# IT- 1.32: Asthma Medication Ratio (AMR)

| **Measure Title** | **Asthma medication ratio: percentage of patients 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.** | | |
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| **Description** | This measure is used to assess the percentage of patients 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. | | |
| **NQF Number** | 1800 | | |
| **Measure Steward** | National Committee for Quality Assurance | | |
| **Link to measure citation** | <http://www.qualitymeasures.ahrq.gov/content.aspx?id=38867> | | |
| **Measure type** | Stand-alone (SA) | | |
| **Measure status** | P4P | | |
| **DSRIP-specific modifications to Measure Steward’s specification** | The Measure Steward’s specification has been modified as follows:   * Remove health plan specific language from description and denominator, replace member with patient. * Removed dates to make measure agnostic to calendar year. | | |
| **Denominator Description** | Patients 5 to 64 years of age by the end of the measurement year with persistent asthma (see the related "Denominator Inclusions/Exclusions" field) | | |
| **Denominator Inclusions** | Patients 5 to 64 years of age by the end of the measurement year with persistent asthma    Note:  • Patients must have had at least one (1) outpatient encounter in the prior 12-month period • Identify patients as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.  • At least one ED visit with asthma as the principal diagnosis  • At least one acute inpatient claim/ with asthma as the principal diagnosis  • At least four outpatient asthma visits on different dates of service, with asthma as one of the listed diagnoses and at least two asthma medication dispensing events  • At least four asthma medication dispensing events  • A patient identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma in any setting, in the same year as the leukotriene modifier. | | |
| **Denominator Exclusions** | • Patients who had at least one encounter, in any setting, with any code to identify a diagnosis of emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, or acute respiratory failure. Look as far back as possible in the patient's history through the end of the measurement year.  • Patients who have no asthma controller or reliever medications dispensed during the measurement year. | | |
| **Denominator Size** | Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)   * For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. * For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. * For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases. | | |
| **Numerator Description** | The number of patients who have a medication ratio of 0.50 or greater during the measurement year (see the related "Numerator Inclusions/Exclusions field) | | |
| **Numerator Inclusions** | Inclusions  The number of patients who have a medication ratio of 0.50 or greater during the measurement year  Note:  • For each patient, count the units of controller medications dispensed during the measurement year. Each dispensing event is one unit. Count the units of reliever medications dispensed during the measurement year. Each dispensing event is one unit. Sum the units of controller medications and reliever medications to determine units of total asthma medications. Calculate the ratio of controller medications to total asthma medications.  • Oral Medication Dispensing Event: One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.  • Multiple prescriptions for different medications dispensed on the same day are assessed separately. If multiple prescriptions for the same medication are dispensed on the same day, the organization should sum the days supply and divide by 30.  • Inhaler Dispensing Event: Each inhaler (i.e., canister) counts as one dispensing event. Multiple dispensing events of the same or different medication are assessed separately (even if medications were filled on the same date of service). The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.  • Injection Dispensing Event: Injections count as one dispensing event. Multiple dispensing events of the same or different medication are assessed separately. The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled. | | |
| **Numerator Exclusions** | The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. | | |
| **Setting** | Ambulatory | | |
| **Data Source** | Administrative and clinical data  Pharmacy data | | |
| **Denominator Sub-set Definition (Optional)** | Providers have the option to further narrow the denominator population for this measure across one or more of the following domains. If providers wish to use this option, they must indicate their preference to HHSC through the measure selection process.  **Payer:** Providers may define the denominator population such that it is limited to one of the following options:   1. Medicaid 2. Uninsured/Indigent 3. Both: Medicaid and Uninsured/Indigent   **Gender:** Providers may define the denominator population such that it is limited to one of the following options:   1. Male 2. Female   **Ethnicity:** Providers may define the denominator population such that it is limited to one of the following options:   1. White/Caucasian 2. Black/African American 3. Latino/Hispanic 4. Asian 5. American Indian/Alaskan Native 6. Native Hawaiian/Other Pacific Islander   **Age:** Providers may define the denominator population such that it is limited to an age range:  Lower Bound: \_\_\_\_ (Provider defined)  Upper Bound: \_\_\_\_ (Provider defined)  **Comorbid Condition:** Providers may define the denominator population such that it is limited to individuals with one or more comorbid conditions:  Comorbid condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Provider defined)  **Setting/Location:** Providers may define the denominator population such that it is limited to individuals receiving services in a specific setting or service delivery location(s).  Service Setting/Delivery Location(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Provider defined) | | |
| **Demonstration Years** | **DY3**  **10/01/13 – 09/30/14** | **DY4**  **10/01/14 – 09/30/15** | **DY5**  **10/01/15 – 09/30/16** |
| **Measurement Periods**  *(Note: For P4P measures, DY3 Measurement Period is equivalent to the Baseline Period for purposes of measuring improvement.)* | **Providers must report data for one of the following DY, SFY, or CY time periods:**  12 Month Period:   1. 10/01/13 – 09/30/14, or 2. 09/01/13 – 08/31/14, or 3. 01/01/13 – 12/31/13, or 4. 10/01/12 – 09/30/13, or 5. 09/01/12 – 08/31/13   6 Month Period:   1. 04/01/14 – 09/30/14, or 2. 03/01/13 – 08/31/14, or 3. 01/01/13 – 06/30/13, or 4. 07/01/13 – 12/31/13   Other: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC. | **Providers must report data across a 12-month time period that meets the following parameters:**  1. Start date: The start date for the reporting period must occur after the provider’s DY3 Measurement Period.  2. End date: The end date for the reporting period must occur on or before 09/30/15. | **Providers must report data across a 12-month time period that meets the following parameters:**  1. Start date: The start date for the reporting period must occur after the provider’s DY4 Measurement Period.  2. End date: The end date for the reporting period must occur on or before 09/30/16. |
| **Reporting Opportunities to HHSC** | 10/31/2014 | 4/30/2015  10/31/2015 | 4/30/2016  10/31/2016 |
| **Pay for Performance Target Methodology**  *(Note: See DSRIP Category 3 Companion Document for detailed P4P target methodology descriptions pertaining to (1) QISMC methodology, and (2) Improvement Over Self methodology.)* | Not Applicable | QISMC | QISMC |
| **Pay for Performance QISMC Benchmark Definition** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC Benchmark Source** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC High Performance Level Definition** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC High Performance Level Value** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC Minimum Performance Level Definition** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC Minimum Performance Level Value** | Not Applicable | TBD | TBD |