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Challenges in Healthcare Quality Transparency Efforts in Respect to U.S. Medical Practices

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ABSTRACT

Healthcare transparency efforts are being encouraged across states, and across markets. These efforts to report on the costs associated with healthcare and provider quality performance are aimed at providing consumers with information that will improve decision making. Many of the current transparency approaches focus on cost comparisons. Yet, evaluation of providers on cost only is inappropriate – quality must also be considered. Additionally, transparency quality measures are increasingly impacting payment practices for providers. Value-based payment systems are shifting traditional payment strategies from pay for quantity to pay for quality.

This paper reviews the key challenges to transparency reporting on quality in health care. Reporting efforts are dependent on the type and accuracy of available data. Most often, the available data are historical claims data. Claims data have limitations as well as benefits. Other important challenges center on strategic reporting decisions such as what type of providers to focus upon, what measures to use, and how to fairly adjust measure results for accurate representation.

INTRODUCTION

The healthcare payment system of the United States has evolved through numerous policy enactments into a market divided by public payment sources (Medicare , Medicaid, and Veteran's Affairs) and private payment sources (commercial health insurance). The healthcare delivery system of the United States has yet primarily relied on a market-based economy. As such, the delivery system focuses on providers (professionals and facilities) who operate under market forces to supply services and resources, to determine prices. And price, as defined by value, is often a function of what the market will bear as well as quality of services.

The key constituents in the US healthcare market are (1) the consumers, (2) the payers (health plans), (3) the purchasers (employer groups), and (4) the providers themselves. Each constituent is known to make decisions based on market forces such as availability, price and quality[1]. Decisions by constituents, therefore, rely on disclosure of data related to these forces: availability, price and quality. Current efforts in the US healthcare system focus on transparency, primarily as directed to the consumer to ensure decisions based on value.

The movement towards transparency has been driven by numerous changes in the US healthcare

system. The Affordable Care Act has promoted the Triple Aim in healthcare. The Triple Aim is focused on the improvement of the value of health care services in terms of improved quality of care for individuals, improved overall population health and reduction in costs[2]. Value is often defined as optimal care at a fair price. These objectives all require measuring, reporting, and rewarding provider performance based on quality measures.

Value based healthcare has also become a mantra for structuring reimbursement/payment practices. CMS has been a leader in value-based payment design. The MACRA (Medicare Access and CHIP Reauthorization Act) Quality Payment Program promotes a merit based incentive payment system (MIPS) that will affect physician payment based upon performance measures. MACRA also offers the option of payment through alternative payment models (APMS), which are commonly thought of as accountable care organizations and bundled payment models, also subject to performance assessment[3].

Value based payment strategies have also been implemented by the private sector as a means to shift from traditional volume based provider payments towards payment agreements based on quality and outcomes. Often referred to as pay-for-performance programs, or P4P (Payment For Performance), or incentive programs, these strategies often supplement established fee schedule rates with additional reimbursement based on provider performance on select quality metrics[4,5].

An underlying principle of the value based system is that there is variance in quality outcomes among similar providers. Continuing increases in healthcare expenditures, along with variations in quality have resulted in the market responses that move provider payment to a system that considers both cost and quality as a determination of value. The analysis of quality requires comprehensive data acquisition, fairness and accuracy in data analysis, and transparency in reporting. This review considers the challenges in these critical factors of healthcare transparency focused primarily on quality analysis of physician providers.

PRIMARY CARE, SPECIALTY, OR GROUP PRACTICE

A transparency project must determine the key questions of WHO is reviewed for quality reporting as well as WHAT measures are reported. The provider types reviewed, hospitals aside, could be (1) individual primary care providers (PCPs), (2) specialists, or (3) clinics or group practices[7]. If PCPs were the subject of the transparency reporting, the measure might focus on general patient management, but if specialists

were the subjects, then perhaps the focus would be on specific procedures or services. The discussion of what measures are available for use follows, and it is evident that the choice of measures is impacted by the question of what type of provider is reviewed. Any approach will have other challenges that must be addressed in the methodology.

MEASURE SELECTION FOR TRANSPARENCY REPORTING

Quality reporting of health plans using administrative claims data has been conducted for many years. Specifically the National Committee for Quality Assurance (NCQA) has developed the HEDIS© measures that assess quality of Medicare, Medicaid, and commercial health plans. The National Quality Forum (NQF) endorses standards used to measure and report on the quality and efficiency of healthcare. These two sets of standards mirror each other and serve as the basis for measuring health plans and Accountable Care Organizations (ACO).

However, the measures developed by NCQA and NQF have been developed to assess services delivered to a captured population. Members of a health plan are "captured" within that health plan and cannot seek services outside the plan. Members of an accountable care organization are essentially "captured" within that ACO, and the ACO accepts responsibility for management of those members. It is very difficult to translate measures designed to evaluate performance within a captured population to the evaluation of an individual provider who cannot "capture" the member.

PQRS Measures

CMS has implemented the Physician Quality reporting System (PQRS) which reports on provider quality of care to Medicare fee-for-service patients. In 2015 CMS applied a payment adjustment to providers who failed to appropriately report, thus reducing their payment for services[8].

For this review, the authors evaluated each of the 284 PQRS measures to assess their appropriateness for provider performance transparency reporting, using claims data. The team reviewed the requirements and components of each measure to identify those that were determined to be feasibly applied to claims data and individual physician measures.

The process was as follows:

1. Filter on measures that could be derived from claims data only.
2. Filter on measures that focus on the following measure types: Efficiency and Process
3. Filter on measures that focus on the following domain: Effective Clinical Care, Efficiency

and Cost Reduction and Patient Safety

4. Then each measure was reviewed in detail which resulted in some further exclusions.

At the end of the filtering and review process we determined that there were only 19 measures that could be accurately assessed using claims data only, and which provided a degree of relevance to the consumer public. Yet, of the 19, only 8 could be applied to primary care physicians, with the remainder directed toward specialists such as emergency medicine, surgery, neurology, and obstetrics/gynecology. (See Appendix A).

QECP Measures

CMS has also established a certification program to review, monitor and approve organizations that agree to produce reports on provider quality. Dubbed the Qualified Entity Certification for Medicare Data Program (QECP), this status came about as a result of the Affordable Care Act of 2010 which included a provision to make available to qualified entities standardized extracts of Medicare fee-for-service claims data for the purpose of measuring health care provider performance. The QECP program is intended to promote transparency of health care services. The QECP compiled a list of standard measures that are suggested for use by Qualified Entities (QEs) to evaluate and report on the performance of providers[9]. Measures included were those endorsed by the CMS PQRS (Physician Quality Reporting System) program, the NQF (National Quality Forum) and NCQA (National Committee on Quality Assurance), in an attempt to identify acceptable measures and methodologies. The list details over 700 measures, many of which are duplicates but reported by more than one agency. When this list is reviewed and reduced to possible measures suitable for reporting on physicians with claims data, the possible measures are limited to 117, with several that are relatively obscure and of questionable interest to the consumer. (See Appendix B).

ACO Measures

Accountable Care Organizations (ACOs) have been promoted by CMS as groups of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that agree to work together to coordinate care for the Medicare Fee-For-Service (FFS) patients they serve. As an organized provider group, the principle concepts of ACO performance can be universally applied to all "captured" patient populations.

For the purposes of provider transparency, we suggest that the measures developed for quality measurement of ACOs in Medicare are best applied to reporting on provider practice groups rather than individual practitioners. The benefit to reporting by group is to allow for common patients to seek various

care services related to the disease condition from any specialty practicing within the group.

The ACO measures are appropriate for a quality measurement program that focuses on coordinated, multi-specialty care and has an appropriate means to attribute patients to provider groups. The measures include specific components related to the following domains[10]:

1. Domain: patient/ caregiver experience: cannot be reported with claims data only
2. Domain: care coordination/ patient safety
3. Domain: preventive health
4. Domain: at-risk populations
    A. Diabetes
    B. Hypertension
    C. Ischemic vascular disease
    D. Heart failure
    E. Coronary artery disease
    F. Depression

Not all of the ACO measures can be accurately analyzed using claims data only.

BRIDGES TO EXCELLENCE Measures

The Bridges to Excellence (BTE) program is a physician quality reporting process produced by Healthcare Incentives Improvement Institute – HCI3, which is a non-profit organization that has created programs to measure health outcomes. The BTE measures are designed to measure the quality of care from specific providers. The measures focus on chronic conditions, and are therefore designed to be applied to general practice physicians who manage patient care[11]. The BTE program has been used by several commercial carriers who analyze claims to assess performance for provider incentive programs[12].

The BTE measures include specific components related to the following disease conditions:

1. Asthma
2. Cardiac
3. Congestive Heart Failure
4. COPD
5. Coronary Artery Disease
6. Diabetes
7. Hypertension

Not all of the BTE measures can be accurately analyzed using claims data only.

RESOURCE USE MEASURES

Resource use measures are designed to assess the value of healthcare delivery in terms of cost and efficiency of health care provision. Resource use measures are constructed using primarily claims data. The Agency for Healthcare Research and Quality (AHRQ) reviewed available resource use measures and classified them into 3 categories[13]:

1) Relatively simple measures: these measures are assessment of the resources used in healthcare, for example: utilization rates, preventable services, and costs.
2) Complex measures of healthcare resource use: these measures require the application of complex econometric techniques to derive rates and costs
3) Measures of episode-based use of resources or population-based resource use.
    a. Episode-based measures: "Episodes of care" describe events wherein all services related to a particular medical condition or acute event are grouped.
    b. Population-based measures: These measures group members into a chronic disease group or a morbidity/risk category to evaluate the cost or use of resources over time.

Several national groups, including NQF and CMS have expressed a preference for episode-based measures. Yet, the validity and practical applicability of resources use measures to transparency reporting is unproven. A central challenge is the ability to apply such measures to an individual provider.

BENEFITS AND LIMITATIONS OF CLAIMS DATA

Claims data are commonly used to analyze healthcare services. Most of the current transparency sites such as the All Payer Claims Databases (APCD) rely on claims data submitted by health plans (public and private). The claims data are aggregated so that providers can be assessed across payers. Total cost of care can be reported using claims data, which can report the average cost of consumers as differentiated by age, gender, chronic disease, or geographic region. Provider performance can also be assessed using claims data, as discussed in the measure review above.

The benefits to the use of claims data are many in that;

(1) the data are readily available,
(2) the data include values that are numeric or codes,
(3) the values are often "standardized" (common across data sources),

(4) the data are generally aggregated by a common population covered by a single payer across an identified time period,
(5) the data encompass large and often diverse populations
(6) the data is objective (not self reported)
(7) claims data provide a reasonable representation of the provision of services
(8) Claims data also do not require patient authorization

Yet, there are also acknowledged limitations to the use of claims data in healthcare research. Claims data are administrative data that are intended to document the delivery of services for the purpose of payment. The clinical content of administrative data is limited to the codes for procedures and services delivered and the diagnoses codes and the demographic characteristics of the members. No clinical values (such as blood pressure, weight, lab values, etc.) or clinical decision notes are included. Additionally, data not essential for reimbursement may be omitted by the provider, thus possibly underreporting co-morbid diagnoses or services that are bundled or not reimbursable. Hospital claims frequently lack detail of specific services and pharmaceutical use due to the use of revenue codes for billing.

Despite such potential gaps in clinical information and the billing documentation found in claims date, administrative data allow some insight into effectiveness and efficiency in healthcare. Specifically, researchers are able to analyze:

(1) the outcomes associated with processes of care
(2) the outcomes related to varying treatment approaches
(3) the sequencing of services delivered across providers
(4) adherence or variation in care guidelines/standards
(5) identification of errors of omission or commission
(6) assessment of groups of patients with rare conditions
(7) assessment of the total cost of care for certain diagnoses
(8) assessment of the total cost of care for certain episodes
(9) assessment of the total cost of care for procedures

ISSUE OF ATTRIBUTION

If the transparency reporting focuses on measures of general patient management (ie: diabetes management), then a key issue is attribution of patients to a single provider. Because members have the

freedom to seek services from any provider, a methodology must be identified to hold a single provider accountable to a single patient.

If alternatively, the transparency reporting focuses on patient management within a clinic or provider group, then the challenge is linking single providers to a clinic, group or multi-specialty group. The type and size of groups to be reviewed would also have to be defined.

Proper methodology for attribution of provider to patient and attribution of provider to provider group requires the inclusion of specific details in the claims data or the provider or member files that support the claims data. This data includes (1) the NPI (National Provider Identification) which uniquely identifies a provider, (2) the servicing provider ID on the claim, and (3) the billing provider ID on the claim or the provider file.

Because patients see many providers, the subsequent challenge is to identify a rule making a single provider the responsible provider, one whose quality reporting includes that patient. This is most often applied to primary care practices, which are generally assumed to be responsible for overall patient management. "Leakage" or the loss of members would need to be assessed and accounted for. For specialty services, when quality is evaluated in terms of specific procedures, the issue of attribution is not as contentious.

Provider quality assessment is often performed using claims data, it becomes by nature retrospective, viewing historical claims to evaluate performance. Attribution may be assigned retrospectively as well, in which case the patient-provider attribution is based on prior year data, or the attribution may be considered concurrent, where the assignment is based on the reporting year (or period) upon completion of that period[14,15].

For primary care attribution, CMS uses a methodology known as the "plurality of primary care attribution method"[15]. Under this method, which applies only to Medicare fee-for-service, members are attributed to the provider that billed the greatest dollar amount of evaluation and management services. Other reporting agencies attribute based on the quantity of evaluation and management services in primary care[16].

NEED FOR ADJUSTING FOR RISK

Risk adjustment is a statistical method of normalizing a population for the purpose of analysis. The process of risk adjustment includes the analysis of individual members to assess their demographic factors, clinical history and history of resource use. This information is then used to assign a risk score to each individual. This risk score can then be used as a factor in statistical analysis to account for differences in individual risk factors that can impact quality outcomes or costs[13]. The intent of risk adjustment is to enable more accurate comparisons of providers, despite the existence of different risk factors among the patients they serve[17]. CMS applies risk adjustment to some of the Physician Quality Reporting System measures.

Transparency projects that rely on claims data can apply risk adjustment methodology to the analysis and reporting. There are several risk adjustment tools and software available as open source or as privately licensed software.

ACCOUNTING FOR PATIENT BEHAVIOR AND LIFESTYLE CHOICES

Risk factors analyzed in risk adjustment processes are related primarily to age, gender, clinical conditions, and historical utilization, which are often beyond the control of the provider. Other factors outside of the provider control or influence are patient behaviors lifestyle choices, and socio-economic or cultural states that can impact health status and access to care. For example, a physician practicing in a low socio-economic (SES) environment may receive lower ratings when patient access to services is limited due to transportation, out-of-pocket fees or lack of delivery sites. Other drivers of patient non-compliance may be related to cultural beliefs, thus impacting scores for physicians practicing in culturally homogenous locations.

Therefore, to account for variations in patient lifestyle, culture and socio-economic status factors that influence health and treatment compliance, results would have to either be adjusted or reported by geographic area or demographic characteristics. These issues would need to be accounted for in measure analysis and reporting to ensure equal expectation of the effect of patient decision-making/recommendations on patient populations.

CONCLUSION

Health care providers compete within the US health care system in their efforts to attract patients and to be included in health plan provider networks. And studies of variations have shown that

providers do not produce identical results in either cost or quality of services. Yet, in the current market, readily available, comprehensive information on provider performance needed to assess both cost and quality is not generally available to the public.

Transparency reporting efforts are quickly growing in both the public and private healthcare markets. Driven by the value-based approach to healthcare reimbursement, consumers and payers need accurate information on price and quality. Cost of care alone, is not sufficient to evaluate provider performance. There is no interest to direct consumers to low-cost providers regardless of quality. Thus quality measures and cost analysis must be reported in conjunction.

Economic theory would suggest that in a true competitive market, both cost and quality should begin to converge to the median. In such a market, when price is similar, competition will be based on quality. Yet, the healthcare market encounters various challenges to quality reporting. Choice of measures, as well as selection of targeted providers (individual primary care, specialist, or groups), and comprehensiveness of available data all complicate the effort. Additionally, accuracy and fairness must be strived for by adjusting results for risk and patient factors that are beyond the provider's control. Adjustment for such factors is not sufficient if the presentation and discussion of the measure results remains too complex for the consumer.

As transparency efforts expand, these challenges must be openly addressed. Recent efforts by the Center for Health Care Transparency, an initiative sponsored by the Network for Regional Healthcare Improvement, attempt to align transparency organizations. The APCD Council, a collaborative organization of all-payer-claims-databases is another organization working towards mutual goals in transparency.

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ATTACHMENT A:

COMPARISON OF QUALIFIED ENTITIES (QE)* QUALITY REPORTING						
QE AND LOCATION	**LOCATION**	**DATA SOURCE**	**MEASURE SOURCE**	**PROVIDER**	**RISK ADJUSTMENT**	**ATTRIBUTION METHOD**
Amino	Nationwide	Claims	Other	All (PCP, Specialists)	Yes	n/a
California Healthcare Performance Information System (CHPI)	California	Claims	Other	Group	Yes	n/a
Center for Improving Value in Health Care (CIVHC)	Colorado	Claims	Mixed	PCPs	Yes	Most Visits (E/M or total PCP visits)
FAIR Health	Nationwide	Claims	n/a	Both	n/a	n/a
Health Care Cost Institute	Nationwide	Claims	n/a	Group	n/a	n/a
HealthInsight	Utah	Hospital Process of Care Measures/HCAHPS	Other	Group	n/a	n/a
Maine Health Management Coalition (MHMC)	Maine	Claims	n/a	PCP	n/a	Most visits
Midwest Health Initiative (MHI)	Illinoi, Missouri, Kansas	Claims	Mixed	Group	n/a	n/a
Minnesota Department of Health, Division of Health Policy (MDH-DHP)	Minnesota	Claims	Other	Clinic	Yes	n/a
OptumLabs	Nationwide	Claims	NQF	n/a	n/a	n/a
Oregon Health Care Quality Corporation (Q Corp)	Oregon	Claims	Mixed	PCP/Clinic including Pediatric and Geriatric and OBGyn	Yes	Most visits

COMPARISON OF QUALIFIED ENTITIES (QE)* QUALITY REPORTING						
QE AND LOCATION	**LOCATION**	**DATA SOURCE**	**MEASURE SOURCE**	**PROVIDER**	**RISK ADJUSTMENT**	**ATTRIBUTION METHOD**
Pittsburgh Regional Health Initiative (PRHI)	Pittsburgh	Claims	Other	Group	n/a	n/a
The Health Collaborative	Ohio, Kentucky	Claims	Mixed	Group	n/a	n/a
Virginia Health Information	Virginia	Claims	n/a	Group	n/a	n/a
Wisconsin Health Information Organization	Wisconsin	Claims	Symmetry EBM Connect: mix HEDIS, NQF	Group	Yes	Most visits

* QE is a Qualified Entity that has achieved Qualified Entity Certification for Medicare Data Program from CMS

Data compiled August 30, 2016 from QE websites and interviews by Joseph Chen, PhD Graduate Student at University of Texas School of Public Health

APPENDIX A: QECP Measures After Filtering

Measure Title	PQRS	Medical Care	Measure Description
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	014	Primary Care	Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months
Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	021	Surgery	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis
Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	022	Surgery	Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	023	Surgery	Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time
Screening for Osteoporosis for Women Aged 65-85 Years of Age	039	Primary Care	Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis
Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	041	Primary Care	Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months

Measure Title	PQRS	Medical Care	Measure Description
Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	051	Primary Care	Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry results documented
Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	054	Emergency Medicine	Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had a 12-lead electrocardiogram (ECG) performed
Acute Otitis Externa (AOE): Topical Therapy	091	Primary Care	Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations
Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	093	Primary Care	Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy
Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure	255	Emergency Medicine	Percentage of Rh-negative pregnant women aged 14-50 years at risk of fetal blood exposure who receive Rh-Immunoglobulin (Rhogam) in the emergency department (ED)
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	326	Primary Care	Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by CHADS2 risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	415	Emergency Medicine	Percentage of emergency department visits for patients aged 18 years and older who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT.

Measure Title	PQRS	Medical Care	Measure Description
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years	416	Emergency Medicine	Percentage of emergency department visits for patients aged 2 through 17 years who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider who are classified as low risk according to the Pediatric Emergency Care Applied Research Network prediction rules for traumatic brain injury.
Osteoporosis Management in Women Who Had a Fracture	418	Primary Care	The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.
Overuse Of Neuroimaging For Patients With Primary Headache And A Normal Neurological Examination	419	Neurology	Percentage of patients with a diagnosis of primary headache disorder for whom advanced brain imaging was not ordered.
Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury	422	Ob/Gyn	Percentage of patients who undergo cystoscopy to evaluate for lower urinary tract injury at the time of hysterectomy for pelvic organ prolapse.
Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy	429	Ob/Gyn	Percentage of patients who are screened for uterine malignancy prior to surgery for pelvic organ prolapse.

Source: Centers for Medicare and Medicaid Services Qualified Entity Program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri

APPENDIX B: REDUCED QECP STANDARD MEASURE LIST

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
0004	NQF-Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Administrative claims, Electronic Clinical Data	National Committee for Quality Assurance (NCQA)
0021	QE CBE-Endorsed: NCQA	Annual Monitoring for Patients on Persistent Medications	Administrative Claims	National Committee for Quality Assurance (NCQA)
0022	QE CBE-Endorsed: NCQA	Use of High Risk Medications in the Elderly	Administrative Claims	National Committee for Quality Assurance (NCQA)
0031	QE CBE-Endorsed: NCQA	Breast Cancer Screening	Administrative Claims	National Committee for Quality Assurance (NCQA)
0033	CMS Program Measure	Chlamydia Screening	Administrative Claims	National Committee for Quality Assurance (NCQA)
0036	QE CBE-Endorsed: NCQA	Use of appropriate medications for people with asthma	Administrative claims	National Committee for Quality Assurance (NCQA)
0046	NQF-Endorsed	Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older	Administrative claims, Electronic Clinical Data	National Committee for Quality Assurance (NCQA)
0052	QE CBE-Endorsed: NCQA	Use of Imaging Studies for Low Back Pain	Administrative claims	National Committee for Quality Assurance (NCQA)
0053	QE CBE-Endorsed: NCQA	OsteoporosisManagement in Women Who Had a Fracture	Administrative claims	National Committee for Quality Assurance (NCQA)

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
0054	CMS Program Measure	C20 - Rheumatoid Arthritis Management	Administrative Claims	National Committee for Quality Assurance (NCQA)
0058	QE CBE-Endorsed: NCQA	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Administrative claims	National Committee for Quality Assurance (NCQA)
0069	QE CBE-Endorsed: NCQA	Appropriate treatment for children with upper respiratory infection (URI)	Administrative claims	National Committee for Quality Assurance (NCQA)
0071	QE CBE-Endorsed: NCQA	Persistence of Beta-Blocker Treatment After a Heart Attack	Administrative claims	National Committee for Quality Assurance (NCQA)
0075	CMS Program Measure	C03 - Cardiovascular Care - Cholesterol Screening	Administrative Claims	National Committee for Quality Assurance (NCQA)
0105	CMS Program Measure	DMC03 - Antidepressant Medication Management (6 months)	Administrative Claims	National Committee for Quality Assurance (NCQA)
0108	NQF-Endorsed	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Administrative claims	National Committee for Quality Assurance (NCQA)
0171	NQF-Endorsed	Acute Care Hospitalization During the First 60 Days of Home Health	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
0171	CMS Program Measure	Acute Care Hospitalization (Claims-Based)	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
0229	NQF-Endorsed	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF)	Administrative claims	Centers for Medicare & Medicaid

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
		hospitalization for patients 18 and older.		Services (CMS)
0229	CMS Program Measure	Mortality-30-HF: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization.	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
0231	NQF-Endorsed	Pneumonia Mortality Rate (IQI #20)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0268	NQF-Endorsed – Time-Limited	Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin	Administrative claims	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
0271	NQF-Endorsed – Time-Limited	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	Administrative claims	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
0272	NQF-Endorsed	Diabetes Short-Term Complications Admission Rate (PQI 01)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0273	NQF-Endorsed	Perforated Appendix Admission Rate (PQI 2)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0274	NQF-Endorsed	Diabetes Long-Term Complications Admission Rate (PQI 03)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0275	CMS Program Measure	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	Administrative Claims	Agency for Healthcare Research &

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
				Quality (AHRQ)
0277	CMS Program Measure	ACO 10 (NQF #0277; AHRQ PQI #08): Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0278	NQF-Endorsed	Low Birth Weight Rate (PQI 9)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0279	CMS Program Measure	Bacterial Pneumonia ACSC Measure	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0280	CMS Program Measure	Dehydration ACSC Measure	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0281	CMS Program Measure	Urinary Tract Infection ACSC Measure	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0283	CMS Program Measure	PQI 15: Adult Asthma Admission Rate	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0283	NQF-Endorsed	Asthma in Younger Adults Admission Rate (PQI 15)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0285	NQF-Endorsed	Rate of Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0337	NQF-Endorsed	Pressure Ulcer Rate (PDI 2)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
0339	NQF-Endorsed	RACHS-1 Pediatric Heart Surgery Mortality	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0340	NQF-Endorsed	Pediatric Heart Surgery Volume (PDI 7)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0344	NQF-Endorsed	Accidental Puncture or Laceration Rate (PDI 1)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0346	NQF-Endorsed	Iatrogenic Pneumothorax Rate (PSI 6)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0347	NQF-Endorsed	Death Rate in Low-Mortality Diagnosis Related Groups (PSI 2)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0349	NQF-Endorsed	Transfusion Reaction (PSI 16)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0351	NQF-Endorsed	Death among surgical inpatients with serious, treatable complications (PSI 4)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0352	NQF-Endorsed	Failure to Rescue In-Hospital Mortality (risk adjusted)	Administrative claims	The Children´s Hospital of Philadelphia
0354	NQF-Endorsed	Hip Fracture Mortality Rate (IQI 19)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0355	NQF-Endorsed	Bilateral Cardiac Catheterization Rate (IQI 25)	Administrative claims	Agency for Healthcare Research & Quality

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
				(AHRQ)
0357	NQF-Endorsed	Abdominal Aortic Aneurysm (AAA) Repair Volume (IQI 4)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0359	NQF-Endorsed	Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate (IQI 11)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0361	NQF-Endorsed	Esophageal Resection Volume (IQI 1)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0363	NQF-Endorsed	Foreign Body Left During Procedure (PSI 5)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0365	NQF-Endorsed	Pancreatic Resection Mortality Rate (IQI 9)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0368	CMS Program Measure	PSI 14 Postoperative wound dehiscence in abdominopelvic surgical patients	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0369	NQF-Endorsed	Dialysis Facility Risk-adjusted Standardized Mortality Ratio	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
0450	CMS Program Measure	PSI 12 Postoperative pulmonary embolism or deep vein thrombosis rate	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0467	NQF-Endorsed	Acute Stroke Mortality Rate (IQI 17)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
0468	NQF-Endorsed	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
0478	NQF-Endorsed	Neonatal Blood Stream Infection Rate (NQI #3)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0505	NQF-Endorsed	Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
0513	NQF-Endorsed	Thorax CT: Use of Contrast Material	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
0514	NQF-Endorsed	MRI Lumbar Spine for Low Back Pain	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
0530	CMS Program Measure	IQI 91 Mortality for Selected Medical Conditions (Composite)	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0531	CMS Program Measure	PSI 90 Complication/patient safety for selected indicators (Composite)	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0531	NQF-Endorsed	Patient Safety for Selected Indicators	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0533	CMS Program Measure	PSI 11: Post Operative Respiratory Failure	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
0533	NQF-Endorsed	Postoperative Respiratory Failure Rate (PSI 11)	Administrative claims	Agency for Healthcare Research &

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
				Quality (AHRQ)
0541	NQF-Endorsed	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Administrative claims	Pharmacy Quality Alliance (PQA, Inc.)
0549	QE CBE-Endorsed: NCQA	Pharmacotherapy Management of COPD Exacerbation	Administrative Claims	National Committee for Quality Assurance (NCQA)
0576	NQF-Endorsed	Follow-Up After Hospitalization for Mental Illness (FUH)	Administrative claims, Electronic Clinical Data	National Committee for Quality Assurance (NCQA)
0577	QE CBE-Endorsed: NCQA	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Administrative claims	National Committee for Quality Assurance (NCQA)
0581	NQF-Endorsed	Deep Vein Thrombosis Anticoagulation >= 3 Months	Administrative claims, Electronic Clinical Data	Resolution Health, Inc.
0583	NQF-Endorsed	Dyslipidemia new med 12-week lipid test	Administrative claims	Resolution Health, Inc.
0587	NQF-Endorsed	Tympanostomy Tube Hearing Test	Administrative claims	Resolution Health, Inc.
0638	NQF-Endorsed	Uncontrolled Diabetes Admission Rate (PQI 14)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0669	NQF-Endorsed	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
0673	NQF-Endorsed	Physical Therapy or Nursing Rehabilitation/Restorative Care for Long-stay Patients with New Balance Problem	Administrative claims	RAND Corporation
0716	NQF-Endorsed	Healthy Term Newborn	Administrative claims	California Maternal Quality Care Collaborative

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
0727	NQF-Endorsed	Gastroenteritis Admission Rate (PDI 16)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
0730	NQF-Endorsed	Acute Myocardial Infarction (AMI) Mortality Rate	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
1463	NQF-Endorsed	Standardized Hospitalization Ratio for Admissions	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
1550	CMS Program Measure	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
1558	NQF-Endorsed	Relative Resource Use for People with Cardiovascular Conditions	Administrative claims	National Committee for Quality Assurance (NCQA)
1768	CMS Program Measure	Plan All-Cause Readmission Rate	Administrative Claims	National Committee for Quality Assurance (NCQA)
1799	QE CBE-Endorsed: NCQA	Medication Management for People with Asthma (MMA)	Administrative claims	National Committee for Quality Assurance (NCQA)
1879	CMS Program Measure	Adherence to Antipsychotics for Individuals with Schizophrenia	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
1893	NQF-Endorsed	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
1932	QE CBE-Endorsed: NCQA	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic	Administrative claims	National Committee for Quality

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
		medications		Assurance (NCQA)
1933	QE CBE-Endorsed: NCQA	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia	Administrative claims	National Committee for Quality Assurance (NCQA)
1959	QE CBE-Endorsed: NCQA	Human Papillomavirus Vaccine for Female Adolescents	Administrative claims	National Committee for Quality Assurance (NCQA)
2065	NQF-Endorsed	Gastrointestinal Hemorrhage Mortality Rate (IQI #18)	Administrative claims	Agency for Healthcare Research & Quality (AHRQ)
2111	NQF-Endorsed	Antipsychotic Use in Persons with Dementia	Administrative claims	Pharmacy Quality Alliance (PQA, Inc.)
2158	CMS Program Measure	Medicare Spending Per Beneficiary	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
2337	NQF-Endorsed – Time-Limited	Antipsychotic Use in Children Under 5 Years Old	Administrative claims	Pharmacy Quality Alliance (PQA, Inc.)
2372	NQF-Endorsed	Breast Cancer Screening	Administrative claims, Electronic Clinical Data	National Committee for Quality Assurance (NCQA)
2379	NQF-Endorsed	Adherence to Antiplatelet Therapy after Stent Implantation	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
2431	NQF-Endorsed	Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI)	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
2436	NQF-Endorsed	Hospital-level, risk-standardized payment associated with a 30-day	Administrative claims	Centers for Medicare &

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
		episode-of-care for heart failure (HF)		Medicaid Services (CMS)
2558	NQF-Endorsed	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	Administrative claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Acute Conditions ACSC Composite	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
Not Applicable	CMS Program Measure	Diabetes ACSC Composite Measure	Administrative Claims	Agency for Healthcare Research & Quality (AHRQ)
Not Applicable	CMS Program Measure	ACO 8 (CMS): Risk-Standardized, All Condition Readmission	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Air Embolism	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Anemia of chronic kidney disease: Dialysis facility standardized transfusion ratio (STrR)	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Blood Incompatibility	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Catheter-Associated Urinary Tract Infections (UTI)	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Condition-specific per capita cost measures for COPD, diabetes, HF, and CAD	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
Not Applicable	CMS Program Measure	Emergency Department Use without Hospitalization	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Hemodialysis Adequacy – Urea Reduction Ratio (URR)	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Pressure Ulcer Stages III & IV	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Total Per Capita Cost Measure	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Vascular Catheter-Associated Infections	Administrative Claims	Centers for Medicare & Medicaid Services (CMS)
Not Applicable	CMS Program Measure	Access to Primary Care Doctor Visits	Administrative Claims	National Committee for Quality Assurance (NCQA)
Not Applicable	CMS Program Measure	Ambulatory Care: Emergency Department Visits	Administrative Claims	National Committee for Quality Assurance (NCQA)
Not Applicable	CMS Program Measure	Children and Adolescents' Access to Primary Care Practitioners	Administrative Claims	National Committee for Quality Assurance (NCQA)
Not Applicable	CMS Program Measure	Glaucoma Testing	Administrative Claims	National Committee for Quality

NQF#	Measure Type	Measure Title	Data Source	Measure Steward
				Assurance (NCQA)
Not Applicable	QE CBE-Endorsed: NCQA	Adults' Access to Preventive/Ambulatory Health Services	Administrative Claims	National Committee for Quality Assurance (NCQA)
Not Applicable	QE CBE-Endorsed: NCQA	Potentially Harmful Drug-Disease Interactions in the Elderly	Administrative Claims	National Committee for Quality Assurance (NCQA)

Source: Centers for Medicare and Medicaid Services Qualified Entity Program: https://www.qemedicaredata.org/SitePages/measures.aspx