A PLACE AT THE TABLE:
Behavioral Health and
CMS’ Physician Quality
Reporting System
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WHY THIS PAPER?

When we embarked on this project, we envisioned a paper that would call on The Centers for Medicare & Medicaid Services (CMS) to move more quickly to include behavioral health in their quality initiatives. As we explored the available material, we came to realize that CMS is already well on its way.

The importance of behavioral health care is clear when one looks into the conditions related to the measures CMS is tracking in its many quality improvement initiatives. Only individuals with cardiovascular disease have more measures being monitored than those with mental health and substance use disorders. In even more hopeful news for consumers, providers, and decision makers confronting behavioral health disorders, the measures being studied, while not perfect or complete, seem likely to provide real opportunities to address the “Three Part Aim.”

Thus, we needed to reframe our efforts toward educating and activating the behavioral health community around CMS’ efforts.

The game plan is clear. CMS, along with other purchasers and payors, is moving from paying for volume to paying for value with quality measurement front and center. This transformation begins with the implementation of a pay for reporting model accompanied by public reporting of performance. This reporting work becomes the foundation for pay for performance within fee for service as well as post-fee for service outcomes-based payment models such as case rates and global budgets.

Many healthcare providers are not ready for this seismic shift in payment and accountability. As reporting begins, a number of organizations that thought they were delivering effective care are receiving low scores. In some cases, the results are ending up on the front page of their local newspaper – not the type of outcome they were anticipating.

Take note! The material and ideas in this paper describe an exciting opportunity for community behavioral health providers – or a threat – depending on your level of readiness. The scenario that will unfold for your organization tomorrow – opportunity or threat – depends on your awareness, activation and action today. Behavioral health now has a clear place at CMS’ quality improvement table, but it’s up to you to take a seat.
INTRODUCTION

CMS is the largest purchaser of health care in the United States, serving more than 100 million Americans through Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) – and growing. Acknowledging its stature, CMS has been taking leadership to “transform itself from a passive payer of services into an active purchaser of higher quality, affordable care.” CMS now has 26 separate quality initiatives in various stages of implementation, tracking 1,152 measures.

As we will discuss below, these initiatives and measures are permeated with evidence that leaders at CMS have determined that effectively assessing and treating individuals with behavioral health disorders is critical to addressing the “Three Part Aim” of Better Care, Healthy People/Healthy Communities, and Affordable Care. In continuing good news, CMS appears to be making every effort to ensure the right data is being collected from the right providers, and that there are suitable incentives in place to encourage participation.

While we have considered and reviewed the full range of CMS quality initiatives, we have focused on the broadly applicable Physician Quality Reporting System (PQRS). We believe that the PQRS represents a relevant way for the behavioral health community to participate in and contribute to improving care for consumers.

Leaders of organizations that bill Medicare will want to immediately review how your current PQRS reporting efforts align with program requirements. All other behavioral health provider organizations should know that what you are about to read is a window into your near future because many payors consider Medicare policy as the gold standard and frequently adopt Medicare standards and practices.
HOW TO NAVIGATE THIS PAPER

You are going to discover unprecedented and exciting work underway in the field of healthcare quality, especially as it relates to behavioral health. We also expect that it will take a hearty soul to work their way through all of the material in this paper — our apologies in advance. But don’t forget, tackling quality improvement and quality measurement in healthcare is the future. To assist, we’ve attempted to use plain language, focus on the most important issues, and offer the following roadmap of what to expect.

**Start Here**
We begin with a description of the CMS Quality Strategy – the framework CMS is using to address quality in support of the Three Part Aim.

**Door #2**
We then move to a brief overview of The Physician Quality Reporting System.

**Door #3**
We then drill down into the heart of the paper, covering more detail of the PQRS and How the Behavioral Health Delivery System Can Get into the Game.

**At This Point...**
Many readers may be scratching their heads asking, so we take a moment to discuss Should I Really Spend My Time on This?

**We End By...**
We end by offering our Conclusion (and don’t forget the Appendices).
CMS QUALITY STRATEGY AND BEHAVIORAL HEALTH

CMS is well over a decade into robust quality improvement activities. The agency’s leaders are now making a concerted effort to tie current and future quality efforts together with a coherent and overarching rationale and strategy, discussed in this section. For behavioral health providers, who might not be immersed in the arcana of CMS activities, developing an understanding of how CMS is framing its work can provide helpful context. Beyond context though, there are key pieces of this framing work that are critical for behavioral health stakeholders to be aware of for their own work and potential collaboration with CMS.

CMS has finalized its Quality Strategy, which is an activity required by the Affordable Care Act, and the result is shaping up to mark a fundamental shift in how CMS envisions itself and approaches its work. The final version closely aligns with the three aims and six priority areas of the National Quality Strategy articulated by the Department of Health and Human Services (HHS).

Aims

1. Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
2. Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
3. Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

Priorities (“Goals” within the CMS Quality Strategy)

1. Make care safer by reducing harm caused in the delivery of care.
2. Ensure that each person and family is engaged as partners in their care.
3. Promote effective communication and coordination of care.
4. Promote the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Work with communities to promote wide use of best practices to enable healthy living.
6. Make quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

To illustrate the extent to which CMS sees this approach as a departure from business as usual, within the draft Quality Strategy released in November 2013, CMS notes that, “[f]or the first time in the nation’s history, we are embarking as a federal partner on a cross-sector, integrated National Quality Strategy that identifies priorities for improving the health of Americans” (emphasis added). CMS clearly articulates what it identifies as its “two roles in implementing this Quality Strategy: driver and enabler.”

There is a lot to like in the plain spoken narrative of the Quality Strategy, and CMS really does spell out what it sees as the goals and rationale.
Making care safer by reducing harm caused in the delivery of care

- “can be achieved through improved communication among patients, families, and providers; empowering patients to become more engaged in their care; better coordination of care within and across settings; and broad implementation of evidence-based safety best practices wherever care is provided.”

Ensuring that each person and family is engaged as partners in their care

- “requires giving patients access to understandable information and decision support tools to equip them and their families to manage their health and navigate the healthcare delivery system.”

Promoting effective communication and coordination of care

- calls for a “patient-centered approach to care” and
- recognition of “the downstream effects of having or not having certain critical pieces of information communicated across providers and settings.”

CMS appears to be setting a promising course for improving care for consumers.

Of particular note for those in the behavioral health delivery system, CMS has included an important component for their Quality Strategy’s fourth priority, related to promoting the most effective prevention and treatment practices for the leading causes of mortality:

As individuals and health systems feel the strain of treating individuals with chronic disease, healthcare providers must do a better job preventing, screening for, and treating the leading causes of mortality and illness in adults and children, including cardiovascular disease, cancer, stroke, diabetes, premature births, and behavioral health conditions.

Within the discussion of this priority, CMS includes a specific objective to “Improve behavioral health (BH) access and quality care” with the following Desired Outcomes:

- Better use of mental health and substance abuse screens to identify, refer, and treat individuals with a BH condition
- Increased use of electronic health records (EHRs) by BH providers to share information with primary care providers, and increased sharing of EHR data by primary care providers with BH providers
- Individuals initially identified with a BH condition receive services within 30 days of screening/identification
- Better availability of evidenced-based practices for individuals with BH conditions
- Reduced admission to inpatient facilities or emergency rooms of individuals with BH conditions (regardless of reason for admission)

These outcomes will require the active involvement of the behavioral health care delivery system, including a concerted effort to collaborate with others throughout the health and human services delivery systems.

As noted above, while this articulation of CMS strategy for quality has not quite been finalized, there are already 26 separate quality initiatives under way, in various stages of implementation, tracking 1,152 measures.⁸

<table>
<thead>
<tr>
<th>1. Hospice Quality Reporting</th>
<th>15. Physician Compare</th>
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</thead>
<tbody>
<tr>
<td>2. Inpatient Rehabilitation Facilities Quality Reporting</td>
<td>16. Medicare and Medicaid EHR Incentive Programs</td>
</tr>
<tr>
<td>3. Long-Term Care Hospitals Quality Reporting</td>
<td>17. Children’s Health Insurance Program Reauthorization Act Quality Reporting</td>
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<td>4. Hospital Inpatient Quality Reporting</td>
<td>18. CMS Nursing Home Quality Initiative and Nursing Home Compare Measures</td>
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<td>5. Hospital Value-Based Purchasing</td>
<td>19. Medicaid Health Home Programs</td>
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<td>6. Prospective Payment System (PPS) Exempt Cancer hospitals</td>
<td>20. Health Insurance Exchange Quality Reporting</td>
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<tr>
<td>7. Inpatient Psychiatric Facility Quality Reporting</td>
<td>21. Initial Core Set of Health Care Quality Measures For Medicaid-Eligible Adults</td>
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<tr>
<td>11. Hospital Outpatient Quality Reporting</td>
<td>25. Dual Eligibles Core Quality Measure Set</td>
</tr>
<tr>
<td>13. Physician Quality Reporting System</td>
<td></td>
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<tr>
<td>14. Medicare Shared Savings Program</td>
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</tbody>
</table>

Each of these programs has promise for addressing the three aims and six priorities of the CMS and National Quality Strategies. For the behavioral health community, we have identified the Physician Quality Reporting System as being one of the best ways to both contribute to and participate in quality improvement efforts.
OVERVIEW OF THE PHYSICIAN QUALITY REPORTING SYSTEM

In general, the Physician Quality Reporting System (PQRS) is straightforward. CMS explains the gist of the program and the associated carrots and sticks as follows:

The Physician Quality Reporting System (PQRS) is a pay-for-reporting program that uses a combination of incentive payments and downward payment adjustments to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment through 2014 to EPs and group practices who satisfactorily report data on quality measures for covered professional services furnished to Medicare Part B fee-for-service beneficiaries during the applicable reporting period. In lieu of satisfactory reporting, beginning in 2014, EPs may satisfy the PQRS by satisfactorily participating in a qualified clinical data registry. Beginning in 2015, a downward payment adjustment will apply to EPs who do not satisfactorily report data on quality measures for covered professional services.9

This sounds simple and almost elegant – encouraging Medicare providers to report on a broad range of well vetted measures, creating a rich data repository to aid with quality improvement efforts. There is even a consumer web site where participation in the program, and, gradually, associated data will be reported: http://www.medicare.gov/physiciancompare/search.html. CMS has recently released the performance data around five diabetes measures reported by 66 group practices and 141 ACOs in 2012.10 For 2014, CMS will publicly report all measures collected through their group practice web interface and for ACOs participating in the Medicare Shared Savings Program.11,12

CARROTS AND STICKS

Don't worry, we summarize these in a table just below this discussion.

For 2014, those who satisfy the PQRS reporting requirements will earn an incentive payment of 0.5% of their estimated total allowed charges for covered services provided during the reporting period (Medicare Part B Physician Fee Schedule (MPFS) services). These providers will also dodge a 2% penalty that will apply in 2016 for those who fail to report into the PQRS during 2014. In 2015 eligible providers who did not report into the PQRS during 2013 will be paid 1.5% less than the Medicare Fee Schedule amount for that service.

Note that these carrots and sticks apply to behavioral health providers who bill Medicare Part B through their individual provider number!

<table>
<thead>
<tr>
<th>REPORTING YEAR</th>
<th>INCENTIVE</th>
<th>ADJUSTMENT YEAR</th>
<th>ADJUSTMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>0.5%</td>
<td>2015</td>
<td>-1.5%</td>
</tr>
<tr>
<td>2014</td>
<td>0.5%</td>
<td>2016</td>
<td>-2.0%</td>
</tr>
<tr>
<td>2015 (and beyond)</td>
<td>N/A</td>
<td>2017</td>
<td>-2.0%</td>
</tr>
</tbody>
</table>
HOW THE BEHAVIORAL HEALTH DELIVERY SYSTEM CAN GET INTO THE GAME

With all of the quality reporting and incentive payment action going on inside CMS, the BH community needs to find a way to bridge out of its silo to learn how to play in this arena and leverage the benefits of that participation. We think the PQRS may be that bridge for many behavioral health provider organizations. Let’s explore this avenue by discussing eligible behavioral health providers, behavioral health-related measures, and how to organize this knowledge into an action plan.

PQRS ELIGIBLE PROVIDERS

To participate in the PQRS, one must be an Eligible Professional. CMS identifies the following professionals that typically work in a behavioral health setting as “eligible” to report into the PQRS.\(^\text{13}\) Remember, these are providers that bill Medicare Part B with their individual provider number. Note that a full list of eligible professionals may be found in Appendix III.

- Doctor of Medicine
- Doctor of Osteopathy
- Occupational Therapist
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Clinical Social Worker
- Clinical Psychologist

PQRS BEHAVIORAL HEALTH MEASURES

Currently there are 33 measures related to behavioral health conditions or persons with serious mental illness or substance use disorders. For 2014, eligible providers must choose at least nine measures that span three of the following six domains.\(^\text{14, a}\)

<table>
<thead>
<tr>
<th>NATIONAL QUALITY STRATEGY DOMAIN</th>
<th>TOTAL MEASURES IN PQRS</th>
<th>CBHO MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and Care Coordination</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>Community/ Population Health</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Effective Clinical Care</td>
<td>183</td>
<td>22</td>
</tr>
<tr>
<td>Efficiency and Cost Reduction</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>30</td>
<td>3</td>
</tr>
<tr>
<td>Person and Caregiver-Centered Experience and Outcomes</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Measures</strong></td>
<td><strong>285</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

\(^{a}\) An alternative to selecting among the six domains is to select nine measures from one of 25 “Measures Groups” that are listed in Appendix III. Although we footnote this for completeness, this alternative is probably not relevant for behavioral health provider organizations.
To provide a better sense of the nature of these measures, we offer a condensed list below. Note that a hand-ful of medical-related measures, such as Diabetes: Foot Exam, are included because of the high comorbidity of these conditions in persons with behavioral health disorders and the need for behavioral health clinicians to ensure that these conditions are adequately managed in order to reduce the high morbidity and early mortality in this population. The full list, with additional detail is provided in Appendix IV.

**Communication and Care Coordination**

2. Functional Outcome Assessment

**Community/Population Health**

3. Maternal Depression Screening
4. Body Mass Index (BMI) Screening and Follow-Up
5. Screening for Clinical Depression and Follow-Up Plan
6. Screening for High Blood Pressure and Follow-Up Documented
7. Tobacco Use: Screening and Cessation Intervention
8. Unhealthy Alcohol Use – Screening

**Effective Clinical Care**

9. ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
10. Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation
11. Adult MDD: Coordination of Care of Patients with Specific Comorbid Conditions
12. Adult MDD: Suicide Risk Assessment
13. Anti-depressant Medication Management
14. Asthma: Tobacco Use: Intervention
15. Asthma: Tobacco Use: Screening
16. Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
17. Controlling High Blood Pressure
18. Dementia: Management of Neuropsychiatric Symptoms
19. Dementia: Neuropsychiatric Symptom Assessment
20. Dementia: Screening for Depressive Symptoms
21. Depression Remission at Twelve Months
22. Depression Utilization of the PHQ-9 Tool
23. Diabetes: Eye Exam
24. Diabetes: Foot Exam
25. Diabetes: Hemoglobin A1c Poor Control
26. Diabetes: Low Density Lipoprotein (LDL-C) Control
27. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
28. Parkinson’s Disease: Psychiatric Disorders or Disturbances Assessment
29. Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence
30. Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence

Patient Safety

31. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
32. Documentation of Current Medications in the Medical Record
33. Medication Reconciliation

BEHAVIORAL HEALTH PQRS ACTION PLAN

With all of the quality reporting and incentive payment action going on inside CMS, the BH community needs to find a way to bridge out of its silo to learn how to play in this arena and leverage the benefits of that participation. We think the PQRS may be that bridge for many behavioral health provider organizations. Let’s explore this avenue by discussing eligible behavioral health providers, behavioral health-related measures, and how to organize this knowledge into an action plan.

Because of the carrots and sticks mentioned above, developing a PQRS action plan is very much a right now sort of activity. We will discuss each of these in a bit more detail below, but the key steps for a behavioral health provider related to the PQRS are:

1. Identify Eligible Providers
2. Select Measures to Report
3. Determine the Reporting Vehicle (EHR, Registry, Claims)
4. Develop an Internal Reporting System
5. Identify a Standing Group to Analyze the Data
6. Design and Implement Rapid Cycle Improvements

As indicated above, the first step to reporting into the PQRS is to determine a provider’s eligibility, including whether they bill Medicare Part B with their individual provider number (Step 1). Next comes selecting the measures to report; at least nine must be included. Because the measures and other details change from year to year, it is important to review these details annually (Step 2).

Providers may report their data in a variety of ways, depending on whether they report as an individual or part of a group. For providers connected to behavioral health organizations, there are essentially three options for reporting: EHR, Registry, and Claims-based reporting (Step 3).
EHR and Registry Reporting: Reporting from an EHR or Patient Registry is quite simple (really!). You pick a CMS approved registry or EHR, let the vendor know the nine or more measures you wish to report on, and then work with the vendor and CMS to ensure data is submitted accurately, participating in any applicable testing. **It is likely not yet too late to participate, as 2014 data needs to be uploaded by February 27, 2015.** Of course, you do need to be sure that data is being captured in the EHR or registry throughout the reporting period for all applicable measures (or develop some sort of retroactive method for capturing the data).

Claims Reporting: To report using claims requires a bit more work. To begin, a provider needs to ensure that they are reporting data on at least 50% of eligible claims during the reporting period. You will want to get started on this right away, training staff in the relevant procedures. The key thing is to report CMS Quality-Data Codes (QDCs) on claims for all encounters related to PQRS measures. CMS has advised that providers should bill these codes with a $0.01 charge associated with them and avoid claims with multiple dates and/or providers. It should also be noted that claims cannot be submitted simply to add QDCs. Hence the need to get started reporting sooner rather than later!

For full details on claims reporting, please review the various materials available on the CMS website and referenced within this paper. CMS has provided a handy reference called **Claims Reporting Made Simple.** There are also references for the other reporting options that are less likely to be relevant for CBHOs: **Qualified Clinical Data Registry (QCDR) Participation Made Simple, Group Practice Reporting Option (GPRO) Web Interface Reporting Made Simple,** and **Certified Survey Vendor Reporting Made Simple.**

In addition to these required activities, behavioral health providers should also develop an internal reporting system that displays the results of the data they collected (Step 4). These reports should have an “analysis home” – a group that meets regularly to review the meaning of the data and identify areas for improvement (Step 5); which will lead to Rapid Cycle Improvement projects to implement strategies that will likely yield better outcomes (Step 6).
SHOULD I REALLY SPEND MY TIME ON THIS?

Of course, the answer to this question depends on the relative priorities of each provider organization and available bandwidth. That said, we think the answer is a resounding YES for five reasons:

1. To earn your bonus for 2014 (it’s already too late for 2013).
2. To avoid the 2.0% penalty in 2016 and beyond.
3. To step up to the challenge to ensure that the most vulnerable and the most expensive consumers get the care they need – and that all consumers are receiving care that meets standards.
4. To use PQRS as a small scale testing ground to learn how to succeed in the CMS quality reporting game, and to prepare for the future and pay-for-performance.
5. To prevent future public humiliation when reporting becomes mandatory for all providers.

The initial results may be somewhat harrowing. In Minnesota, for example, where they have recently begun reporting quality data at MNHealthScores.org, here is what has been revealed about depression treatment:

- The average rate of PHQ-9 use by all reporting clinics is 68%
- The average PHQ-9 follow-up rate at 6 months for all reporting clinics is 28%
- The average PHQ-9 follow-up rate at 12-months for all reporting clinics is 22%
- The average 6-month depression remission rate for all reporting clinics is 7%
- The average 12-month depression remission rate for all reporting clinics is 6%

While these results may rightfully present unpleasant realities, the point is to be part of an improvement effort early. By participating in quality initiatives such as the PQRS and others, the behavioral health care delivery system has the opportunity to truly transform the care consumers receive, resulting in Better Care, Healthy People/Healthy Communities, and Affordable Care.

CONCLUSION

The PQRS system now offers the potential for broad measurement of what one might describe as the key sentinel behavioral health conditions: depression screening, unhealthy alcohol use screening, and tobacco use screening. CMS has begun to trace these conditions out to related conditions, screening mothers for postpartum and maternal depression, querying asthmatics about tobacco exposure (including second hand), looking for depression in dementia and Parkinson’s patients, appraising for suicide risk in people with major depression (MDD). CMS has even begun work to ensure that care is meeting certain standards, measuring use of the PHQ-9 for adult consumers, and tracking care coordination for consumers with MDD and other specific comorbid conditions.

Clearly, the PQRS is a work in progress, as are CMS’ other quality improvement efforts. More does need to be done in the area of behavioral health, including the development of more behavioral health measures and the adoption of behavioral health measures in more reporting programs. But the quality of the measures is improving from year to year and, as CMS increases public reporting of the data, providers and even consumers will increasingly be able to use the information to improve the quality of their care.
In spite of these good omens, challenges remain. One of the world’s top experts on innovation and growth, Harvard’s Clayton Christenson, has noted that health care has become more complex than virtually any other industry. CMS can be seen wrestling with this complexity as it crafts improvement activities and creates elaborate flow charts for participation. Making inroads toward the Three Part Aim is going to continue to be a challenge for all members of the health care delivery system.

But the fact remains that CMS has included behavioral health in its efforts to improve health care and offered payment carrots and sticks to encourage participation. It is now up to the behavioral health delivery system to join the efforts. While there are gaps in behavioral health reporting, we hope and expect that CMS and other stakeholders will continue and expand their work to ensure that all parts of the health care delivery system effectively assess and treat behavioral health disorders.
APPENDICES

APPENDIX I: CMS QUALITY MEASUREMENT PROGRAMS SUMMARY

1. Hospice Quality Reporting
   - ACA Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.
   - Public reporting, pay-for-reporting
   - Hospice Quality Reporting

2. Inpatient Rehabilitation Facilities Quality Reporting
   - ACA Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.
   - Public reporting, pay-for-reporting
   - IRF Quality Reporting

3. Long-Term Care Hospitals Quality Reporting
   - ACA Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.
   - Public reporting, pay-for-reporting
   - LTCH Quality Reporting

4. Hospital Inpatient Quality Reporting
   - Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003; The Deficit Reduction Act of 2005 section 5001(a)
   - Public reporting, pay-for-reporting
   - Hospital Inpatient Quality Reporting (IQR) Program Overview

5. Hospital Value-Based Purchasing
   - ACA Sec. 3001. Hospital Value-Based purchasing program.
   - Value-based purchasing
   - Hospital Value-Based Purchasing

6. Prospective Payment System (PPS) Exempt Cancer hospitals
   - ACA Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.
   - Public reporting, pay-for-reporting
   - PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Overview

7. Inpatient Psychiatric Facility Quality Reporting
   - ACA Sec. 10322. Quality reporting for psychiatric hospitals
   - Public reporting, pay-for-reporting
   - Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Overview
8. Hospital Readmission Reduction Program
   - ACA Sec. 3025. Hospital readmissions reduction program.
   - Public reporting, pay-for-reporting
   - Hospital Readmissions Reduction Program

9. End-Stage Renal Disease (ESRD) Quality Incentive Program
   - Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c).
   - Value-based purchasing. This first-of-its-kind program provides the ESRD community with the opportunity to enhance the overall quality of care that ESRD patients receive as they battle this devastating disease.
   - ESRD Quality Incentive Program

10. Home Health Quality Reporting
    - 42 CFR §§ 484.55 OASIS Reporting as Condition of Participation for HHAs
    - Public reporting. Since 1999, CMS has required Medicare-certified home health agencies to collect and transmit OASIS data for all adult patients whose care is reimbursed by Medicare and Medicaid with the exception of patients receiving pre- or postnatal services only. OASIS data are used for multiple purposes including calculating several types of quality reports which are provided to home health agencies to help guide quality and performance improvement efforts.
    - Since fall 2003, CMS has posted a subset of OASIS-based quality performance information on the Medicare.gov website “Home Health Compare”.
    - Home Health Quality Initiative

11. Hospital Outpatient Quality Reporting
    - Tax Relief and Health Care Act of 2006
    - Public reporting, pay-for-reporting. In addition to providing hospitals with a financial incentive to report their quality of care measure data, the Hospital OQR program provides CMS with data to help Medicare beneficiaries make more informed decisions about their health care.
    - Hospital Outpatient Quality Reporting (OQR) Program Overview

12. Ambulatory surgical centers
    - ACA Sec. 10301. Plans for a Value-Based purchasing program for ambulatory surgical centers.
    - Pay for reporting, public reporting
    - ASC Quality Reporting

13. Physician Quality Reporting System
    - The ACA authorized incentive payments through 2014 and requires a penalty, beginning in 2015, for EPs who do not satisfactorily report. Also authorizes an additional 0.5 percent incentive for 2011 through 2014 for EPs who satisfactorily meet Maintenance of Certification Program requirements as described in the law.
- Tax Relief and Health Care Act of 2006 (TRHCA) initially authorized the Physician Quality Reporting System.
- Pay-for-reporting, PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. The program provides an incentive payment to practices with eligible who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries
- Physician Compare Initiative

14. Medicare Shared Savings Program
- ACA Sec. 3022. Medicare shared savings program.
- Value-based purchasing, public reporting, voluntary participation
- EHR Incentive Programs

15. Physician Compare
- ACA Sec. 10331. Public Reporting Of Performance Information.
- Public reporting
- Physician Compare Initiative

16. Medicare and Medicaid EHR Incentive Programs
- Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the American Recovery and Reinvestment Act (ARRA) of 2009
- A reimbursement incentive for physician and hospital providers who are successful in becoming “meaningful users” of an electronic health record (EHR). These incentive payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the “meaningful use” definition or they will be subject to financial penalties under Medicare.
- EHR Incentive Programs

17. Children’s Health Insurance Program Reauthorization Act Quality Reporting
- Title IV of Children’s Health Insurance Program Reauthorization Act (CHIPRA) 2009
- CHIPRA encourages voluntary, standardized reporting of a core set of child health quality measures for children enrolled in Medicaid and CHIP
- CHIPRA Initial Core Set of Children’s Health Care Quality Measures

18. CMS Nursing Home Quality Initiative and Nursing Home Compare Measures
- Omnibus Budget Reconciliation Act (OBRA) of 1987. OBRA 87 requires nursing homes to use a uniform Resident Assessment Instrument for all nursing home residents.
- The Resident Assessment Instrument includes a standardized set of data elements (the Minimum Data Set).
- Public reporting
- Nursing Home Quality Initiative
19. Medicaid Health Home Programs

- ACA Subtitle I—Improving the Quality of Medicaid for Patients and Providers:
  - Sec. 2703. State option to provide health homes for enrollees with chronic conditions.
  - Report on quality measures. As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements, as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

- Health Homes

20. Health Insurance Exchange Quality Reporting

- ACA SEC. 2201. Enrollment Simplification And Coordination With State Health Insurance Exchanges.
  - The ACA helps create a competitive private health insurance market through the establishment of Affordable Insurance Exchanges. These State-based, competitive marketplaces, which launch in 2014, will provide millions of Americans and small businesses with “one-stop shopping” for affordable coverage.

- Request For Comment

21. Initial Core Set of Health Care Quality Measures For Medicaid-Eligible Adults

- ACA Section 2701
  - Voluntary, for State use. For voluntary use by State programs administered under title XIX of the Social Security Act, health insurance issuers and managed care entities that enter into contracts with Medicaid, and providers of items and services under these programs.

- Quality of Care –PM - Adult Health Care Quality Measures

22. Medicare Part C Plan Rating – Quality and Performance Measures

- ACA Subtitle C—Provisions Relating to Part C
  - SEC. 3201. Medicare Advantage Payment.
  - Public reporting, value-based purchasing, mandatory. In 2012, CMS will start a three-year demonstration project for Medicare Advantage plans wherein CMS will award “quality bonus payments” (QBPs) to plans based on the plan's star ratings.

- Data Reports

23. Medicare Part D Plan Rating – Quality and Performance Measures

  - Public reporting. Part D sponsors’ performance and quality data star ratings which are displayed at three levels: summary score, domain, and measure level on the Medicare Prescription Drug Plan Finder (MPDPF), prepared for open enrollment period to help beneficiaries make informed decisions about selecting a Part D plan in which to enroll

- Data Reports
24. Physician Feedback/Value-Based Modifier Program

- ACA Sec. 3007. Value-based payment modifier under the physician fee schedule.
- Physician feedback reporting was initiated under Section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), and was expanded by section 3003 of the Affordable Care Act of 2010
- Value-based purchasing
- Medicare FFS Physician Feedback Program/Value-Based Payment Modifier

25. Dual Eligibles Core Quality Measure Set

- The Medicare-Medicaid Coordination Office (MMCO) was established pursuant to Section 2602 of the Affordable Care Act.
- Promoting integrated care, ensuring cultural competence, health equity. To develop this national measurement strategy for the dual eligible population, the Department of Health and Human Services (HHS) engaged the Measure Applications Partnership (MAP), a multi-stakeholder group of public and private-sector organizations and experts convened by the National Quality Forum (NQF).
- NQF Dual Eligible Beneficiaries Workgroup

26. Hospital Acquired Conditions program

- The Deficit Reduction Act of 2005 (DRA). Section 5001(c)
- Pay-for-reporting, mandatory
- Hospital-Acquired Conditions

APPENDIX II: THE IMPORTANCE OF BEHAVIORAL HEALTH

What follows below is a selection of data illustrating the high prevalence, high cost, high comorbidity, and many treatment challenges associated with behavioral health disorders.

High Level Business Case

The overall state of affairs surrounding behavioral health is captured perfectly in a 2008 Milliman report:

> [I]f a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members...the cost of doing nothing may exceed $300 billion per year in the United States. 23

High Prevalence

- In 2011, more than 41 million U.S. adults (18 percent) had any mental illness, and nearly 20 million (8 percent) had a substance use disorder.24
- In that same year, nearly 9 million U.S. adults (4 percent) had mental illness that greatly affected day-to-day living, or serious functional impairment.25
- Behavioral health disorders are the leading cause of disability in the U.S. and Canada.26
- Behavioral health disorders result in more than twice the disease burden in the U.S. and Canada as all forms of heart disease (33,759 Disability-Adjusted Life Years compared with 15,217).27
High Cost

- Behavioral health disorders were one of the five most costly conditions in the United States in 2006, with expenditures at $57.5 billion.\textsuperscript{28}
- Of the most expensive Medicaid beneficiaries with disabilities, 24 percent had psychiatric conditions, cardiovascular disease and central nervous disorders
- 11% of Californians in the fee-for-service Medi-Cal system have a serious mental illness. Healthcare spending for these individuals is 3.7 times greater than it is for all Medi-Cal fee-for-service enrollees—$14,365 per person per year compared with $3,914.\textsuperscript{29}

High Co-Morbidity

- Mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, epilepsy and cancer.\textsuperscript{30}
- Mental illness is associated with lower use of medical care, reduced adherence to treatment therapies for chronic diseases and higher risks of adverse health outcomes.\textsuperscript{31}
- In 2009, the Center for Healthcare Strategies analyzed the Medicaid data set for the entire population of disabled Medicaid enrollees in the U.S. and discovered that 49% of Medicaid beneficiaries with disabilities have a psychiatric illness; and among the highest-cost 5% of this group, psychiatric illness is represented in three of the top five most prevalent pairs of diseases. These include psychiatric and cardiovascular (#1 most expensive), psychiatric and central nervous system (#2), psychiatric and pulmonary (#5), and psychiatric and gastrointestinal (#10).\textsuperscript{32}

Treatment Challenges

- Up to one-in-four primary care patients suffer from depression; yet, primary care doctors identify less than one-third (31 percent) of these patients.\textsuperscript{33}
- Among the 8.9 million people with co-occurring mental health and substance use disorders, 44 percent received either substance use treatment or mental health treatment in the past year, 13.5 percent received both mental health treatment and substance use treatment and 37.6 percent did not receive any treatment.\textsuperscript{34}
- People with psychotic disorders and bipolar disorder are 45 percent and 26 percent less likely, respectively, to have a primary care doctor than those without mental disorders.\textsuperscript{35}

APPENDIX III: DETAILS OF THE PQRS

Eligible Professionals

1. Medicare physicians
   - Doctor of Medicine
   - Doctor of Osteopathy
   - Doctor of Podiatric Medicine
   - Doctor of Optometry
   - Doctor of Oral Surgery
   - Doctor of Dental Medicine
   - Doctor of Chiropractic
2. **Therapists**
   - Physical Therapist
   - Occupational Therapist
   - Qualified Speech-Language Therapist

3. **Practitioners**
   - Physician Assistant
   - Nurse Practitioner
   - Clinical Nurse Specialist
   - Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
   - Certified Nurse Midwife
   - Clinical Social Worker
   - Clinical Psychologist
   - Registered Dietician
   - Nutrition Professional
   - Audiologists

**PQRS Measures Groups for 2014**

In addition to the option of reporting nine measures across three of the six NQS domains, providers can instead select nine measures from within one of the following 25 “Measures Groups:”

- Asthma
- Back Pain
- Cardiovascular Prevention
- Cataracts
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Bypass Graft (CABG)
- Coronary Artery Disease (CAD)
- Dementia
- Diabetes
- General Surgery
- Heart Failure (HF)
- Hepatitis C
- HIV/AIDS
- Hypertension (HTN)
- Inflammatory Bowel Disease (IBD)
- Ischemic Vascular Disease (IVD)
- Oncology
- Optimizing Patient Exposure to Ionizing Radiation (OPEIR)
- Parkinson’s Disease
- Perioperative Care
- Preventive Care
- Rheumatoid Arthritis (RA)
- Sleep Apnea
- Total Knee Replacement (TKR)
### APPENDIX IV: PQRS MEASURES RELATED TO CBHO CARE

<table>
<thead>
<tr>
<th>NQF #</th>
<th>PQRS #</th>
<th>NATIONAL QUALITY STRATEGY DOMAIN</th>
<th>MEASURE DESCRIPTION</th>
<th>REPORTING OPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 &amp; 6</td>
<td>321</td>
<td>Communication and Care Coordination</td>
<td>CG-CAHPS Clinician/Group Survey</td>
<td>Certified Survey Vendor</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Functional Outcome Assessment: Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies</td>
<td>Claims, Registry</td>
</tr>
<tr>
<td>AQA adopted</td>
<td>182</td>
<td>Communication and Care Coordination</td>
<td>Maternal Depression Screening: The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life</td>
<td>EHR</td>
</tr>
<tr>
<td>1401</td>
<td>372</td>
<td>Community/ Population Health</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ ACO, Measures Groups (Prev Care)</td>
</tr>
<tr>
<td>421</td>
<td>128 GP</td>
<td>Community/ Population Health</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter: Normal Parameters: Age 65 years and older BMI ≥ 23 and &lt; 30; Age 18 – 64 years BMI ≥ 18.5 and &lt; 25</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ ACO</td>
</tr>
<tr>
<td></td>
<td>PREV-9</td>
<td></td>
<td>Preventive Care and Screening: Clinical Depression and Follow-Up Plan: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen</td>
<td>GPRO Web Interface/ ACO</td>
</tr>
<tr>
<td></td>
<td>317 GP</td>
<td>Community/ Population Health</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented: Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ ACO, Measures Group (Cardiovascular Prevention)</td>
</tr>
<tr>
<td></td>
<td>PREV-12</td>
<td></td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ ACO, Measures Group (Cardiovascular Prevention)</td>
</tr>
<tr>
<td>N/A</td>
<td>226 GP</td>
<td>Community/ Population Health</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ ACO, Measures Groups (CAD, COPD, HF, IBD, IVD, Prev Care, HTN, Cardiovascular Prevention, Oncology)</td>
</tr>
<tr>
<td></td>
<td>PREV-10</td>
<td></td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ ACO, Measures Groups (CAD, COPD, HF, IBD, IVD, Prev Care, HTN, Cardiovascular Prevention, Oncology)</td>
</tr>
<tr>
<td>AQA adopted</td>
<td>173</td>
<td>Community/ Population Health</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use – Screening: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method</td>
<td>Registry, Measures Group (Prev Care)</td>
</tr>
<tr>
<td>108</td>
<td>366</td>
<td>Effective Clinical Care</td>
<td>ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.</td>
<td>EHR</td>
</tr>
<tr>
<td>103</td>
<td>106</td>
<td>Effective Clinical Care</td>
<td>Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity: Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified</td>
<td>Claims, Registry</td>
</tr>
<tr>
<td>NQF #</td>
<td>PQRS #</td>
<td>NATIONAL QUALITY STRATEGY DOMAIN</td>
<td>MEASURE DESCRIPTION</td>
<td>REPORTING OPTIONS</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>N/A</td>
<td>325</td>
<td>Effective Clinical Care</td>
<td>Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions: Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition</td>
<td>Registry</td>
</tr>
<tr>
<td>104</td>
<td>107</td>
<td>Effective Clinical Care</td>
<td>Adult Major Depressive Disorder (MDD): Suicide Risk Assessment: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified</td>
<td>Claims, Registry, EHR</td>
</tr>
<tr>
<td>105</td>
<td>9</td>
<td>Effective Clinical Care</td>
<td>Anti-depressant Medication Management: Percentage of patients 18 years of age and older who were diagnosed with major depression, and who remained on antidepressant medication treatment. Two rates are reported</td>
<td>Registry, EHR</td>
</tr>
<tr>
<td>N/A</td>
<td>232</td>
<td>Effective Clinical Care</td>
<td>Asthma: Tobacco Use: Intervention - Ambulatory Care Setting: Percentage of patients aged 5 through 64 years with a diagnosis of asthma who were identified as tobacco users (or their primary caregiver) who received tobacco cessation intervention at least once during the one-year measurement period</td>
<td>Claims, Registry, Measures Group (Asthma)</td>
</tr>
<tr>
<td>N/A</td>
<td>231</td>
<td>Effective Clinical Care</td>
<td>Asthma: Tobacco Use: Screening - Ambulatory Care Setting: Percentage of patients aged 5 through 64 years with a diagnosis of asthma (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke within their home environment at least once during the one-year measurement period</td>
<td>Claims, Registry, Measures Group (Asthma)</td>
</tr>
<tr>
<td>110</td>
<td>367</td>
<td>Effective Clinical Care</td>
<td>Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use: Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use</td>
<td>EHR</td>
</tr>
<tr>
<td>18</td>
<td>236</td>
<td>Effective Clinical Care</td>
<td>Controlling High Blood Pressure: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt; 140/90 mmHg) during the measurement period</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ACO, Measures Groups (Cardiovascular Prevention, IVD)</td>
</tr>
<tr>
<td>N/A</td>
<td>284</td>
<td>Effective Clinical Care</td>
<td>Dementia: Management of Neuropsychiatric Symptoms: Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period</td>
<td>Measures Group (Dementia)</td>
</tr>
<tr>
<td>N/A</td>
<td>283</td>
<td>Effective Clinical Care</td>
<td>Dementia: Neuropsychiatric Symptom Assessment: Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of patients’ neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period</td>
<td>Measures Group (Dementia)</td>
</tr>
<tr>
<td>N/A</td>
<td>285</td>
<td>Effective Clinical Care</td>
<td>Dementia: Screening for Depressive Symptoms: Percentage of patients, regardless of age, with a diagnosis of dementia who were screened for depressive symptoms within a 12 month period</td>
<td>Measures Group (Dementia)</td>
</tr>
<tr>
<td>710</td>
<td>370</td>
<td>Effective Clinical Care</td>
<td>Depression Remission at Twelve Months: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score &gt; 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment</td>
<td>EHR</td>
</tr>
<tr>
<td>712</td>
<td>371</td>
<td>Effective Clinical Care</td>
<td>Depression Utilization of the PHQ-9 Tool: Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4-month period in which there was a qualifying visit</td>
<td>EHR</td>
</tr>
<tr>
<td>NQF #</td>
<td>PQRS #</td>
<td>NATIONAL QUALITY STRATEGY DOMAIN</td>
<td>MEASURE DESCRIPTION</td>
<td>REPORTING OPTIONS</td>
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</tr>
<tr>
<td>55</td>
<td>117</td>
<td>Effective Clinical Care</td>
<td>Diabetes: Eye Exam: Percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 and type 2) who had a retinal or dilated eye exam in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period</td>
<td>Claims, Registry, EHR, Measures Group (DM)</td>
</tr>
<tr>
<td>56</td>
<td>163</td>
<td>Effective Clinical Care</td>
<td>Diabetes: Foot Exam: Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period</td>
<td>Claims, Registry, EHR, Measures Group (DM)</td>
</tr>
<tr>
<td>59</td>
<td>1 GPRO DM-2</td>
<td>Effective Clinical Care</td>
<td>Diabetes: Hemoglobin A1c Poor Control: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ACO, Measures Group (DM)</td>
</tr>
<tr>
<td>64</td>
<td>2</td>
<td>Effective Clinical Care</td>
<td>Diabetes: Low Density Lipoprotein (LDL-C) Control (&lt;100 mg/dL): Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately controlled (&lt;100 mg/dL) during the measurement period</td>
<td>Claims, Registry, EHR, Measures Groups (DM, Cardiovascular Prevention)</td>
</tr>
</tbody>
</table>
| 4     | 305    | Effective Clinical Care          | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following: Two rates are reported  
  a. Percentage of patients who initiated treatment within 14 days of the diagnosis  
  b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit | EHR |
| N/A   | 290    | Effective Clinical Care          | Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment: All patients with a diagnosis of Parkinson's disease who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually | Measures Group (Parkinson's Disease) |
| AQA adopted | 247 | Effective Clinical Care | Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence: Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period | Claims, Registry |
| AQA adopted | 248 | Effective Clinical Care | Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence: Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period | Claims, Registry |
| 1365  | 382    | Patient Safety                   | Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment: Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk | EHR |
| 419   | 130    | Patient Safety                   | Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbs, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration | Claims, Registry, EHR, Measures Groups, (Oncology) |
| 97    | 46 GPRO CARE-1 | Patient Safety | Medication Reconciliation: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented | Claims, Registry, GPRO Web Interface/ACO |
ENDNOTES


14. In addition to the option of reporting nine measures across three of the six NQS domains, providers can instead select nine measures from within one of 25 “Measures Groups,” such as Asthma, Diabetes, or Dementia. (While there is no Measures Group for behavioral health, the full list of Measures Groups may be found in Appendix III). CMS has also provided a method for providers to report less than nine measures, described at “2014 PQRS Measure-Applicability Validation (MAV) Process for Claims and Registry-Based Reporting of Individual Measures” available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html.


A Place at the Table

32. The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions Center for Health Care Strategies, Inc., October 2009