-OBSTETRICS (OB)
UBREV	0113	ROOM & BOARD-PRIVATE (ONE BED)-PEDIATRIC
UBREV	0114	ROOM & BOARD-PRIVATE (ONE BED)-PSYCHIATRIC
UBREV	0116	ROOM & BOARD-PRIVATE (ONE BED)-DETOXIFICATION
UBREV	0117	ROOM & BOARD-PRIVATE (ONE BED)-ONCOLOGY
UBREV	0118	ROOM & BOARD-PRIVATE (ONE BED)-REHABILITATION
UBREV	0119	ROOM & BOARD-PRIVATE (ONE BED)-OTHER
UBREV	0120	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-GENERAL CLASSIFICATION
UBREV	0121	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-MEDICAL/SURGICAL/GYN
UBREV	0122	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-OBSTETRICS (OB)
UBREV	0123	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-PEDIATRIC
UBREV	0124	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-PSYCHIATRIC
UBREV	0126	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-DETOXIFICATION
UBREV	0127	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-ONCOLOGY
UBREV	0128	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-REHABILITATION
UBREV	0129	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-OTHER
UBREV	0130	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-GENERAL CLASSIFICATION
UBREV	0131	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-MEDICAL/SURGICAL/GYN
UBREV	0132	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-OBSTETRICS (OB)
UBREV	0133	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-PEDIATRIC
UBREV	0134	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-PSYCHIATRIC
UBREV	0136	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-DETOXIFICATION
UBREV	0137	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-ONCOLOGY
UBREV	0138	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-REHABILITATION
UBREV	0139	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-OTHER
UBREV	0140	ROOM & BOARD-DELUXE PRIVATE-GENERAL CLASSIFICATION
UBREV	0141	ROOM & BOARD-DELUXE PRIVATE-MEDICAL/SURGICAL/GYN
UBREV	0142	ROOM & BOARD-DELUXE PRIVATE-OBSTETRICS (OB)
UBREV	0143	ROOM & BOARD-DELUXE PRIVATE-PEDIATRIC
UBREV	0144	ROOM & BOARD-DELUXE PRIVATE-PSYCHIATRIC
UBREV	0146	ROOM & BOARD-DELUXE PRIVATE-DETOXIFICATION
UBREV	0147	ROOM & BOARD-DELUXE PRIVATE-ONCOLOGY
UBREV	0148	ROOM & BOARD-DELUXE PRIVATE-REHABILITATION
UBREV	0149	ROOM & BOARD-DELUXE PRIVATE-OTHER

CODE TYPE	CODE	DESCRIPTION
UBREV	0150	ROOM & BOARD-WARD-GENERAL CLASSIFICATION
UBREV	0151	ROOM & BOARD-WARD-MEDICAL/SURGICAL/GYN
UBREV	0152	ROOM & BOARD-WARD-OBSTETRICS (OB)
UBREV	0153	ROOM & BOARD-WARD-PEDIATRIC
UBREV	0154	ROOM & BOARD-WARD-PSYCHIATRIC
UBREV	0156	ROOM & BOARD-WARD-DETOXIFICATION
UBREV	0157	ROOM & BOARD-WARD-ONCOLOGY
UBREV	0158	ROOM & BOARD-WARD-REHABILITATION
UBREV	0159	ROOM & BOARD-WARD-OTHER
UBREV	0160	ROOM & BOARD-OTHER-GENERAL CLASSIFICATION
UBREV	0164	ROOM & BOARD-OTHER-STERILE ENVIRONMENT
UBREV	0167	ROOM & BOARD-OTHER-SELF CARE
UBREV	0169	ROOM & BOARD-OTHER-OTHER
UBREV	0170	NURSERY-GENERAL CLASSIFICATION
UBREV	0171	NURSERY-NEWBORN-LEVEL I
UBREV	0172	NURSERY-NEWBORN-LEVEL II
UBREV	0173	NURSERY-NEWBORN-LEVEL III
UBREV	0174	NURSERY-NEWBORN-LEVEL IV
UBREV	0179	NURSERY-OTHER NURSERY
UBREV	0190	SUBACUTE CARE-GENERAL CLASSIFICATION
UBREV	0191	SUBACUTE CARE-SUBACUTE CARE-LEVEL I
UBREV	0192	SUBACUTE CARE-SUBACUTE CARE-LEVEL II
UBREV	0193	SUBACUTE CARE-SUBACUTE CARE-LEVEL III
UBREV	0194	SUBACUTE CARE-SUBACUTE CARE-LEVEL IV
UBREV	0199	SUBACUTE CARE-OTHER SUBACUTE CARE
UBREV	0200	INTENSIVE CARE UNIT-GENERAL CLASSIFICATION
UBREV	0201	INTENSIVE CARE UNIT-SURGICAL
UBREV	0202	INTENSIVE CARE UNIT-MEDICAL
UBREV	0203	INTENSIVE CARE UNIT-PEDIATRIC
UBREV	0204	INTENSIVE CARE UNIT-PSYCHIATRIC
UBREV	0206	INTENSIVE CARE UNIT-INTERMEDIATE ICU
UBREV	0207	INTENSIVE CARE UNIT-BURN CARE
UBREV	0208	INTENSIVE CARE UNIT-TRAUMA
UBREV	0209	INTENSIVE CARE UNIT-OTHER INTENSIVE CARE
UBREV	0210	CORONARY CARE UNIT-GENERAL CLASSIFICATION
UBREV	0211	CORONARY CARE UNIT-MYOCARDIAL INFARCTION
UBREV	0212	CORONARY CARE UNIT-PULMONARY CARE
UBREV	0213	CORONARY CARE UNIT-HEART TRANSPLANT
UBREV	0214	CORONARY CARE UNIT-INTERMEDIATE CCU
UBREV	0219	CORONARY CARE UNIT-OTHER CORONARY CCU
UBREV	1000	BEHAVIORAL HEALTH ACCOMMODATIONS-GENERAL CLASSIFICATION
UBREV	1001	BEHAVIORAL HEALTH ACCOMMODATIONS-RESIDENTIAL-PSYCHIATRIC (TITLE EFFECTIVE 10/1/13)
UBREV	1002	BEHAVIORAL HEALTH ACCOMMODATIONS-RESIDENTIAL-CHEMICAL DEPENDENCY (TITLE EFFECTIVE 10/1/13)

### SNF, non-acute hospital care, and hospice

Figure 11 includes revenue codes used to identify SNF services for both Medicare beneficiaries and commercially insured members for the IMPAQ International, Timely Follow-Up After Acute Exacerbations for Chronic Conditions measure.

**FIGURE 11: SNF REVENUE CODES**

CODE TYPE	CODE	DEFINITION
UBREV	0022	HEALTH INSURANCE-PROSPECTIVE PAYMENT SYSTEM (HIPPS)-SKILLED NURSING FACILITY PPS
UBREV	0524	FREESTANDING CLINIC-VISIT BY RHC/FQHC PRACTITIONER TO A MEMBER IN A SNF OR SKILLED SWING BED IN A COVERED PART A STAY
UBREV	0525	FREESTANDING CLINIC-VISIT BY RHC/FQHC PRACTITIONER TO A MEMBER IN A SNF (NOT IN A COVERED PART A STAY) OR NF OR ICF MR OR OTHER RESIDENTIAL FACILITY

CODE TYPE	CODE	DEFINITION
UBREV	0550	SKILLED NURSING-GENERAL CLASSIFICATION
UBREV	0551	SKILLED NURSING-VISIT CHARGE
UBREV	0552	SKILLED NURSING-HOURLY CHARGE
UBREV	0559	SKILLED NURSING-OTHER SKILLED NURSING

Figure 12 includes revenue codes used to identify non-acute hospital care for both Medicare beneficiaries and commercially insured members for the IMPAQ International, Timely Follow-Up After Acute Exacerbations for Chronic Conditions measure.

**FIGURE 12: NON-ACUTE HOSPITAL CARE REVENUE CODES**

CODE TYPE	CODE	DEFINITION
UBREV	0024	HEALTH INSURANCE-PROSPECTIVE PAYMENT SYSTEM (HIPPS)/INPATIENT REHAB FACILITY PPS
UBREV	0118	ROOM & BOARD-PRIVATE (ONE BED)-REHABILITATION
UBREV	0128	ROOM & BOARD-SEMI-PRIVATE TWO BEDS-REHABILITATION
UBREV	0138	ROOM & BOARD-SEMI-PRIVATE-THREE AND FOUR BEDS-REHABILITATION
UBREV	0148	ROOM & BOARD-DELUXE PRIVATE-REHABILITATION
UBREV	0158	ROOM & BOARD-WARD-REHABILITATION
UBREV	0190	SUBACUTE CARE-GENERAL CLASSIFICATION
UBREV	0191	SUBACUTE CARE-SUBACUTE CARE-LEVEL I
UBREV	0192	SUBACUTE CARE-SUBACUTE CARE-LEVEL II
UBREV	0193	SUBACUTE CARE-SUBACUTE CARE-LEVEL III
UBREV	0194	SUBACUTE CARE-SUBACUTE CARE-LEVEL IV
UBREV	0199	SUBACUTE CARE-OTHER SUBACUTE CARE
UBREV	0660	RESPIRE CARE-GENERAL CLASSIFICATION
UBREV	0661	RESPIRE CARE-HOURLY CHARGE-NURSING
UBREV	0662	RESPIRE CARE-HOURLY CHARGE-AIDE/HOMEMAKER/COMPANION
UBREV	0663	RESPIRE CARE-DAILY RESPIRE CHARGE
UBREV	0669	RESPIRE CARE-OTHER RESPIRE CARE
UBREV	1000	BEHAVIORAL HEALTH ACCOMMODATIONS-GENERAL CLASSIFICATION
UBREV	1001	BEHAVIORAL HEALTH ACCOMMODATIONS-RESIDENTIAL-PSYCHIATRIC (TITLE EFFECTIVE 10/1/13)
UBREV	1002	BEHAVIORAL HEALTH ACCOMMODATIONS-RESIDENTIAL-CHEMICAL DEPENDENCY (TITLE EFFECTIVE 10/1/13)

Figure 13 includes Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), and revenue codes used to identify hospice services for both the Medicare beneficiaries and commercially insured members for the IMPAQ International, Timely Follow-Up After Acute Exacerbations for Chronic Conditions measure.

**FIGURE 13: HOSPICE HCPCS, CPT, AND REVENUE CODES**

CODE TYPE	CODE	DEFINITION
HCPCS	G9473	Services performed by chaplain in the hospice setting, each 15 minutes (G9473)
HCPCS	G9474	Services performed by dietary counselor in the hospice setting, each 15 minutes (G9474)
HCPCS	G9475	Services performed by other counselor in the hospice setting, each 15 minutes (G9475)
HCPCS	G9476	Services performed by volunteer in the hospice setting, each 15 minutes (G9476)
HCPCS	G9477	Services performed by care coordinator in the hospice setting, each 15 minutes (G9477)
HCPCS	G9478	Services performed by other qualified therapist in the hospice setting, each 15 minutes (G9478)
HCPCS	G9479	Services performed by qualified pharmacist in the hospice setting, each 15 minutes (G9479)
HCPCS	Q5003	Hospice care provided in nursing long term care facility (ltc) or non-skilled nursing facility (nf) (Q5003)
HCPCS	Q5004	Hospice care provided in skilled nursing facility (SNF) (Q5004)
HCPCS	Q5005	Hospice care provided in inpatient hospital (Q5005)
HCPCS	Q5006	Hospice care provided in inpatient hospice facility (Q5006)
HCPCS	Q5007	Hospice care provided in long term care facility (Q5007)

CODE TYPE	CODE	DEFINITION
HCPCS	Q5008	Hospice care provided in inpatient psychiatric facility (Q5008)
HCPCS	Q5010	Hospice home care provided in a hospice facility (Q5010)
HCPCS	S9126	Hospice care, in the home, per diem (S9126)
HCPCS	T2042	Hospice routine home care; per diem (T2042)
HCPCS	T2043	Hospice continuous home care; per hour (T2043)
HCPCS	T2044	Hospice inpatient respite care; per diem (T2044)
HCPCS	T2045	Hospice general inpatient care; per diem (T2045)
HCPCS	T2046	Hospice long term care, room and board only; per diem (T2046)
UBREV	0115	Private medical or general-hospice
UBREV	0125	Semi-private 2 bed (medical or general)-hospice
UBREV	0135	Semi-private 3 and 4 beds-hospice
UBREV	0145	Private (deluxe)-hospice
UBREV	0155	Room&Board ward (medical or general)-hospice
UBREV	0235	Incremental Nursing Charge-Hospice
UBREV	0650	Hospice Service-General Classification
UBREV	0651	Hospice Service-Routine Home Care
UBREV	0652	Hospice Service-Continuous Home Care
UBREV	0655	Hospice Service-Inpatient Respite Care
UBREV	0656	Hospice Service-General Inpatient Care Non-Respite
UBREV	0657	Hospice Service-Physician Services
UBREV	0658	Hospice Service-Hospice Room & Board-Nursing Facility
UBREV	0659	Hospice Service-Other Hospice Service
CPT	99377	Hospice care supervision
CPT	99378	Hospice care supervision
HCPCS	G0182	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other healthcare professionals involved in the patient's care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy, within a calendar month, 30 minutes or more (G0182)

Figure 14 includes the factor loadings for the 2018 MHDRI.

**FIGURE 14: 2018 AND 2021 MHDRI FACTOR ANALYSIS**

SDOH CHARACTERISTIC	VARIABLE NAME	DATA SOURCE	2018 ZCTA FACTOR LOADING	2018 COUNTY FACTOR LOADING	2021 ZCTA FACTOR LOADING	2021 COUNTY FACTOR LOADING
<b>Living in a Rural Area</b>	Primary Rural-Urban Commuting Area (RUCA)	RUCA Codes, U.S. Department of Agriculture	-	-	-	-
<b>Food Insecurity</b>	Percent of Population with Food Insecurity	Map the Meal Gap Data, Feeding America <sup>60</sup>	-	0.611	-	0.514
<b>Race and Ethnicity</b>	Percent of Population Black	American Community Survey (ACS), U.S. Census Bureau	0.459	0.484	0.431	0.468
<b>Race and Ethnicity</b>	Percent of Population Hispanic		0.707	0.597	0.732	0.643
<b>Race and Ethnicity</b>	Percent of Population white		-0.875	-0.843	-0.897	-0.866
<b>Race and Ethnicity</b>	Percent of Population Other Race		-	-	-	-
<b>Income Level</b>	Percent of Population Less than 100% of the Federal Poverty Level (FPL)		0.713	0.718	0.610	0.632
<b>Family Structure</b>	Percent of Single Parent Families with Dependents < 18 Years		0.656	0.636	0.595	0.621
<b>Education</b>	Percent of Population 25 Years or More With < 12 Years of Education		0.776	0.720	0.705	0.655
<b>Occupation</b>	Percent of Population Unemployed		0.535	0.619	0.476	0.558
<b>Transportation Access</b>	Percent of Households with No Vehicle		0.525	0.458	0.492	0.443

SDOH CHARACTERISTIC	VARIABLE NAME	DATA SOURCE	2018 ZCTA FACTOR LOADING	2018 COUNTY FACTOR LOADING	2021 ZCTA FACTOR LOADING	2021 COUNTY FACTOR LOADING
<b>Safe Housing: Renter-Occupied</b>	Percent of Households Living in Renter-Occupied Housing Units		0.681	0.582	0.681	0.628
<b>Safe Housing: Crowded Housing</b>	Percent of Households Living in Crowded Housing Units		0.701	0.651	0.486	-
<b>Language</b>	Percent of Population Speaks Only English		-0.726	-0.627	-0.782	-0.687
<b>Immigrant Status</b>	Percent of Population Foreign-Born		0.591	0.463	0.660	0.540
<b>Internet Access</b>	Percent of Households with Broadband Internet Subscription (i.e., high speed Internet access)		-0.464	-0.433	-	-

Figure 15 includes the measure specifications for each quality measure by year.

FIGURE 15: MEASURE SPECIFICATION BY YEAR

	2018	2019	2020	2021	2022
<b>CMS, 2022 Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report</b>					
EDAC After Hospitalization for AMI		X	X		
EDAC After Hospitalization for HF		X	X		
EDAC After Hospitalization for PNA		X	X		
<b>CMS, 2023 Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report</b>					
EDAC After Hospitalization for AMI				X	
EDAC After Hospitalization for HF				X	
EDAC After Hospitalization for PNA				X	
<b>NCQA, Measure Year 2020 - 2021 HEDIS Specifications</b>					
Plan All-Cause Readmissions (PCR)		X	X	X	
Follow-Up Visit within 7 Days of ED Visit for Adults with Multiple High-Risk Chronic Conditions (FMC)		X	X	X	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)		X	X	X	
Pharmacotherapy Management of COPD Exacerbation (PCE)	X	X	X	X	
<b>IMPAQ International, Timely Follow-up After Acute Exacerbations of Chronic Conditions, October 2018</b>					
Timely Follow-Up After Acute Exacerbations for Chronic Conditions (TFU)	X	X	X	X	
<b>CMS, Timely Follow-up After Acute Exacerbations of Chronic Conditions, May 2024</b>					
Timely Follow-Up After Acute Exacerbations for Chronic Conditions (TFU)					X

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