MATHEMATICA
Policy Research

1100 1st Street, NE, 12th Floor
Washington, DC 20002-4221
Telephone (202) 484-9220
Fax (202) 863-1763
www.mathematica-mpr.com

MEMORANDUM

TO: Amanda Eby, Christina Goe

FROM: Nancy McCall, Juliet Rubini

DATE: 3/23/2015
2

SUBJECT: Guidance on Quality of Care Measures

The reporting of quality measures is not a new phenomenon for most provider practices. The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and negative payment adjustments to promote reporting of quality information be eligible professionals (EPs). EPs satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer).[1]

PQRS structures measures into measure groups. Measures groups include reporting on a group of clinically-related measures identified by CMS for use in PQRS through a registry-based submission process. Twenty-five measures groups have been established for 2014 PQRS: Diabetes, Chronic Kidney Disease, Preventive Care, Coronary Artery Bypass Graft, Rheumatoid Arthritis, Perioperative Care, Back Pain, Hepatitis C, Heart Failure, Coronary Artery Disease, Ischemic Vascular Disease, HIV/AIDS, Asthma, Chronic Obstructive Pulmonary Disease, Inflammatory Bowel Disease, Sleep Apnea, Dementia, Parkinson's Disease, Hypertension, Cardiovascular Prevention, Cataracts, Oncology, Total Knee Replacement, General Surgery, and Optimizing Patient Exposure to Ionizing Radiation.[2]

For pediatric reporting, The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions to strengthen the quality of care provided to and health outcomes of children in Medicaid and CHIP. CHIPRA required HHS to identify and publish a core measure set of children's health care quality measures for voluntary use by State Medicaid and CHIP programs. On December 29, 2009, the Secretary posted for public comment in the Federal Register, an initial core set of 24 children's health care quality measures for voluntary

[1] CMS Physician Quality Reporting System: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/

[2] Ibid.

This document was developed with the support from the Robert Wood Johnson Foundation's State Health and Value Strategies Program.

use by Medicaid and CHIP programs. The core set includes a range of children's quality measures encompassing both physical and mental health[3].

As described in Montana's draft guidance to providers, the methods for calculating and reporting the four required quality metrics follow below. We have compared the Montana PCMH and PQRS denominator and numerator criteria to help illustrate differences and inconsistencies which may increase difficulty of reporting on the provider side. We reference the PQRS and Medicaid programs to allow for understanding of what providers are currently reporting on and what future enhancements you may consider for the next reporting period.

There are two measures for which there is considerable difference between the PQSR and CHIPRA specifications, Tobacco Use and Intervention and Age-appropriate Immunization for Children, respectively. We understand that there was a conscious decision to align the childhood immunization measure with reporting requirements from the Department of Health. Thus, the current specification may be less of a burden to providers than modifying their reporting to more align with the CHIPRA specifications.

We recommend assessing the degree to which practices modified their PQRS reporting processes to report the three adult measures for the PCMH project and the degree of burden the modifications placed upon them. The State may wish to modify its specifications to more align with PQSR, notably for Tobacco Use and Intervention measure, for the next reporting period if providers would find it to be less burdensome. Further, we will give special attention to the analysis of rates of tobacco cessation generated from the current specifications relative to publicly reported rates.

---

[3] CMS Medicaid: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html

Measure 1: Blood Pressure Control (PQRS Hypertension and Ischemic Vascular Disease measures groups)

Montana PCMH Documentation	PQRS Measure Group Specification	Differences
Denominator (D#): all adults aged ≥18 through 85 years in the PCMH patient population who (a) have the diagnosis of hypertension, and (b) had one or more outpatient visits during the reporting period: calendar year 2014. *Hypertension diagnosis: ICD-9 code groups: 362.11; 401.00-401.99; 402.00-402.99; 403.00-403.99; 404.00-404.99.*	Patient sample criteria for the Hypertension Measures Group are patients aged 18 through 90 years with a specific diagnosis of hypertension, and without a diagnosis of stage 5 chronic kidney disease (GFR of < 15ml/min per 1.72 m2 or end-stage kidney disease), accompanied by a specific patient encounter. One of the following diagnosis codes indicating hypertension: ICD-9-CM [for use 1/01/2014-9/30/2014]: 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.10, 403.90, 404.00, 404.01, 404.10, 404.11, 404.90, 404.91 ICD-10-CM [for use 10/01/2014-12/31/2014]: I10, I11.0, I11.9, I12.9, I13.0, I13.10 Accompanied by one of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439 AND NOT Diagnosis for stage 5 chronic kidney disease: ICD-9-CM [for use 1/01/2014-9/30/2014]: 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 585.5, 585.6 ICD-10-CM [for use 10/01/2014-12/31/2014]: I12.0, I13.11, I13.2, N18.5, N18.6	1. Age Range: Montana 18 to 85 years PQRS 18 to 90 years 2. Guidance on appropriate outpatient visit codes in the Montana documentation. 3. ICD codes – The Montana documentation includes code groups where the PQRS specifications include specific codes from both ICD9 and ICD10. 4. Exclusions – The Montana documentation does not discuss excluding for stage 5 chronic kidney disease.

Montana PCMH Documentation	**PQRS Measure Group Specification**	**Differences**
Numerator (N#): number of these adults for whom documented blood pressure at time of most recent outpatient visit during the reporting period was systolic <140 mmHg and diastolic <90 mmHg. *Note: If blood pressure was not documented during the most recent outpatient visit, then blood pressure is not controlled for this measure.* *If multiple blood pressures were taken at the most recent outpatient visit, report the lowest blood pressure*	Patients whose most recent blood pressure was under control. **Numerator Instructions:** If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure. To be “under control”, both systolic and diastolic blood pressures must be below the target values (e.g., for a patient, systolic BP =143 mmHg and diastolic BP =70 mmHg is not “under control”). Patients for whom the goals of care are predominantly palliative or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded. **Definitions: Treatment of hypertension with standard treatment goals is not clinically appropriate -** For some patients, treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer’s disease.	1. *Guidance on numerator exclusions* (i.e. Palliative care or Alzheimer’s patients).

Measure 2: Tobacco use and Intervention (preventive care measures group)

Montana PCMH Documentation	**PQRS Measure Group Specification Manual**	**Differences**
Denominator (D#): all adults aged ≥18 years in the PCMH patient population who had two or more outpatient visits for any reason, or who had one preventive care visit during the reporting period: calendar year 2014	Patient sample criteria for the Preventive Care Measures Group are for patients aged 18 years and older with a specific patient encounter. One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	1. *Specific encounter codes not indicated in Montana documentation*
Numerator (N#): number of these adults documented to be tobacco users *<u>Measurement for tobacco cessation intervention</u>:* *Denominator: number of adult tobacco users from above (N#).* *Numerator: number of tobacco users who received a tobacco cessation intervention during the measurement period.*	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user Definitions: Tobacco Use – Includes use of any type of tobacco. Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy. *NUMERATOR NOTE*: *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.* Numerator Options: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F) OR Current tobacco non-user (1036F) OR Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons) (4004F *with* 1P) OR Tobacco screening OR tobacco cessation intervention not performed, reason NOS (40045 with 8P)	1. *The PQRS measure is a single measure rather htan separation of measure into two measures –* *2. Mathematica would encourage the use of "screened" instead of "documented" in the language of the Montana numerator. This is more specific and gets to the intent of the measure – identifying if the providers are performing the screening.*

Measure 3: A1C Control (Diabetes measures group)

Montana PCMH Documentation	PQRS Measure Group Specification Manual	Differences
Denominator (D#): all adults aged ≥18 through 75 years in the PCMH patient population who *(a)have the diagnosis of diabetes mellitus* (type 1 or type 2), and* *(b) had one or more outpatient visits during the reporting period: calendar year 2014.* **Diabetes diagnosis: ICD-9 code groups: 249.00-249.99; 250.00-250.99.*	Patient sample criteria for the Diabetes Measures Group are patients aged 18 through 75 years with a specific diagnosis of diabetes accompanied by a specific patient encounter: The following diagnosis codes indicating diabetes: ICD-9-CM [for use 1/1/2014 – 9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04 ICD-10-CM [for use 10/1/2014 – 12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13 Accompanied by: One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213,	1. *Specificity with diagnosis and encounter codes – PQRS documentation includes specific allowable encounter codes.*

Montana PCMH Documentation	**PQRS Measure Group Specification Manual**	**Differences**
	99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402, G0438, G0439	
Numerator: number of these adults for whom the most recent documented A1C during the reporting period was >9.0%. *Note: If A1C is not documented during the measurement period, then A1C is not controlled for this measure.*	Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%. Numerator Instructions: Patient is numerator compliant if most recent HbA1c level is > 9.0% or is missing a result or if an HbA1c test was not done during the measurement year. *NUMERATOR NOTE: The performance period for this measure is 12 months from date of encounter.* *A lower calculated performance rate for this measure indicates better clinical care or control.* Numerator Options: Most recent hemoglobin A1c level > 9.0% (3046F) OR Hemoglobin A1c level was not performed during the performance period (12 months) (3046F *with* 8P) OR Most recent hemoglobin A1c (HbA1c) level < 7.0% (3044F) OR Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0% (3045F)	No differences noted.

Measure 4: Age-appropriate immunization for children

Montana PCMH Documentation	**CHIPRA Specification Manual**	**Differences**
Denominator (D#): all children in the PCMH population whose 3rd birthday occurred from January 1, 2014 through January 1, 2015 and who had one or more outpatient visits during calendar year 2014	Children who turn 2 years old during the measurement year.	1. *Age: Two versus three years during the measurement period*
Numerator (N#): number of these children who had received all age-appropriate immunizations before their third birthday (see list of immunizations below) __________(#) : for 4 DTAP __________(#) : for 3 polio __________(#) : for 1 MMR __________(#) : for 3 Hib __________(#) : for 3 HepB __________(#) : for 1 Var __________(#) : for 4 PCV *Note: If there is documentation that a child has a medical contraindication (MC) for an immunization, or that the immunization was offered but refused (R), you may report the number with MC or R. However, the MC and R numbers will be considered as part of the "not immunized" number in the denominator for calculating the percent of children with age-appropriate immunizations for this reporting year. If an EMR/EHR does not have the capability to report the (MC) or (R) numbers, they should be reported in the (No) category.*	For MMR, Hep B, VZV and Hep A, count any of the following: • Evidence of the antigen or combination vaccine, or • Documented history of the illness, or • A seropositive test result for each antigen For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count only: • Evidence of the antigen or combination vaccine. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), evidence of all the antigens must be found DTaP: At least four DTaP vaccinations (DTaP Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. IPV: At least three IPV vaccinations (IPV Value Set), with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted. MMR: Any of the following with a date of service on or before the child's second birthday meet criteria: • At least one MMR vaccination (MMR Value Set).	1. *Exclusions for medical contraindication or refusal.* The language in the Montana documentation seems to indicate that those cases will still be calculated in the denominator which will affect the provider's rate. This should be addressed with providers.

Montana PCMH Documentation	CHIPRA Specification Manual	Differences
	• At least one measles and rubella vaccination (Measles/Rubella Value Set) and at least one mumps vaccination (Mumps Value Set) on the same date of service or on different dates of service. • At least one measles vaccination (Measles Value Set) and at least one mumps vaccination (Mumps Value Set) and at least one rubella vaccination (Rubella Value Set) on the same date of service or on different dates of service. HiB: At least three HiB vaccinations (HiB Value Set), with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth cannot be counted. Hepatitis B: Either of the following on or before the child's second birthday meet criteria: • At least three hepatitis B vaccinations (Hepatitis B Value Set), with different dates of service. • History of hepatitis (Hepatitis B Diagnosis Value Set). VZV: At least one VZV vaccination (VZV Value Set), with a date of service falling on or before the child's second birthday. Pneumococcal Conjugate: At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. Hepatitis A: At least one hepatitis A vaccination (Hepatitis A Value Set), with a date of service on or before the child's second birthday. Rotavirus: Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.	

Montana PCMH Documentation	CHIPRA Specification Manual	Differences
	• At least two doses of the two-dose rotavirus vaccine (Rotavirus Two-Dose Schedule Value Set) on different dates of service. • At least three doses of the three-dose rotavirus vaccine (Rotavirus Three-Dose Schedule Value Set) on different dates of service. • At least one dose of the two-dose rotavirus vaccine (Rotavirus Two-Dose Schedule Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus Three-Dose Schedule Value Set), all on different dates of service. Influenza: At least two influenza vaccinations (Influenza Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to six months (180 days) after birth.	