**Connecticut Quality Council**
**Annual Review**
**Candidate Measure Specifications**
February 13, 2025

## H. Achievement of External Standards for Health Equity

### OVERVIEW

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|---|---|
| **Measure Name** | Achievement of External Standards for Health Equity |
| **Steward** | MassHealth (Relying on standards established by the National Committee for Quality Assurance (NCQA), Health Policy Commission (HPC), The Joint Commission (TJC)) |
| **NQF Number** | N/A |
| **Data Source** | Supplemental |
| **Performance Status: PY2** | Pay-for-Reporting |

### POPULATION HEALTH IMPACT

To be successful in addressing persistent and longstanding health disparities, healthcare organizations must adopt structures and systems that systemically and comprehensively prioritize health equity as a fundamental component of high-quality care. These goals include collaboration and partnership with other sectors that influence the health of individuals, adoption and implementation of a culture of equity, and the creation of structures that support a culture of equity. External health equity certification independently and objectively assesses attainment of these and other relevant health equity goals to ensure that healthcare organizations are providing a comprehensively high standard of equitable care.

### MEASURE SUMMARY

This measure assesses ACO progress towards and/or achievement of external standards related to health equity established by NCQA, HPC, and The Joint Commission.

NCQA's Health Equity Accreditation Standards are intended to serve as a foundation for Health Plans and ACOs to address health care disparities. These Health Equity Standards build on the equity-focused Health Plan Accreditation standards to recognize organizations that go above and beyond to provide high quality and equitable care. HPC's ACO Certification Program, or ACO Learning, Equity, and Patient-Centeredness (LEAP), is a program designed

to accelerate care delivery transformation in Massachusetts and promote a high quality, efficient health system. The Joint Commission's Health Care Equity Certification recognizes acute hospitals that go above and beyond to high quality and equitable care. Together, these three certification programs provide a comprehensive and objective assessment of the necessary health equity systems and structures across the entire health system.

This measure incentivizes ACOs to demonstrate achievement of the following:

1. Health Plans and PCACOs: Progress towards/achievement of the NCQA Health Equity Accreditation
2. All ACOs: Achievement/maintenance of the HPC ACO Certification (ACO LEAP) for the 2024-2025 and 2026-2027 cycles.
3. ACO's partnered-Hospitals (per the Joint Accountability partnerships formed in the HQEIP): Progress towards/achievement of TJC's Health Care Equity Certification Program

ACOs must demonstrate that all three requirements listed above are met to earn full credit for this measure. Alternatively, for ACPPs, if both the Health Plan and ACO Partner achieve NCQA Health Equity Accreditation, the ACPP will receive full credit for this measure.

## DEFINITIONS

| | |
|---|---|
| **Health Plan** | For the purpose of this measure, the Health Plan is defined as the MassHealth Contractor, or Managed Care Organization, for the Accountable Care Partnership Plan (ACPP) contract. |
| **ACO Partner** | The ACO Partner is defined as the ACO entity the Contractor or Health Plan has an arrangement with for the ACPP contract. |

## ADMINISTRATIVE SPECIFICATIONS

By December 31, 2024, complete and timely submission of the **"External Standards for Health Equity Report"** that includes, at a minimum:

1. NCQA Health Equity Accreditation Report (either 1a or 1b must be included):
    a. Documentation of achievement of NCQA Health Equity Accreditation (at the Health Plan and/or PCACO level); or
    b. Progress Report related to achievement of NCQA Health Equity Accreditation (at the Health Plan and/or PCACO level), including:

i. List of NCQA Health Equity Standards achieved to date (may be from the Health Plan or ACOs (or ACO Partner, as applicable) own assessment of standards achieved)
ii. List of NCQA Health Equity Standards in progress (may be from the Health Plan or ACOs (or ACO Partner, as applicable) own assessment of standards in progress)
iii. Description of any efforts undertaken in PY2 (CY2024) to make progress towards achieving NCQA Health Equity Accreditation
iv. Description of any anticipated efforts, resources, etc. needed to achieve Accreditation by the end of PY3.

2. Documentation of achievement of the HPC ACO Certification (ACO LEAP)
3. TJC Health Care Equity Certification Report
    a. List of Partnered Hospitals (per HQEIP Joint Accountability partnership attestations to MassHealth) and each hospital's status in meeting HQEIP "Achievement of External Standards for Health Equity" Performance Requirements for PY2

Alternatively, ACPPs may submit both of the following in place of the "External Standards for Health Equity Report":

1. Documentation of achievement of NCQA Health Equity Accreditation for the Health Plan
2. Documentation of achievement of NCQA Health Equity Accreditation for the ACO Partner

## ADDITIONAL MEASURE INFORMATION

ACOs without partnered-Hospitals or in-network Hospitals are exempt from the third component of this measure, the requirement that the ACO's Partnered-Hospital achieves TJC Health Care Equity Certification.

## PY2 PERFORMANCE REQUIREMENTS AND ASSESSMENT

| | |
|---|---|
| **Performance Requirements** | **By December 31, 2024**, the ACO must submit either:<br>1) An "External Standards for Health Equity Report" or, for ACPPs only, documentation of achievement of NCQA Health Equity Accreditation for both the Health Plan and ACO Partner in a form and format to be further specified by MassHealth; |

| | |
|---|---|
| **Performance Assessment** | • The ACO will earn 100% of the points attributed to this measure if it submits a timely, complete, and responsive "External Standards for Health Equity Report" or, for ACPPs only, documentation of achievement of NCQA Health Equity Accreditation for both the Health Plan and ACO Partner to MassHealth by December 31, 2024.<br>• The ACO will earn 0% of the points attributed to the measure if the "External Standards for Health Equity Report" or, for ACPPs only, documentation of achievement of NCQA Health Equity Accreditation for both the Health Plan and ACO Partner submission is not timely, complete, and responsive. |

**PERFORMANCE REQUIREMENTS AND ASSESSMENT FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3**

NATIONAL QUALITY FORUM

## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

## Brief Measure Information

**NQF #:** 1381
**Corresponding Measures:**
De.2. **Measure Title:** Asthma Emergency Department Visits
Co.1.1. **Measure Steward:** Alabama Medicaid Agency
De.3. **Brief Description of Measure:** Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period.
1b.1. **Developer Rationale:** Allows for the identification of persons seen in the emergency room with a primary diagnosis (first diagnosis) of Asthma. By identifying these persons, their providers can be made aware of the visits, care managers/coordinators can work with them, potential for targeting for directed education and self-management education for person/parent/caregiver. Also can be incorporated as a clinical ALERT for providers in an EHR to notify the provider that this patient has been seen in the ER for Asthma.

S.4. **Numerator Statement:** Measuring percentage of people with Asthma that have an emergency room visit during a 12 month measurement period.
S.7. **Denominator Statement:** Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with ICD-9-CM codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91,and 493.92 (excludes 493.20, 493.21 and 493.22)asprimary and secondary diagnoses with the dates of service"Begin Date through End Date" equal any consecutive 12 month period with paid dates from "Begin Date through End Date which includes 3 month tail". This is the measurement period. Total period of our pilot initiative was 24 months. We used Baseline Measurement period of March 1, 2006 through February 28, 2007 with paid dates through May 31, 2007 to provide a 3 month claims tail.

A "Measurement period is any 12 consecutive months".
S.10. **Denominator Exclusions:** Excludes children less than age two or greater than age twenty.

De.1. **Measure Type:** Outcome
S.23. **Data Source:** Claims
S.26. **Level of Analysis:** Health Plan, Population : Community, County or City

**IF Endorsement Maintenance – Original Endorsement Date:** Aug 15, 2011 **Most Recent Endorsement Date:** Aug 15, 2011

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

De.4. **IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** N/A

## 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the***

***remaining criteria.***

**1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form**
1381_Evidence_MSF5.0_Data.doc

**1b. Performance Gap**

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. **Briefly explain the rationale for this measure** *(e.g., the benefits or improvements in quality envisioned by use of this measure)*
Allows for the identification of persons seen in the emergency room with a primary diagnosis (first diagnosis) of Asthma. By identifying these persons, their providers can be made aware of the visits, care managers/coordinators can work with them, potential for targeting for directed education and self-management education for person/parent/caregiver. Also can be incorporated as a clinical ALERT for providers in an EHR to notify the provider that this patient has been seen in the ER for Asthma.

1b.2. **Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** *(This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*
Focused on variation for this from one county to the next although individual provider variation was reviewed it was not the specific focus of the pilot implemented. Overall performance was considered to be poor with the overall (combined counties) measure being higher than anticipated.

1b.3. **If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**
http://www.medicaid.alabama.gov/Transformation/Pilot_Counties_Asthma_Measures.aspx
The county to county variation is noted at the above URL.

1b.4. **Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*
Not looked at for this pilot. The logic itself will allow review by race/ethnicity, geographic area (county, provider and gender).

1b.5. **If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**
N/A

**1c. High Priority** (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. **Demonstrated high priority aspect of healthcare**
Affects large numbers
1c.2. **If Other:**

1c.3. **Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.**
213,825 Medicaid eligibles/enrollees in the pilot area
21,780 identified as being "Asthmatic" based on the logic developed to identify persons at risk for possible targeted interventions.

1,296 recipients were enrolled in a chronic care management pilot called Q4U.

1c.4. **Citations for data demonstrating high priority provided in 1a.3**
Alabama Asthma Coalition State Plan and Burden Document, Alabama Department of Public Health, April 2009
http://www.adph.org/steps/assets/ALAsthmaStatePlan2009.pdf
It is estimated that by 2025 the number of people with asthma will grow by more than 100 million. See World Health Organization. Global surveillance,prevention and control of chronic respiratory diseases: a comprehensive approach, 2007.
Asthma accounts for 217,000 emergency room visits and 10.5 million office visits a year. See Pitts SR, Niska RW, Xu J, Burt CW. National Hospital Ambulatory Medical Care Survey: 2006 emergency department summary. National health statistics reports; no. 7. Hyattsville, MD: National Center for Health Statistics. 2008.

1c.5. **If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful.** *(Describe how and from whom their input was obtained.)*

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. **Subject/Topic Area** *(check all the areas that apply):*
Respiratory : Asthma

De.6. **Non-Condition Specific** *(check all the areas that apply):*

S.1. **Measure-specific Web Page** *(Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)*
http://www.medicaid.alabama.gov/documents/Transformation-TFQ-Documents/Pilot%20Counties%20Asthma%20Measures/TFQ_Asthma_Measures_Revised_8-26-10.pdf

S.2a. **If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)
**Attachment:**

S.2b. **Data Dictionary, Code Table, or Value Sets** *(and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)*
URL **Attachment:**

S.3. **For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. **Numerator Statement** *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)*
*IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.*
Measuring percentage of people with Asthma that have an emergency room visit during a 12 month measurement period.

S.5. **Time Period for Data** *(What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)*
The measurement period is a 12 consecutive month period. This can be calendar year, fiscal year or as otherwise determined. For the Together for Quality Pilot a baseline period was determined and then two 12 month periods were defined as measurement periods during the pilot.

S.6. **Numerator Details** *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
*IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.*
Emergency Department Visits
Numerator is patients with = 1 asthma related ED visits as identified via ED visit codes (procedure codes 99281-99285) AND also has an asthma diagnosis code ICD-9-CM codes 493.00, 493.01, 493.02, 493.10,493.11, 493.12, 493.81, 493.82, 493.90, 493.91, and 493.92 as the primary diagnosis on the emergency
room claim during the measurement period).

Use table of denominator recipient IDs to pull all recipients that have received claims described above.

S.7. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with ICD-9-CM codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91,and 493.92 (excludes 493.20, 493.21 and 493.22)asprimary and secondary diagnoses with the dates of service"Begin Date through End Date" equal any consecutive 12 month period with paid dates from "Begin Date through End Date which includes 3 month tail". This is the measurement period. Total period of our pilot initiative was 24 months. We used Baseline Measurement period of March 1, 2006 through February 28, 2007 with paid dates through May 31, 2007 to provide a 3 month claims tail.

A "Measurement period is any 12 consecutive months".

S.8. **Target Population Category** *(Check all the populations for which the measure is specified and tested if any):*
Children

S.9. **Denominator Details** *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses , code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
SQL for Asthma Denominator

```
(
SELECT
DSS.T_CA_ICN.ID_MEDICAID,
trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12),
DSS.T_CA_RECIP_KEY.CDE_RECIP_COUNTY || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RECIP_COUNTY,
DSS.T_CA_RECIP_KEY.CDE_RACE || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RACE,
DSS.T_CA_RECIP_KEY.CDE_SEX || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_SEX
FROM
DSS.T_CA_ICN,
DSS.T_RE_BASE_DN,
DSS.T_CA_RECIP_KEY,
DSS.T_CA_AID_GROUP
WHERE
( DSS.T_CA_ICN.RECIP_KEY=DSS.T_CA_RECIP_KEY.RECIP_KEY )
AND ( DSS.T_RE_BASE_DN.SAK_RECIP(+)=DSS.T_CA_ICN.SAK_RECIP )
AND ( DSS.T_CA_AID_GROUP.SAK_AID_GROUP=DSS.T_CA_ICN.SAK_AID_GROUP )
AND (
```

```
(DSS.T_CA_ICN.CDE_DIAG_PRIM IN (´49300´, ´49301´, ´49302´, ´49310´, ´49311´, ´49312´, ´49381´, ´49382´, ´49390´, ´49391´,
´49392´)
OR DSS.T_CA_ICN.CDE_DIAG_2 IN (´49300´, ´49301´, ´49302´, ´49310´, ´49311´, ´49312´, ´49381´, ´49382´, ´49390´, ´49391´,
´49392´))
AND DSS.T_CA_ICN.DTE_FIRST_SVC BETWEEN ´03-01-2006 00:00:00´ AND ´02-28-2007 00:00:00´
AND DSS.T_CA_ICN.DTE_PTN BETWEEN ´03-01-2006 00:00:00´ AND ´05-31-2007 00:00:00´
AND trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12) != 0
AND DSS.T_CA_ICN.CDE_DTL_STATUS != ´D´
AND DSS.T_CA_AID_GROUP.CDE_GROUP_D NOT IN (´D98´, ´D99´, ´D1 ´, ´D2 ´, ´D3 ´, ´D4 ´, ´D5 ´, ´D6 ´, ´D7 ´, ´D8 ´, ´D9 ´)
AND DSS.T_CA_ICN.CDE_CLM_TYPE IN (´I´, ´A´, ´C´, ´M´, ´O´, ´B´)
)
GROUP BY
DSS.T_CA_ICN.ID_MEDICAID,
trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12),
DSS.T_CA_RECIP_KEY.CDE_RECIP_COUNTY || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RECIP_COUNTY,
DSS.T_CA_RECIP_KEY.CDE_RACE || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RACE,
DSS.T_CA_RECIP_KEY.CDE_SEX || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_SEX
HAVING
( count(DISTINCT DSS.T_CA_ICN.NUM_ICN) >= 1)
UNION
SELECT
DSS.T_CA_ICN.ID_MEDICAID,
trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12),
DSS.T_CA_RECIP_KEY.CDE_RECIP_COUNTY || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RECIP_COUNTY,
DSS.T_CA_RECIP_KEY.CDE_RACE || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RACE,
DSS.T_CA_RECIP_KEY.CDE_SEX || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_SEX
FROM
DSS.T_CA_ICN,
DSS.T_RE_BASE_DN,
DSS.T_CA_RECIP_KEY,
DSS.T_CA_DRUG,
DSS.T_CA_AID_GROUP
WHERE
( DSS.T_CA_ICN.RECIP_KEY=DSS.T_CA_RECIP_KEY.RECIP_KEY )
AND ( DSS.T_CA_DRUG.SAK_CLAIM(+)=DSS.T_CA_ICN.SAK_CLAIM and DSS.T_CA_DRUG.DTE_PTN(+)=DSS.T_CA_ICN.DTE_PTN )
AND ( DSS.T_RE_BASE_DN.SAK_RECIP(+)=DSS.T_CA_ICN.SAK_RECIP )
AND ( DSS.T_CA_AID_GROUP.SAK_AID_GROUP=DSS.T_CA_ICN.SAK_AID_GROUP )
AND (
DSS.T_CA_DRUG.NUM_DRUG_GCN_SEQ IN (05037, 04963, 04964, 04966, 04967, 04968, 05032, 05033, 05034, 05039, 05040,
16033, 22230, 28090,
41848, 41849, 48698, 48699, 49871, 51197, 51198, 54687, 57879, 58890)
AND DSS.T_CA_ICN.DTE_FIRST_SVC BETWEEN ´03-01-2006 00:00:00´ AND ´02-28-2007 00:00:00´
AND DSS.T_CA_ICN.DTE_PTN BETWEEN ´03-01-2006 00:00:00´ AND ´05-31-2007 00:00:00´
AND trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12) != 0
AND DSS.T_CA_ICN.CDE_DTL_STATUS != ´D´
AND DSS.T_CA_AID_GROUP.CDE_GROUP_D NOT IN (´D98´, ´D99´, ´D1 ´, ´D2 ´, ´D3 ´, ´D4 ´, ´D5 ´, ´D6 ´, ´D7 ´, ´D8 ´, ´D9 ´)
AND DSS.T_CA_ICN.CDE_CLM_TYPE IN (´P´, ´Q´)
)
GROUP BY
DSS.T_CA_ICN.ID_MEDICAID,
trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12),
DSS.T_CA_RECIP_KEY.CDE_RECIP_COUNTY || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RECIP_COUNTY,
DSS.T_CA_RECIP_KEY.CDE_RACE || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RACE,
DSS.T_CA_RECIP_KEY.CDE_SEX || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_SEX
HAVING
```

(
count(DISTINCT DSS.T_CA_ICN.NUM_ICN) >= 2
)
)
Make a table of the recipient IDs retrieved from Asthma Denominator query.

S.10. **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*
Excludes children less than age two or greater than age twenty.

S.11. **Denominator Exclusion Details** *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
Anyone under age two. Actually Query language states "Recipient Age FDOS - Calculated Between Age 2 and 20"

S.12. **Stratification Details/Variables** *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*
Recipient Gender & Description
Recipient Race Code & Description
Recipient County & Description

S.13. **Risk Adjustment Type** (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)
No risk adjustment or risk stratification
If other:

S.14. **Identify the statistical risk model method and variables** *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*
N/A

S.15. **Detailed risk model specifications** *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*
*Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.*

S.15a. **Detailed risk model specifications** (*if not provided in excel or csv file at S.2b*)

S.16. **Type of score:**

If other:

S.17. **Interpretation of Score** *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*
Better quality = Lower score

S.18. **Calculation Algorithm/Measure Logic** *(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*
N/A-Measure results were simply reviewed in relationship to the established target goal.

S.19. **Calculation Algorithm/Measure Logic Diagram URL or Attachment** *(You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

S.20. **Sampling** *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*
IF a PRO-PM, identify whether (and how) proxy responses are allowed.
N/A

S.21. **Survey/Patient-reported data** *(If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)*
IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. **Missing data** (specify how missing data are handled, e.g., imputation, delete case.)
Required for Composites and PRO-PMs.

S.23. **Data Source** *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
*If other, please describe in S.24.*
Claims

S.24. **Data Source or Collection Instrument** *(Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)*
IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.
It is Business Objects software with the Client side version known as DeskTop Intelligence or DI. It uses SQL structured business language and rules to allow for the development of queries of the administrative claims database. It is provided through our MMIS contract with HP Enterprises.

S.25. **Data Source or Collection Instrument** *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*
URL

S.26. **Level of Analysis** *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*
Health Plan, Population : Community, County or City

S.27. **Care Setting** *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*
Inpatient/Hospital
If other:

S.28. **COMPOSITE Performance Measure** - Additional Specifications *(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)*

**2a. Reliability – See attached Measure Testing Submission Form**
**2b. Validity – See attached Measure Testing Submission Form**
1381_MeasureTesting_MSF5.0_Data.doc

## 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

**3a. Byproduct of Care Processes**

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. **Data Elements Generated as Byproduct of Care Processes.**
Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

**3b. Electronic Sources**

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. **To what extent are the specified data elements available electronically in defined fields?** *(i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)*

Yes

3b.2. **If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.**

3b.3. **If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.**

**Attachment:**

**3c. Data Collection Strategy**

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. **Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.**

Prior to assigning individuals identified in the numerator directly to a care coordinator would incorporate verification of the diagnosis with their primary care provider into the care coordination protocol before attempting enrollment. Limiting the identification of persons in the denominator to only those with the diagnosis would reduce the number of persons who indicated they did not have a diagnosis of asthma (13.1% of 1667 persons who were identified for care management but Never Enrolled) but would prevent the inclusion of persons who had asthma but were unaware of the diagnosis which was felt to be more relevant clinically.

3c.2. **Describe any fees, licensing, or other requirements to use any aspect of the measure as specified** *(e.g., value/code set, risk model, programming code, algorithm)*.

## 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

**4a. Accountability and Transparency**

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. **Current and Planned Use**

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

| Planned | Current Use (for current use provide URL) |
|---|---|
| Public Reporting<br><br>Quality Improvement (Internal to the specific organization) | |

4a.1. **For each CURRENT use, checked above, provide:**

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

4a.2. **If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (*e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?*)

4a.3. **If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

**4b. Improvement**

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. **Progress on Improvement. (Not required for initial endorsement unless available.)**
**Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:**

- **Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)**
- **Geographic area and number and percentage of accountable entities and patients included**

4b.2. **If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

**4c. Unintended Consequences**

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. **Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**
Potential to identify persons as being asthmatic due to provider error in coding. This is the same as for any claims data. Since the purpose of our use of this measure was to target persons who potentially could benefit from interventions we were not worried about including people without a confirmed diagnosis of asthma but were alright with potentially identifying others we could potentially keep out of the emergency room for respiratory problems.

## 5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

**5. Relation to Other NQF-endorsed Measures**
Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

5.1a. **List of related or competing measures (selected from NQF-endorsed measures)**

5.1b. **If related or competing measures are not NQF endorsed please indicate measure title and steward.**

**5a. Harmonization**

The measure specifications are harmonized with related measures;
**OR**
The differences in specifications are justified

5a.1. **If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**
**Are the measure specifications completely harmonized?**

5a.2. **If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**

**5b. Competing Measures**

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);
**OR**
Multiple measures are justified.

5b.1. **If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**
**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**
n/a

Related Measures: Unaware of any. Checked NQF endorsed list and could not find one related to Asthma and Emergency Room Visits.

## Appendix

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**Attachment:**

## Contact Information

Co.1 **Measure Steward (Intellectual Property Owner):** Alabama Medicaid Agency
Co.2 **Point of Contact:** Sylisa, Lee-Jackson, Sylisa.Lee-Jackson@medicaid.alabama.gov, 334-353-4599-
Co.3 **Measure Developer if different from Measure Steward:** Alabama Medicaid Agency

Co.4 **Point of Contact:** Mary, McIntyre, mary.mcintyre@medicaid.alabama.gov, 334-242-5574-

## Additional Information

Ad.1 **Workgroup/Expert Panel involved in measure development**
**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**
http://www.medicaid.alabama.gov/documents/Transformation-TFQ-Documents/Charter/TFQ%20Clinical_Workgroup_Charter_V%207%2030%202009_revised%20(3).pdf
List is available at this URL.
Group helped identify the codes, age group, etc. Included Domain Experts from University in the development. See meeting documents.

**Measure Developer/Steward Updates and Ongoing Maintenance**
Ad.2 **Year the measure was first released:** 2008
Ad.3 **Month and Year of most recent revision:** 04, 2010
Ad.4 **What is your frequency for review/update of this measure?** Reviewed Yearly
Ad.5 **When is the next scheduled review/update for this measure?** 04, 2011

Ad.6 **Copyright statement:** State Government
Ad.7 **Disclaimers:**

Ad.8 **Additional Information/Comments:**

**Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting – National Quality Strategy Domain: Effective Clinical Care**

**2016 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of patients aged 5 years and older with a diagnosis of persistent asthma who were prescribed long-term control medication

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for all patients with a diagnosis of persistent asthma seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

**This measure will be calculated with 3 performance rates:**
1) Patients prescribed inhaled corticosteroids (ICS) as their long-term control medication
2) Patients prescribed alternative long-term control medications (non-ICS)
3) Total patients prescribed long-term control medication

**Measure Reporting via Registry:**
ICD-10-CM diagnosis codes, CPT codes, QDC code and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

**DENOMINATOR:**
All patients aged 5 years and older with a diagnosis of persistent asthma

**Denominator Instructions:** Documentation of persistent asthma must be present. One method of identifying persistent asthma is, at a minimum, daily use of short-acting bronchodilators

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 5 years on date of encounter
**AND**
**Diagnosis for asthma (ICD-10-CM):** J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
**AND**
**Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
**AND**
Persistent Asthma (mild, moderate or severe) **(1038F)**

**NUMERATOR:**
Patients who were prescribed long-term control medication

**Definition:**
**Long-Term Control Medication Includes:**

Patients prescribed inhaled corticosteroids (the preferred long-term control medication at any step of asthma pharmacological therapy)
**OR**

Patients prescribed alternative long-term control medications (inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, methylxanthines) OR an acceptable alternative long-term control medication at one or more visits in the 12-month period OR patient already taking inhaled corticosteroid OR an acceptable alternative long-term control medication as documented in current medication list

**Numerator Options:**

***Performance Met:*** Inhaled corticosteroids prescribed **(4140F)**

**OR**

***Performance Met:*** Alternative long-term control medication prescribed **(4144F)**

**OR**

***Patient Performance Exclusion:*** Documentation of patient reason(s) for not prescribing inhaled corticosteroids or alternative long-term control medication (eg, patient declined, other patient reason) **(4140F *with* 2P)**

**OR**

***Performance Not Met:*** Inhaled corticosteroids or alternative long-term control medication **not** prescribed, reason not otherwise specified **(4140F *with* 8P)**

**RATIONALE:**

The following statement is quoted verbatim from the NHLBI/NAEPP guideline (NHLBI, 2007):

"The broad action of ICS on the inflammatory process may account for their efficacy as preventive therapy. Their clinical effects include reduction in severity of symptoms; improvement in asthma control and quality of life; improvement in PEF and spirometry; diminished airway hyper-responsiveness; prevention of exacerbations; reduction in systemic corticosteroid courses; emergency department (ED) care; hospitalizations, and deaths due to asthma; and possibly the attenuation of loss of lung function in adults". (Rafferty P 1985; Haahtela T 1991; Jeffery PK 1992; Van Essesn-Zandvliet EE 1992; Barnes NC 1993; Fabbri L 1993; Gustafsson P 1993; Kamada AK 1996; Suissa S 2000; Pauwels RA 2003; Barnes PJ October 1992)

**CLINICAL RECOMMENDATION STATEMENTS:**

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The Expert Panel recommends that long-term control medications be taken daily on a long-term basis to achieve and maintain control of persistent asthma. The most effective long-term control medications are those that attenuate the underlying inflammation characteristic of asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most potent and clinically effective long-term control medication for asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most effective long-term therapy available for patients who have persistent asthma, and, in general, ICS is well tolerated and safe at the recommended dosages. (Evidence A) (NHLBI, 2007)

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The American Academy of Allergy Asthma and Immunology (AAAAI) and PCPI owned and developed measure, Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting, specifications are copied verbatim from the 2016 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.

**Measure Type:** Process