Quality Measures Crosswalk for 2019

An Overview of Corresponding Washington State and Centers for Medicare & Medicaid Services (CMS) Quality Payment Program Initiatives (QPP)

Created by Qualis Health and the Healthier Washington Practice Transformation Support Hub

Quality Improvement Organizations
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Washington State Department of Health

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Simplify Your Quality Improvement Reporting

Developed to assist providers with their practice transformation efforts, this tool is a crosswalk of measures and improvement activities shared across the Washington State Medicaid Transformation Project Demonstration, the Health Care Authority (HCA) 2019 Apple Health Contract Metrics, and the Medicare Quality Payment Program (QPP).

It reflects the measures currently approved for 2019 for the HCA Apple Health contracts and Medicare Quality Payment Program, and will be updated with new measures each year. This is not intended to be an exhaustive list; some Medicaid Transformation Project measures are not included as they are a hybrid of national and state-specific metrics.

When choosing your Improvement Activities and Quality Measures for the QPP Merit-based Incentive Payment System (MIPS), consider national initiatives such as Million Hearts and Medication Safety and Adverse Drug Event Prevention. Consider also Washington State's strategy to reduce morbidity and mortality associated with opioids -- the Washington State Interagency Opioid Working Plan. Many of these initiatives have associated quality measures and improvement activities that can be tracked and reported as part of your MIPS data submission and your state contracts and demonstration projects.

About the Healthier Washington Practice Transformation Support Hub

The Practice Transformation Support Hub (Hub) is an investment area of Healthier Washington managed by the Washington State Department of Health.

The Hub delivers tools, technical assistance, training, and onsite coaching and support to providers in small to medium practices, including physical and behavioral health. The Hub includes a practice coaching and regional health connector network, and a website that hosts practice transformation and health system transformation resources.

The Hub's goals are to help physical and behavioral healthcare practices:

- Achieve bi-directional physical and behavioral healthcare integration
- Move from volume- to value-based care
- Improve population health through clinical community linkages

For more information on the Healthier Washington Practice Transformation Support Hub:

- Hub Help Desk: (206) 288-2540 or (800) 949-7536 ext. 2540
- Email: HubHelpDesk@qualishealth.org
- Healthier Washington: www.hca.wa.gov/hw/
- Qualis Health: www.QualisHealth.org/hub
- Hub Resource Portal: www.waportal.org

Hub coaching and connector services are provided through Qualis Health. They provide individualized assistance to practices with 20 or fewer providers, and help any practice link up with the services or tools they need to successfully navigate practice transformation issues.

About the Quality Payment Program

Qualis Health has been selected by the Centers for Medicare & Medicaid Services (CMS) to help Idaho and Washington clinicians transition to the Quality Payment Program. Our goal is to help practices successfully prepare for and understand this new program. We offer customized technical assistance that includes regular office hours and webinars, monthly program updates, access to key tools and resources and more. For more information, visit the QPP resource center at medicare.qualishealth.org/QPP or email QPP@qualishealth.org.

Crosswalk Terminology

Washington State Medicaid Transformation Demonstration

A five-year agreement between Washington State and the Centers for Medicare and Medicaid Services to provide federal investment in the State's health system transformation efforts.

Project Metrics: Outcome measures for individual projects used by the state to award funds to the Accountable Communities of Health to distribute to partnering providers for each project.

Statewide Accountability Metrics: Outcome measures for the state to demonstrate progress towards meeting the Medicaid Transformation Demonstration's objectives.

HCA 2019 Apple Health Contract Metrics: A subset of performance measures from the Statewide Common Measure Set that is tied to incentives through the managed care 1.5% withhold for 2019.

Medicare Quality Payment Program 2019 Quality Measures: Quality measures that measure and quantify care delivered to patients to ensure quality and appropriate care.

For the Quality Measures performance category, a MIPS eligible clinician or group would report at least six quality measures including at least one outcome measure. If an applicable outcome measure is not available, the MIPS eligible clinician or group would be required to report one other high priority measure (appropriate use, patient safety, efficiency, patient experience, or care coordination measures) instead of an outcome measure.

Medicare QPP Merit-Based Incentive Payment System (MIPS) 2019 Improvement Activities: Improvement Activities (IA) that assess participation in activities that improve clinical practice or care delivery.

This performance category includes incentives that help drive participation in certified patient-centered medical homes and Alternative Payment Methods (APMs).

For the IA performance category, a MIPS eligible clinician or group must perform improvement activities for at least 90 consecutive days.

Each IA is weighted either medium or high. To obtain the maximum score of 40 points for the IA score, groups with more than 15 clinicians may select any of these combinations: a) two high-weighted activities, b) one high-weighted activity and two medium-weighted activities, or c) four medium-weighted activities. A medium-weighted IA is worth 10 points; a high-weighted IA is worth 20 points.

To obtain the maximum score of 40 points for groups with 15 or fewer clinicians, non-patient facing clinicians, and/or clinicians located in a rural area or Health Provider Shortage Area (HPSA), clinicians may select a) one high-weighted activity or b) medium-weighted activities. For these clinicians, the IA weights are doubled with each medium-weighted activity worth 20 points and each high-weighted activity worth 40 points.

Acronyms:

- Quality Payment Program (QPP)
- Health Care Authority (HCA)
- National Quality Forum (NQF)

Quality Measures Crosswalk

Measure Name	Measure Number	Measure Description	WA State Medicaid Transformation Project Demonstration		HCA 2019 Apple Health Contract Metrics *Medicaid*	Quality Payment Program *All Payer or Medicare Part B* (depending on data submission methodology)
			Project Metrics *Medicaid*	Statewide Accountability Metrics *Medicaid*		
Antidepressant Medication Management	NQF 0105 QPP Quality #009	The percentage of individuals 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication and who remained on an antidepressant medication treatment. Two rates are reported.	Yes	Yes	Yes	Yes
Childhood Immunization Status	NQF 0038 QPP Quality #240	Percentage of children 2 years of age who had 4 diphtheria, tetanus and acellular pertussis (DTaP); 3 polio (IPV), 1 measles, mumps and rubella (MMR); 3 H influenza type B (HiB); 3 hepatitis B (HepB); 1 chicken pox (VZV); 4 pneumococcal conjugate (PCV); 1 hepatitis A (HepA); 2 or 3 rotavirus (RV); and 2 influenza (flu) vaccines by their second birthday.	Yes		Yes	Yes
Chlamydia Screening in Women Ages 16 to 24	NQF 0033 QPP Quality #310	The percentage of women 16 – 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	Yes			Yes
Diabetes: Hemoglobin A1C (HbA1c) Poor Control (>9.0%)	NQF 0059 QPP Quality #001	Percentage of patients 18 – 75 years of age with diabetes whose most recent hemoglobin A1c level during the measurement year was greater than 9% (poor control).		Yes	Yes	Yes (Outcome Measure) (High Priority Measure)
Diabetes: Eye Exam (Retinal) Performed	NQF 0055 QPP Quality #117	The percentage of individuals 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	Yes			Yes
Diabetes: Medical Attention for Nephropathy	NQF 0062 QPP Quality #119	The percentage of individuals 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement year or the year prior.	Yes			Yes

Quality Measures Crosswalk

Measure Name	Measure Number	Measure Description	WA State Medicaid Transformation Project Demonstration		HCA 2019 Apple Health Contract Metrics *Medicaid*	Quality Payment Program *All Payer or Medicare Part B* (depending on data submission methodology)
			Project Metrics *Medicaid*	Statewide Accountability Metrics *Medicaid*		
Diabetes: Blood Pressure Control	NQF 0061	The percentage of individuals 18 – 75 years of age with diabetes (type 1 and Type 2) whose most recent blood pressure (BP) reading is < 140/90 mm Hg.		Yes	Yes	
Controlling High Blood Pressure	NQF 0018 QPP Quality #236	The percentage of individuals 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.		Yes	Yes	Yes (Outcome Measure) (High Priority Measure)
Follow-Up After Hospitalization for Mental Illness	NQF 0576 QPP Quality #391	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: The percentage of discharges for which the patient received follow-up within 30 days of discharge. The percentage of discharges for which the patient received follow-up within 7 days of discharge.	Yes		Yes (FIMC regions only)	Yes (High Priority Measure)
Medication Management for People with Asthma (5 to 64 Years)	NQF 1799 QPP Quality #444	The percentage of individuals 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	Yes	Yes	Yes	Yes
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NQF 1516	The percentage of Medicaid-covered children 3-6 years of age who had one or more well-child visits with a primary care provider during the measurement year.	Yes	Yes	Yes	

Quality Payment Program Improvement Activities aligned with Washington State Medicaid Transformation Project

Section 1115(a) Medicaid Demonstration

Improvement Activity ID	Subcategory Name	Activity Name	Activity Weighting
IA_EPA_2	Expanded Practice Access	Use of telehealth services that expand practice access	Medium
IA_PM_3	Population Management	Rural Health Center (RHC), Indian Health Service (HIS), or Federally Qualified Health Center (FQHC) quality improvement activities	High
IA_PM_5	Population Management	Engagement of community for health status improvement, collaborating with key partners including Quality Improvement Organizations.	Medium
IA_CC_4	Care Coordination	Transforming Clinical Practice Initiative (TCPI) Participation	Medium
IA_PSPA_5	Patient Safety & Practice Assessment	Annual registration in the Prescription Drug Monitoring Program	Medium
IA_PSPA_10	Patient Safety & Practice Assessment	Completion of training and receipt of approved waiver for provision of opioid medication-assisted treatments	Medium
IA_PSPA_19	Patient Safety & Practice Assessment	Adopt a formal quality improvement model and create a culture for staff participation.	Medium
IA_BMH_2	Behavioral and Mental Health	Tobacco use: Integrated prevention and treatment interventions	Medium
IA_BMH_3	Behavioral and Mental Health	Unhealthy alcohol use: Integrated prevention and treatment interventions	Medium
IA_BMH_4	Behavioral and Mental Health	Depression screening and follow-up plan	Medium
IA_BMH_5	Behavioral and Mental Health	Major Depressive Disorder (MDD) prevention and treatment interventions, including suicide risk assessment	Medium
IA_BMH_6	Behavioral and Mental Health	Implementation of co-location Primary Care Practice (PCP) and Mental Health (MH) services	High
IA_BMH_7	Behavioral and Mental Health	Implementation of integrated Primary Care Behavioral Health (PCBH) model	High
IA_BE_16	Beneficiary Engagement	Evidenced-based techniques to promote self-management into usual care	Medium
IA_BE_20	Beneficiary Engagement	Implementation of condition-specific chronic disease self-management support programs	Medium
IA_AHE_1	Achieving Health Equity	Seeing new and following Medicaid and dual eligible patients in a timely manner (defined as 10 days).	High

Many other Improvement Activities can be found on the MIPS Data Validation Criteria.