Behavioral Health and Substance Use, Spring 2018 Cycle: CDP Report

TECHNICAL REPORT

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NATIONAL QUALITY FORUM

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Executive Summary

One in five American adults experience a mental illness in a given year.[1] Mental illness and substance use disorders are leading causes of disability and premature mortality in the United States. Access to high-quality behavioral healthcare is essential to leading a healthy, productive life. To improve care for individuals with mental illness, performance measurement needs to remain operational and current.

The review and evaluation of behavioral health measures has long been a priority of the National Quality Forum (NQF), and with the ever-changing behavioral health landscape, new measures focusing on identified needs and gaps continue to come to fruition. The background and description of the previous and current projects and an overview of NQF's behavioral health portfolio are available on NQF's project webpage. This work aims to endorse performance measures of accountability for improving the delivery of behavioral health and substance use services and achieving better health outcomes for the U.S. population. The most recent work, detailed in this report, examines measures of suicide risk assessments; medication adherence and management; diabetes and cardiovascular screening and monitoring for individuals with schizophrenia and bipolar disorder; concurrent use of opioids and benzodiazepines; and the use of pharmacotherapy for opioid use disorder.

In addition to evaluating performance measures in critical behavioral health and substance use areas, this project focuses on several overarching measurement areas including how to measure medication adherence accurately, as well as how to further drive quality metrics at the point of care in behavioral health settings.

For this project, the Standing Committee evaluated two newly submitted measures and seven measures undergoing maintenance review against NQF's standard evaluation criteria. All nine measures have been endorsed:

- 0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (PCPI)
- 0105 Antidepressant Medication Management (AMM) (NCQA)
- 1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia (CMS/NCQA)
- 1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (CMS/NCQA)
- 1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (NCQA)
- 1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) (NCQA)
- 1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) (NCQA)
- 3389 Concurrent Use of Opioids and Benzodiazepines (COB) (PQA)
- 3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD) (CMS/Mathematica Policy Research)

Brief summaries of the measures are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

Behavioral healthcare refers to a continuum of services for individuals at risk of—or suffering from—mental (i.e., emotional and/or cognitive [thoughts, problem solving] issues) or addictive disorders, challenges broadly ranging from mood and anxiety disorders, to learning disabilities and substance use disorders. In the United States, nearly one in five adults lives with a mental illness (44.7 million in 2016).[1] Suicide is a leading cause of death in the United States, and the Centers for Disease Control and Prevention (CDC) recently reported that suicide rates have increased more than 30 percent in half of states between 1999 and 2016.[2] In 2016, 20.1 million people aged 12 or older had a substance use disorder of which 8.2 million also had a mental disorder, also known as a co-occurring disorder.[3]

Behavioral health disorders are a leading cause of disabilities that contributes to rising healthcare expenditure, costing employers billions of dollars each year. Mental health and substance use disorder treatment spending from all public and private sources is expected to total $280.5 billion in 2020—an increase from $171.7 billion in 2009.[4]

While many of the illnesses and disorders that fall under the behavioral health umbrella are often chronic, people can and do recover when provided with timely, high-quality, coordinated, and evidence-based care. Proper screening and assessment of populations at risk, consistent evaluation and management of illnesses, and ongoing care have the potential to change recovery trajectories over time. Improving quality measures and shifting towards a culture of measurement-based care enhance the quality and, ultimately, the outcomes of behavioral health services.

NQF Portfolio of Performance Measures for Behavioral Health and Substance Use Conditions

The Behavioral Health and Substance Use Standing Committee (Appendix C) oversees NQF's portfolio of behavioral health and substance use measures; it includes measures for alcohol and drug use, care coordination, depression, medication use, experience of care, tobacco, and physical health (Appendix B). This portfolio contains 54 measures: 45 process measures, eight outcome and resource use measures, and one composite measure (see table below).

Table 1. NQF Behavioral Health and Substance Use Portfolio of Measures

	Process	Outcome/Resource Use	Composite
Alcohol and Drug Use	8	0	1
Care Coordination	2	0	0
Depression	5	4	0
Medication Use	10	0	0
Experience of Care	3	0	0
Tobacco	8	0	0
Physical Health	9	4	0
Total	45	8	1

Additional measures related to behavioral health and substance use are assigned to other topic areas. These include various patient experience measures (Patient Experience and Function project), antipsychotic use in persons with dementia measure (Neurology project), unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (All-Cause Admissions and Readmissions project), antipsychotic use in children under five measure (Patient Safety project), and a smoking prevalence measure (Prevention and Population Health project).

Behavioral Health and Substance Use Measure Evaluation

On June 14, 15, and 19 the Behavioral Health and Substance Use Standing Committee evaluated two new measures and seven measures undergoing maintenance review against NQF's standard evaluation criteria.

Table 2. Behavioral Health and Substance Use Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	7	2	9
Measures recommended for endorsement	7	2	9

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on April 24, 2018 and closed on August 22, 2018. As of June 5, 2018, no comments were submitted.

Comments Received After Committee Evaluation

Following the Committee's evaluation of the measures under consideration, NQF received 57 comments from 17 organizations (including nine member organizations) and individuals pertaining to the draft report and to the measures under consideration. Appendix A summarizes all comments for each measure under consideration.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. Four NQF members provided their expression of support.

Overarching Themes

During the Standing Committee's discussion of the measures, several overarching themes emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Medication Adherence

The Committee discussed differences in measurement proxies for medication initiation and adherence. Specifically, many of the new substance use disorder measures calculate medication initiation and adherence using different metrics and proxies than mental health disorder medication adherence measures, such as those for antipsychotic and antidepressant medication adherence. In addition, new long acting injectable medications and behavioral risk factors for adherence, such as schizophrenia, were identified by the Committee as topics to consider when developing these types of measures. The Committee would like to see consistent language across behavioral health and substance use for all medication adherence measures.

NQF Measure Criteria Changes

NQF made changes to *subcriterion 2b. Validity* in August 2017 for maintenance of endorsement. It stated that empirical validity testing is now expected; if it is not possible, a justification is required. The decision to tighten validity testing requirements for maintenance measures was made because NQF believes it is important to have empirical demonstration of validity. For the spring 2018-cycle submissions, NQF received several communications from measure developers expressing concern that the change in the subcriterion allowed for a very short window of time to respond to the new testing requirement. In response, NQF confirmed that the guidance includes provision of justification in lieu of empirical validity testing if it is not possible to provide at the time of maintenance review. In addition, NQF updated its guidance for standing committee members to evaluate justifications in lieu of empirical validity testing for maintenance measures. Unlike other criteria that typically carry over from the previous maintenance review (e.g., evidence), justifications must use specific voting options that include:

- **Moderate.** (highest vote per the algorithm). The Committee should vote Moderate if they accept the previous analysis and results of face validity **and** they accept the justification provided by the measure developer.
- **Low.** The Committee should vote Low if they do not accept the previous analysis and results of face validity. If the Committee votes Low, the measure will fail the validity criteria and the justification will not hold.
- **Insufficient**. The Committee should vote Insufficient if they accept the previous analysis and results of the face validity **and** they do not agree with the justification provided by the measure developer.

Overall Performance Improvement Rates

This cycle included the evaluation of seven measures for maintenance of endorsement for which the updated performance data showed little overall performance improvement despite continued variation, indicating a gap in care. The Committee discussed potential reasons for so little change, identifying low rates of use due to the optional reporting of many behavioral health measures in incentive programs. In addition, the Committee questioned keeping measures endorsed that are not showing improvement, to which many argued that without additional data on how the measure is being implemented, or the nature of the denominator population, it is hard to understand exactly why the performance is not improving.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (PCPI Foundation): Endorsed

Description: 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; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Emergency Department and Services, Other, Outpatient Services; **Data Source**: Electronic Health Records

This process measure, originally endorsed in 2009, aims to improve rates of clinician assessment of suicide risk during an encounter where a new or recurrent episode of major depressive disorder is identified. The Standing Committee agreed that the performance rates reported by the developer continue to indicate a gap in care specific to assessment of suicide risk in individuals with major depressive disorder (MDD). The Committee discussed the frequency of assessment outlined in the measure specifications, and encouraged the developer to increase the frequency to include assessments beyond first diagnosis and recurrence, such as life stressors that may trigger an assessment or other risk factors. In addition, one Committee member suggested that the measure be expanded beyond major depression disorder to a larger more general patient population. The Committee discussed the lack of a standardized suicide risk assessment tool in the measure specifications. The developer responded to the Committee by confirming that the guidelines do not require a specific tool; however, the developer agreed that a standardized approach is important for this measure, so it included four standardized questions in the specifications that can map to a risk assessment SNOMED code. The measure is currently in use in CMS' MIPS program, and the developer shared that during the annual update later this year, it will add telehealth to the specifications. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement.

0105 Antidepressant Medication Management (AMM) (NCQA): Endorsed

Description: The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months). **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims

This process measure, originally endorsed in 2009, promotes patient compliance, monitors treatment effectiveness, and aids providers in identifying and managing side effects for individuals who are on an antidepressant medication regimen. The Standing Committee confirmed that the evidence base for the measure has not changed since the 2014 review, and agreed to accept the previous vote on evidence. The updated performance data for the measure indicated only a slight increase in overall performance.

The Committee, however, noted variation in performance despite the small increase and agreed that a performance gap still exists. Some Committee members suggested that the measure should be expanded to include additional treatment modalities such as lifestyle, electroconvulsive therapy, or cognitive behavioral therapy. Other Committee members suggested that measuring the outcomes of medication management would be far more beneficial. The Committee emphasized that this measure, like many other behavioral health measures, is part of optional reporting, which makes overall performance increases difficult, if not impossible. The Committee had no concerns with the updated reliability and validity testing. The measure is currently used in the Medicaid Core Set, CMS' Quality Payment Program (QPP) and in NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) program. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement.

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia (CMS/NCQA): Endorsed

Description: Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months); **Measure Type**: Process; **Level of Analysis**: Clinician : Group/Practice, Health Plan, Population : Regional and State; **Setting of Care**: Outpatient Services; **Data Source**: Claims

This process measure, originally endorsed in 2012, helps providers identify and develop interventions for patients who are not adherent to treatment with antipsychotic medications. The measure is currently used and publicly reported in CMS' Quality Payment Program. The Standing Committee agreed that the evidence base for the measure had not changed since the previous review and consented to the previous vote on evidence. The Committee discussed the adherence proxy detailed in the measure specifications and asked the developer to think about how to identify adherence in ways other than the existence of two prescription drug claims. For example, it was noted that individuals with schizophrenia often fill their prescriptions but do not take the medications. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement. The Committee also suggested that the data from this measure be used to help identify individuals with adherence issues who may be good candidates for long acting antipsychotic medications.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (CMS/NCQA): Endorsed

Description: Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months); **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Health Plan, Integrated Delivery System, Population: Regional and State; **Setting of Care**: Outpatient Services; **Data Source**: Claims

This process measure, originally endorsed in 2009, calculates the percentage of adults with bipolar I disorder who adhere to mood stabilizer medications. The intent of this measure is to help providers

identify and develop interventions for patients with bipolar I disorder who are not adherent to treatment with mood stabilizer medications. The Standing Committee agreed that the evidence for the measure had not changed significantly since the previous evaluation, and consented to the previous vote. The Committee had no concerns with the reliability of the measure, other than a brief discussion in regards to the criteria for adherence in the measure specification. Several members of the Committee suggested broadening the adherence criteria beyond two prescriptions. The Committee did not reach consensus when voting on validity—a must-pass criterion. The measure developer submitted a justification for not providing updated empirical validity testing; however, there was some confusion on the Committee's part in regards to how to interpret the justification, which was reflected in their vote. The Committee completed the evaluation of the measure with the exception of a vote for overall endorsement. The measure was brought to the post-evaluation web meeting for further discussion on June 27, 2018.

NQF staff provided the Committee with additional guidance on how to vote on the validity criterion with a justification in advance of the post-evaluation meeting. Following the guidance, the Committee re-voted on validity, taking into consideration the existing face validity testing and the developer's justification for not having empirical testing. The measure passed on the validity vote during the post-evaluation meeting. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement.

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (NCQA): Endorsed

Description: The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System, Population: Regional and State; **Setting of Care**: Outpatient Services, Other; **Data Source**: Claims

Evidence suggests that individuals with serious mental illness (SMI), specifically those with schizophrenia and bipolar disorder, are at increased risk of developing diabetes due to a higher prevalence of risk factors including tobacco use, poor nutrition, and obesity and weight gain from the use of antipsychotics.[5] Despite these risks, people with SMI are less likely to have annual A1c testing or glucose screening.[5–7] This measure, initially endorsed in 2012, assesses if patients with schizophrenia or bipolar disorder were dispensed an antipsychotic medication and had a diabetes screening test. The Committee agreed that the evidence base for the measure has not changed since the last evaluation and moved to accept the previous vote on evidence. The measure is currently used in the Medicaid Adult Core Set and NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) programs. Updated performance data were submitted, and the Committee agreed that the data indicate room for improvement. In addition, the developer submitted updated empirical validity testing, and the Committee agreed with the construct hypothesis that the measure correlates to other diabetes monitoring measures. The Committee questioned whether a screening measure for this population guaranteed improved outcomes, but all agreed that screening is the first step on the improvement pathway. One Committee member also mentioned that states that have higher rates of screening individuals with schizophrenia or bipolar disorder for diabetes also have higher rates of monitoring, which leads to improved health

outcomes. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) (NCQA): Endorsed

Description: The percentage of patients 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System, Population: Regional and State; **Setting of Care**: Outpatient Services; **Data Source**: Claims

Evidence suggests that individuals with SMI, specifically those with schizophrenia, are at increased risk of developing metabolic syndrome and subsequent cardiometabolic disorders due to a higher prevalence of risk factors including poor diet, lack of physical activities, smoking, substance abuse, older age, higher body mass index, and side effects from the use of antipsychotics.[8,9] Despite these risks, people on antipsychotics, including individuals with schizophrenia, are less likely to receive routine, cardiovascular monitoring.[10] This process measure, initially endorsed in 2012, assesses if patients with schizophrenia and cardiovascular disease had an LDL-C test. The Committee agreed that the evidence base for the measure had not changed since the last evaluation and moved to accept the previous vote on evidence. Given that cardiovascular disease is often not diagnosed in patients with schizophrenia, the Committee questioned why the denominator requires a prior diagnosis of cardiovascular disease rather than giving all patients with schizophrenia an LDL-C test annually. The developer responded that this is based on the evidence guidelines and that the developer has a separate cardiovascular screening measure in addition to this monitoring measure that strictly looks at individuals who already have a diagnosis of cardiovascular disease. Ultimately, the Committee agreed that performance results are critical to improving outcomes for individuals with schizophrenia and to addressing early mortality in this population, and that the benefits of this measure far outweigh any possible unintended consequences. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement.

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) (NCQA): Endorsed

Description: The percentage of patients 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System, Population: Regional and State; **Setting of Care**: Outpatient Services; **Data Source**: Claims

Evidence suggests that individuals with SMI, specifically those with schizophrenia, are at increased risk of developing diabetes due to a higher prevalence of risk factors including tobacco use, poor nutrition, and obesity and weight gain from the use of antipsychotics.[5] Despite these risks, people with SMI and diabetes receive less ongoing diabetes monitoring and have a higher risk for diabetes complications and diabetes-related mortality compared to non-mental health patients.[7] This process measure, initially endorsed in 2012, assesses if patients with schizophrenia and diabetes have had both an LDL-C test and an HbA1c test. The Committee agreed that the evidence base for the measure had not changed since the last evaluation and moved to accept the previous vote on evidence. The Committee noted that

collecting data on diabetes management in this population is a critical public health priority and is essential to improving the health of people with schizophrenia and addressing early mortality. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for continued endorsement.

3389 Concurrent Use of Opioids and Benzodiazepines (COB) (PQA, Inc.): Endorsed

Description: The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year. A lower rate indicates better performance; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Health Plan; **Data Source**: Claims

Overdose deaths involving prescription opioids were five times higher in 2016 than in 1999, and more than 200,000 people have died in the U.S. from overdoses related to prescription opioids.[11] Scientific research has identified high-risk prescribing practices that have contributed to the opioid overdose epidemic, including overlapping opioid and benzodiazepine prescriptions. Concurrent use of opioids and benzodiazepines—both central nervous system (CNS) depressants—increases the risk for severe respiratory depression, which can be fatal.[12] This newly submitted measure evaluates concurrent use of benzodiazepines and opioids, which is associated with an increased risk of opioid overdose. The Standing Committee agreed that the measure addresses a significant performance gap and had no concerns in regards to the scientific acceptability testing of the measure. There was a brief discussion about the feasibility of the measure with respect to the impact on claims measurement if beneficiaries start to pay for their prescriptions out of pocket, but ultimately the Committee agreed that this was something worth monitoring in future performance rates. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for endorsement.

3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD) (CMS/Mathematica Policy Research): Endorsed

Description: The percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone. **Measure Type** Process; **Level of Analysis**: Population: Regional and State; **Setting of Care**: Emergency Department and Services, Inpatient/Hospital, Outpatient Services; **Data Source**: Claims

Of the 52,404 drug overdose deaths in the United States in 2015, 33,091 (63.1 percent) were due to opioid use, and an estimated 2.5 million individuals have an OUD for abuse or dependence with most not receiving treatment or not receiving the most effective care.[13] There is evidence that pharmacotherapy is related to improved outcomes; therefore, this newly submitted measure, which is intended to increase access to pharmacotherapy, is expected to yield better care for beneficiaries with an OUD. The measure is currently in voluntary use in CMS' Quality Payment Program. The measure developer provided state-level performance data indicating a large amount of variation on state-level performance. The measure developer noted that there are higher documented rates of pharmacotherapy for elderly, male, and urban beneficiaries that contribute to the wide range of

variation. The Standing Committee discussed the omission of psychosocial support in the measure and agreed that it would be beneficial to include this in future versions. The Committee also a discussed the impact on the denominator of including individuals in remission and not on pharmacotherapy. The measure developer provided additional background that patients in remission tend to be on pharmacotherapy and that they excluded the remission cohort of patients in testing but there was minimal change. The measure developer shared with the Committee that two states participating in the measure testing did not have methadone billing codes, so it is possible that there was under reporting. Overall, the Committee agreed that this is an important measure and voted to recommend this measure for endorsement.

Measures Withdrawn from Consideration

Two measures previously endorsed by NQF were not re-submitted for maintenance of endorsement or have been withdrawn during the endorsement evaluation process. Endorsement for these measures has been removed.

Table 3. Measures Withdrawn from Consideration

Measure	Reason for withdrawal
1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	This measure was withdrawn by the developer given that it is not currently in use in the Healthcare Effectiveness Data and Information Set (HEDIS) measurement set, and therefore may not provide sufficient data to meet NQF's updated use/usability and validity standards.
1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	The developer withdrew this measure given that the developer has an existing Follow-Up After Hospitalization measure for the general population, which is already endorsed through NQF and includes this subpopulation.

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Endorsed Measures

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Submission | Specifications

Description: 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.

Numerator Statement: Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

Denominator Statement: All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD).

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Emergency Department and Services, Other, Outpatient Services

Type of Measure: Process

Data Source: Electronic Health Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING 6/19/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-6**; **M-9**; **L-0**; **I-0**

Rationale:

- The measure developer provided updates to the previous evidence submitted for the 2014 review, including a 2015 reaffirmation of the American Psychiatric Association (APA) guideline for the treatment of patients with major depressive disorder.
- The Standing Committee agreed that the evidence base for the measure has not changed and consented to the prior 2014 vote on evidence.
- The measure developer provided performance data from the 2015 CMS Physician Quality Reporting System (PQRS) for which the average performance rate was 71.3%.
- The measure developer was not able to provide updated disparities data as the reporting programs have not yet made these data available. The developer, however, was able to identify studies that examine disparities in suicide assessment rates among people with MDD including a 2017 Centers for Disease Control and Prevention report on suicide.

- The Committee agreed that based on the performance data provided by the developer, a gap in care continues to exist. One Committee member requested the developer include racial and ethnic disparities data for the next maintenance review.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-4; M-11; L-0; I-0** 2b. Validity: **H-2; M-13; L-0; I-0**

<u>Rationale</u>:

- The measure developer used a beta-binomial model to assess the signal to noise ratio. The overall average reliability is 0.94.
- The Standing Committee encouraged the developer to increase the frequency of assessment to include assessments beyond initial diagnosis and recurrent episodes.
- The Committee expressed concern regarding the reliability of the measure due to the lack of a designated standardized tool to assess suicide risk in the measure specifications. The Committee also indicated that telehealth should be included in the specifications.
- The measure developer provided rationale for not including a specific tool in the specifications and noted that four standard questions based on the guidelines are included in the specifications and implementers of the measure can map the risk assessment to a SNOMED code.
- The Committee agreed that the four standardized questions included in the measure specifications were acceptable.
- The measure developer provided updated empirical validity testing that included a correlation analysis with the Depression Utilization of the PHQ-9 Tool measure. A positive correlation was found between the measures with a coefficient of 0.39 and p-value of 0.45.
- The Committee agreed that there was a moderate, but positive correlation.

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3. Feasibility: H-2; M-12; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Standing Committee agreed the measure is feasible for implementation. Data element feasibility scorecard was calculated across three EHR vendors (Epic, NextGen, and Point Click Care), and all data elements are in a structured format across the EHRs with the exception of "ED visit", which was not defined in two EHRs. In addition, identifying patients to meet the numerator may be challenging as suicide risk assessment is consistently documented in free text notes requiring manual review.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-15; No Pass-0** 4b. Usability: **H-1; M-14; L-0; I-0**

<u>Rationale</u>:

- The measure is publically reported and used in accountability programs: CMS' Merit-based Incentive Payment System (MIPS) and prior to 2016, Physician Quality Reporting System (PQRS).
- The Committee had no other concerns, and agreed that the measure meets the use and usability criterion.

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5. Related and Competing Measures

- There are no competing measures. The developer provided one related measure:
    - NQF# 1365: Child and Adolescent Major Depressive Disorder (MDD) Suicide Risk Assessment
- Both measures, #1365 and #0104, were developed by PCPI and harmonized to the extent possible.

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6. Standing Committee Recommendation for Endorsement: **Y-15; N-0**

7. Public and Member Comment

- Six comments were received on this measure during the post-evaluation commenting period. Two comments were in support of the Committee's decision to recommend the measure and three additional commenters encouraged the developer to expand the measure to require suicide risk assessment for all patients with any mental health or substance use condition rather than only focusing on those with major depressive disorder. Another commenter raised concerns with the feasibility of the measure noting that clinicians who are administering a suicide risk assessment are not always working in an environment where an EHR is available (e.g. non-hospital based clinicians) so data collection could present a challenge.
    - Developer response: Thank you for your comment. This measure is specified and has been tested within the population with major depressive disorder. Expanding the measure beyond this population would require consultation with our TEP and additional testing to assess the feasibility, reliability and validity of the measure within a broader population. We plan to bring this suggestion back to our TEP for consideration in future updates and maintenance of this measure.

      Your point about EHR availability is a good one. The PCPI has long recognized the great potential of Electronic Health Records (EHRs) and clinical data registries to advance quality measurement and quality improvement initiatives. As such, the PCPI has been an advocate for "next generation" methods that leverage clinical data for measure development, specification and testing. Access to clinical data has the potential to provide feedback to physicians and other health care providers that is timely, actionable and leads to improvement in the care delivered to patients. We hope that providers and other stakeholders continue to consider the implementation of EHR technology to advance their quality improvement efforts.

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8. Consensus Standards Approval Committee (CSAC) Vote: Y-17; N-0

CSAC Decision: Approved for endorsement on October 23, 2018.

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9. Appeals

No appeals were received.

0105 Antidepressant Medication Management (AMM)

Submission | Specifications

Description: The percentage of members 18 years of age and older who were treated antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported.

a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

Numerator Statement: Adults 18 years of age and older who were newly treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.

Denominator Statement: Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.

Exclusions: Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.

Exclude patients who filled a prescription for an antidepressant 105 days prior to the IPSD.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/15/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-4; M-11; L-0; I-0**

Rationale:

- The measure developer provided updates to the evidence submitted previously for the 2014 review, including guidelines and systematic reviews to support the diagnosis and treatment of patients with major depressive disorder with antidepressant medications. In addition, the measure developer provided an updated logic model linking the continuation of antidepressant medications to less episodes of major depression and lower morbidity.
- The Standing Committee agreed that the evidence base for the measure has not changed and consented to the previous vote on evidence.
- The Committee noted the low overall change in performance of the measure, but agreed that there was still evidence of variation in care indicating a performance gap.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-9; M-7; L-0; I-0**; 2b. Validity: **H-4; M-12; L-0; I-0**

<u>Rationale</u>:

- The measure developer provided updated measure score reliability testing using 2016 Healthcare Effectiveness Data and Information Set (HEDIS) data that included Medicare, Medicaid, and commercial health plans.
- A beta-binomial model was used to calculate the signal to noise ratio for the two reported rates of the measure (acute phase treatment and continuation phase treatment) across all three plan types: Commercial, acute phase and continuation phase were both 0.97; Medicare, acute phase and continuation phase were both 0.97; and Medicaid, acute phase and continuation phase were both 0.99.
- The measure developer provided updated empirical testing for construct validity by exploring whether the Antidepressant Medication Management measure correlated with the Statin Therapy for Patients with Diabetes measure in Medicare, Commercial, and Medicaid plans. The Pearson correlation coefficient was used and the results indicate a positive correlation across all three plans:
    - Medicaid: correlation coefficient for acute phase is 0.50 and continuation phase is 0.49;
    - Commercial: correlation coefficient for the acute phase is 0.69 and continuation phase is 0.69; and
    - Medicare: correlation coefficient for the acute phase is 0.56 and continuation phase is 0.60.
- The Standing Committee had no concerns with the updated reliability and validity testing.

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3. Feasibility: H-10; M-6; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Standing Committee agreed the measure is feasible for implementation. The measure is specified for claims and electronic health records. All data elements are in defined fields and available in a combination of electronic sources.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-16; No Pass-0** *4b. Usability:* **H-3; M-13; L-0; I-0**

<u>Rationale</u>:

- The measure is publically reported and used in accountability programs, including: Medicaid Adult Core Set; Merit Based Incentive Payment System (MIPS) Quality Payment Program (QPP); Health Insurance Exchange Quality Rating System (QRS); State of Health Care Annual Report; Health Plan Rating/Report Cards; Health Plan Accreditation; and Quality Compass.

- The Standing Committee questioned the overall 1% increase in performance, but agreed that without implementation data (e.g. how stable is the denominator population, how the measure is being implemented, or how the measure is incentivized) it was difficult to determine what a reasonable increase in performance should be.

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5. Related and Competing Measures

- This measure is related to NQF #1880 – Adherence to Mood Stabilizers for People with Bipolar I Disorder. Measures #1880 and #0105 both assess medication adherence for specific populations. The developer notes measure #1880 differs from #0105 in two ways: 1) it focuses on a population with bipolar disorder, rather than major depressive disorder, and 2) it tracks medication adherence using a "proportion of days covered" method, rather than a calculation of number of days of a dispensed prescription. The developer has not submitted a plan to harmonize the two measures. The developer's rationale was acceptable to the Committee and no additional action was taken.

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6. Standing Committee Recommendation for Endorsement: **Y-16; N-0**

7. Public and Member Comment

- Four comments were received on this measure during the post-evaluation commenting period. Two comments were in support of the Committee's decision to recommend the measure and one commenter encouraged the developer to expand the measure's population to consist of anyone prescribed antidepressants as guided by current evidence.
    - Developer response: The measure in question specifically assesses the management of anti-depressant medication among members with major depression. Expanding the measure to include populations receiving anti-depressant medication for conditions other than major depression is outside the current scope of the measure, but is something we can explore.

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8. Consensus Standards Approval Committee (CSAC) Vote: Y-17; N-0

CSAC Decision: Approved for endorsement

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9. Appeals

No appeals were received.

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Submission | Specifications

Description: Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

Numerator Statement: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

Denominator Statement: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

Exclusions: Individuals with any diagnosis of dementia during the measurement period.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice, Health Plan, Population : Regional and State

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING 6/15/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted** 1b. Performance Gap: **H-0; M-16; L-0; I-0**

Rationale:

- The measure developer provided updates to evidence including two clinical practice guidelines.
- The measure developer provided updated performance data from 2015, Physician Compare, reflecting a continued opportunity for improvement.
- Updated disparities data were also submitted by the measure developer demonstrating low rates of adherence among individuals with schizophrenia who are prescribed antipsychotic medications.
- The Standing Committee agreed that the overall evidence for the measure had not changed since the prior review and consented to hold the previous vote.
- The Committee was satisfied with the updated performance data but noted that this is a disparities sensitive measure and they would like to see additional analysis in a future submission.

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2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-2; M-12; L-1; I-0** 2b. Validity: **M-15; L-0; I-0**

Rationale:

- The measure developer provided updated reliability testing at the health plan level that included inter-rater agreement of measure scores randomly selected from Medicare Part D plans. The results indicate moderate to high reliability.
- Previous state and physician level reliability testing, for the measure's last endorsement evaluation, included beta-binomial model to assess signal to noise ratio demonstrating reliable scores.
- The measure developer provided a justification for not submitting empirical validity testing with an analysis plan and timeline for updated testing submission.

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3. Feasibility: H-6; M-9; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Standing Committee had no concerns in regards to feasibility, but noted that it is typical for schizophrenics to fill prescriptions and not take medications.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-14; No Pass-0** *4b. Usability:* **H-3; M-12; L-0; I-0**

Rationale:

- The measure is currently in use in CMS' Quality Payment Program, New York State DSRIP Program, and a SAMHSA demonstration program.
- The measure went through a re-evaluation process through NCQA's measure advisory panel for which medications were added or removed based on FDA approvals.
- No unintended consequences were identified during testing or have been brought to the developer's attention since implementation.

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5. Related and Competing Measures

- There are no competing measures.
- This measure is related to multiple adherence measures including:
    - NQF #0541 Proportion of Days Covered: 3 Rates by Therapeutic Category;
    - NQF# 1880: Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder.
- The measure developer states that the measure specifications are harmonized with the related measures where possible using the same calculation for adherence across.

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6. Standing Committee Recommendation for Endorsement: **Y-14**; **N-0**

7. Public and Member Comment

- Six comments were received on this measure during the post-evaluation commenting period. Three comments were in support of the Committee's decision to recommend the measure and

several commenters suggested additional medication and diagnosis exclusions. Another commenter expressed concern about data collection for the measure due to the nature of separating pharmaceutical claims data from regular claims by many health plans.

- Developer response: We appreciate and agree with the comment. The measure currently includes long-acting (depot) injectable antipsychotic medications in the adherence calculation. The days' supply is imputed for depot injectable antipsychotic medications billed under Medicare Part D and Part B, and include the below (see S.7 of the submission):
  - fluphenazine decanoate
  - haloperidol decanoate
  - aripiprazole
  - aripiprazole lauroxil
  - olanzapine pamoate
  - paliperidone palmitate
  - risperidone microspheres

  We appreciate your comments about the challenges of data collection for this measure. At this time, we believe claims data is the most appropriate data source for this measure. We will encourage measure implementers, such as CMS or NCQA, to work closely with health plans that are submitting data to minimize data collection burdens.

  Although some members with dementia who have schizophrenia or schizoaffective disorder may be appropriately managed on an antipsychotic medication, we exclude these members from the measure because of the public health advisory and black box warning issued by the Food and Drug Administration (FDA). In April 2005, the FDA issued a Public Health Advisory warning of increased risk of mortality associated with the use of atypical antipsychotics in elderly patients with dementia. This warning was based on the findings of a meta-analysis of 17 short-term, randomized, placebo-controlled trials and showed that the risk of death in drug-treated patients was 1.6 to 1.7 times the risk of death in placebo-treated patients (Schneider et al., 2005). In 2008, the FDA advisory and black box warning was extended to all antipsychotic medications when further studies (Liperoti et al., 2009; Schneeweiss et al., 2007; Setoguchi et al., 2008) showed that conventional antipsychotics were associated with a similar increased risk of death when administered to elderly patients with a diagnosis of dementia. (See section 2b2 in the testing attachment). Excluding individuals with dementia from the measure denominator does not preclude physicians from prescribing antipsychotic medications to these individuals. Physicians may still decide with patients through shared decision making whether the benefits of treatment with antipsychotic medications outweigh the risks.

  References:

  Liperoti, R., Onder, G., Landi, F., Lapane, K. L., Mor, V., Bernabei, R., & Gambassi, G. (2009). All-cause mortality associated with atypical and conventional antipsychotics among nursing home residents with dementia: A retrospective cohort study. Journal of Clinical Psychiatry, 70(10),1340-1347.

  Schneeweiss, S., Setoguchi, S., Brookhart, A., Dormuth, C., & Wang, P. S. (2007). Risk of death associated with the use of conventional versus atypical antipsychotic drugs among elderly patients. CMAJ, 176, 627–632. [PubMed: 17325327]

Schneider, L. S., Dagerman, K. S., & Insel, P. (2005). Risk of death with atypical antipsychotic drug treatment for dementia: Meta-analysis of randomized placebo-controlled trials. Journal of the American Medical Association, 294, 1934–1943. [PubMed: 16234500]

Setoguchi, S., Wang, P. S., Brookhart, M., Canning, C. F., Kaci, L., & Schneeweiss, S. (2008). Potential causes of higher mortality in elderly users of conventional and atypical antipsychotic medications. JAGS, 56, 1644–1650.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-17; N-0

CSAC Decision: Approved for endorsement on October 23, 2018.

9. Appeals

No appeals were received.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Submission | Specifications

Description: Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).

Numerator Statement: Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.

Denominator Statement: Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).

Exclusions: Not Applicable

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : Regional and State

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING 6/15/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted** 1b. Performance Gap: **H-3; M-11; L-0; I-0**

Rationale:

- The measure developer provided updates to the evidence submitted previously for the 2014 review, including two clinical practice guidelines. Additionally, the developer provided an updated logic model outlining how the process of identifying patients with Bipolar I Disorder who are not adherent to mood stabilizer medication treatment is related to improved symptom control for those patients identified and a reduction in hospitalization.
- The Standing Committee agreed that the evidence base for the measure has not changed and consented to the previous vote on evidence.
- The measure developer provided updated performance data. The previous submission included 2007 and 2008 Medicare claims data indicating performance gaps and a wide variation in adherence to mood stabilizer medications across health plans, states and provider groups.
- The measure developer provided an updated literature review on disparities reporting higher adherence rates among White persons with Bipolar I Disorder than among African- American and Hispanic persons with Bipolar I Disorder.
- The Committee agreed that based on the performance and disparities data provided by the developer, a gap in care continues to exist.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-3; M-11; L-0; I-0** 2b. Validity: **M-7; L-4; I-3 Validity re-vote on June 27, 2018: M-13; L-0; I-0**

<u>Rationale</u>:

- The measure developer provided updated reliability testing at the health plan level. Reliability was assessed using Cohen's Kappa. The measure scores for five randomly selected Medicare Part D plans from two states were compared, and inter-rater agreement was calculated. Results obtained by two independent programmers were 1.00, which is greater than the Kappa threshold of 0.9.
- Previously submitted reliability testing included signal-to-noise ratio to assess variability across multiple measurement units including states, prescription drug plans, Accountable Care Organizations, and physician groups.
- The Standing Committee agreed the measure was reliable. One Committee member recommended the developer broaden the measure criteria by broadening the proxy for adherence, which is currently specified as two prescriptions.
- The measure developer provided a justification that included a plan with a timeline and methodological details to support previous face validity in lieu of updated empirical validity testing.
- During the initial evaluation webinar, the Committee did not reach consensus on the validity vote.
- After the initial evaluation webinar, NQF refined its guidance for Committee members on how to consider and vote on validity when only face validity and justification are submitted for a maintenance measure in lieu of empirical validity. The Committee re-voted and agreed to accept the existing face validity analysis and the measure developer's justification for not having empirical testing.

3. Feasibility: H-0; M-7; L-7; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Standing Committee agreed the measure is feasible for implementation. The measure is specified for electronic claims. All data elements are in defined fields and readily available and accessible.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-14; No Pass-0** *4b. Usability:* **H-1; M-13; L-0; I-0**

Rationale:

- The measure is publically reported and used in accountability programs, including: New York State Delivery System Reform Incentive Payment (DSRIP) Program, Value Based Payment (VBP) Quality Measure Set for the Health and Recovery Plan (HARP) subpopulation and Substance Abuse and Mental Health Services Administration (SAMHSA) Section 223 Demonstration Program.
- The Committee agreed that the measure meets the use and usability criterion.

5. Related and Competing Measures

- There are no competing measures.
- The developer notes the following related measures:
    - NQF# 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
    - NQF# 1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia
    - NQF# 1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using
    - Antipsychotic Medications (SSD)
    - N/A: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NCQA measure)
- The measure developer indicates measure #1880 has been harmonized to the extent possible with measures #1879, #0542, #0543, #0545, #0541, #1879, #1927, and #1932.

6. Standing Committee Recommendation for Endorsement: **Y-13**; **N-0**

Rationale

- During the post-evaluation meeting on June 27, 2018, the Standing Committee voted on overall suitability and recommended the measure for endorsement

7. Public and Member Comment

- Six comments were received on this measure during the post-evaluation commenting period. Three comments were in support of the Committee's decision to recommend the measure and one comment was specific to unintended consequence of medication adherence. Two additional comments were received specific to the measure specifications list of mood stabilizer drugs.
    - Developer response: We appreciate and agree with the comment. The measure currently includes long-acting (depot) injectable antipsychotic medications FDA-approved for the treatment of bipolar disorder in the adherence calculation. The days' supply is imputed for these medications billed under Medicare Part D and Part B, and include the below (see S.7 of the submission):
        - aripiprazole
        - risperidone microspheres

      This measure includes all FDA-approved treatments for bipolar disorder (anticonvulsants, atypical antipsychotics, phenothiazine/related antipsychotics, other antipsychotics, lithium salts, and long-acting injectable antipsychotic medications). Based on feedback from our expert panel, the measure developer decided to not include any medications used off-label to treat bipolar I disorder. This decision is consistent with our approach for measure #1879. Experts who advised on this measure agreed that while individuals with bipolar I disorder are sometimes treated with medications which are not FDA-approved for that condition, it is not appropriate to include those medications in a quality measure. We also want to note that individuals treated with off-label medications would not be included in the denominator of this measure, and thus, taking this approach, a provider's or health plan's performance on the measure would not be penalized. In order to qualify for the denominator, the patient must be dispensed two prescriptions for one of the medications included in the measure.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-17; N-0

CSAC Decision: Approved for endorsement on October 23, 2018.

9. Appeals

No appeals were received.

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Submission | Specifications

Description: The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Numerator Statement: Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

Denominator Statement: Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

Exclusions: Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients with diabetes during the measurement year or the year prior to the measurement year.

Exclude patients who had no antipsychotic medications dispensed during the measurement year.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan, Integrated Delivery System, Population : Regional and State

Setting of Care: Other, Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/19/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-3; M-10; L-0; I-0**

Rationale:

- In the previous submission, the measure developer provided evidence in the form of guidelines and recommendations from the American Diabetes Association that suggested that individuals with schizophrenia and bipolar disorder are at higher risk for diabetes than the general population and that use of certain antipsychotic medications increases this risk.
- For this submission, the measure developer provided updated guidelines from the American Diabetes Association and the American Psychiatric Association, which show that patients with schizophrenia or bipolar disorder are at an increased risk for diabetes, and antipsychotic medications are an expected treatment that increases the risk of metabolic diseases. Therefore, screening for diabetes will allow for proper diagnosis and treatment.
- The Standing Committee agreed these updates were directionally the same as the evidence presented in the last review, hence there was no need to repeat the discussion and revote on evidence.

- The measure developer summarized the performance data at the health plan level using Healthcare Effectiveness Data and Information Set (HEDIS) health plan performance rates from 2015-2017 which demonstrates a continued performance gap with the 90th percentile performing at 87.4% and the 10th percentile performing at 74%. The Committee agreed that while there is little improvement, an important gap remains.
- The measure developer did not provide disparities data since HEDIS data are stratified by type of insurance. While not specified in this measure, this measure can also be stratified by demographic variables in order to assess other health care disparities.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-5; M-8; L-0; I-0** 2b. Validity: **H-3; M-10; L-0; I-0**

<u>Rationale</u>:

- The measure developer used a beta-binominal model to assess the signal-to-noise ratio that showed high reliability. The Standing Committee agreed that the data elements are clearly defined and unlikely to be prone to unreliability.
- To assess the validity of the measure, the measure developer conducted construct validity testing using the Pearson correlation coefficient to examine the association between using this measure and measure 1934, which both focus on patients with schizophrenia and whether they received care for diabetes. The developer found that there is a statistically significant (0.25) and positive relationship between the two measures. The Committee questioned whether the statistically significant results are because the providers are simply doing a large amount of screening but cautioned that it does not mean they are providing higher quality of care. Ideally, one would want to see if the measure was associated with better outcomes (e.g., lower hyperglycemic events among the population).

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3. Feasibility: H-8; M-5; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Standing Committee agreed that this measure is feasible given that all data elements are in defined fields in electronic claims, no fees are associated with the use of this measure, and that no manual abstraction is required.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-13; No Pass-0** 4b. Usability: **H-5; M-8; L-0; I-0**

<u>Rationale</u>:

- This measure is currently used in several programs including the Medicaid Adult Core Set and various NCQA programs.

- The Standing Committee agreed that although there has been little improvement in the past six years (3 percent), the measure continues to move in the right direction.
- The Committee noted that the small amount of improvement for this measure, specifically for the Medicaid population, may require special attention and incentives.
- The Committee agreed that there are no known harms associated with this measure and that the benefits are considerable given the risks of diabetes for this population.

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5. Related and Competing Measures

- There are no competing measures.
- The measure developer notes the following related measures:

  1933: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

  1934: Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
- The measure developer noted that the specifications are harmonized to the extent possible.

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6. Standing Committee Recommendation for Endorsement: **Y-13**; **N-0**

7. Public and Member Comment

- Four comments were received on this measure during the post-evaluation commenting period, all of which were in support of the Committee's decision to recommend the measure.

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8. Consensus Standards Approval Committee (CSAC) Vote: Y-17; N-0

CSAC Decision: Approved for endorsement on October 23, 2018.

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9. Appeals

No appeals were received.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Submission | Specifications

Description: The percentage of patients 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

Numerator Statement: An LDL-C test performed during the measurement year.

Denominator Statement: Patients 18-64 years of age as of the end of the measurement year (e.g., December 31) with a diagnosis of schizophrenia and cardiovascular disease.

Exclusions: Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan, Integrated Delivery System, Population : Regional and State

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/19/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-1; M-12; L-0; I-0**

Rationale:

- In the previous submission, the measure developer provided evidence in the form of studies that demonstrated that individuals with schizophrenia have a higher prevalence of cardiovascular disease than the general population.
- For this submission, the measure developer provided updated guidelines from the American Psychiatric Association that show that appropriate monitoring of individuals with schizophrenia and cardiovascular disease may lead to proper treatment and management.
- The Standing Committee agreed these updates were directionally the same as the evidence presented in the last review and therefore there was no need to repeat the discussion and revote on evidence.
- The measure developer summarized the performance data at the health plan level using Healthcare Effectiveness Data and Information Set (HEDIS) health plan performance rates from 2015-2017 which demonstrates a continued performance gap. The Committee agreed that while there is little improvement, an important gap remains.
- The measure developer did not provide disparities data since HEDIS data are stratified by type of insurance. While not specified in this measure, this measure can also be stratified by demographic variables in order to assess other health care disparities.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-3; M-10; L-0; I-0** 2b. Validity: **H-4; M-9; L-0; I-0**

<u>Rationale</u>:

- The measure developer used a beta-binominal model to assess the signal-to-noise ratio, which showed high reliability. The Committee agreed that there is no reason that this measure cannot be consistently implemented.
- Given that cardiovascular disease is often not diagnosed in patients with schizophrenia, the Committee questioned why the denominator requires a prior diagnosis of cardiovascular disease rather than giving all patients with schizophrenia an LDL-C test annually. The measure developer responded that this is based on the evidence guidelines; the developer has a separate cardiovascular screening measure, in addition to this measure, that strictly looks at individuals who already have a diagnosis of cardiovascular disease.
- To assess the validity of the measure, the measure developer conducted construct validity testing using the Pearson correlation coefficient to examine the association between using this measure and measure 1934, which both focus on patients with schizophrenia and whether their chronic condition (diabetes or cardiovascular disease) is being monitored. They found that there is a statistically significant (0.66) and positive relationship between the two measures.

3. Feasibility: H-11; M-2; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Standing Committee agreed that given that all data elements are in defined fields in electronic claims and no fees are associated with use, that this measure is feasible.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-13; No Pass-0** 4b. Usability: **H-5; M-8; L-0; I-0**

<u>Rationale</u>:

- This measure is currently used in several programs including the Physician Value-Based Payment Modifier and various NCQA programs.
- The Standing Committee agreed that the performance results are critical to improving outcomes for individuals with schizophrenia and addressing early mortality in this population and that the benefits of this measure far outweigh any possible unintended consequences.

5. Related and Competing Measures

- There are no competing measures.
- The measure developer notes the following related measures:

1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

1934: Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

- The measure developer noted that the specifications are harmonized to the extent possible.

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6. Standing Committee Recommendation for Endorsement: **Y-13**; **N-0**

7. Public and Member Comment

- Four comments were received on this measure during the post-evaluation commenting period. Three comments were in support of the Committee's decision to recommend the measure. Another comment questioned whether the measure should be diagnostically specific, while one comment cautioned the use of the measure in regards to cardiovascular monitoring outside of the acute care setting suggesting this type of monitoring may be beyond practice scope.
    - Developer response: For this measure, members who have a diagnosis of schizophrenia or schizoaffective disorder and cardiovascular disease are identified using claims data that signifies the member received care in a variety of allowable care settings (e.g., outpatient, emergency department, acute inpatient, telehealth). Among members identified as having a diagnosis of schizophrenia and cardiovascular disease, the measure assesses the percentage who had an LDL-C test during the measurement year, which can be identified using administrative claims data or automated laboratory data. Guidelines and evidence do not specify the type of provider that can order and review the laboratory tests required for monitoring in these measures.

The two measures in question are meant to assess appropriate monitoring of individuals with schizophrenia and either cardiovascular disease or diabetes. Guidelines for the treatment of patients with schizophrenia recommend that laboratory tests to evaluate health status, including glucose and cholesterol, be performed. Evidence suggests that the prevalence of diabetes and cardiovascular disease among patients with schizophrenia is higher than among the general population. Additionally, there is a known relationship between the use of antipsychotic medications and increased cardiac and metabolic effects. Guidelines and evidence do not specify the type of provider that can order and review the laboratory tests required for monitoring in these measures.

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8. Consensus Standards Approval Committee (CSAC) Vote: Y-17; N-0

CSAC Decision: Approved for endorsement on October 23, 2018.

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9. Appeals

No appeals were received.

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Submission | Specifications

Description: The percentage of patients 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

Numerator Statement: One or more HbA1c tests and one or more LDL-C tests performed during the measurement year.

Denominator Statement: Patients age 18-64 years of age as of the end of the measurement year (e.g. December 31) with a schizophrenia and diabetes diagnosis.

Exclusions: Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan, Integrated Delivery System, Population : Regional and State

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 6/19/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-9; M-4; L-0; I-0**

Rationale:

- In the previous submission, the measure developer provided evidence in the form of studies that demonstrated that there is a higher prevalence of diabetes and non-treatment rates for individuals with schizophrenia and that monitoring may lead to proper management for diabetes in this population and may reduce morbidity and mortality.
- For this submission, the measure developer provided updated guidelines from the American Psychiatric Association and the American Diabetes Association that furthers the known link between metabolic side effects and antipsychotics used to treat schizophrenia.
- The Standing Committee agreed these updates were directionally the same as the evidence presented in the last review and so there was no need to repeat the discussion and revote on evidence.
- The measure developer summarized the performance data at the health plan level using Healthcare Effectiveness Data and Information Set (HEDIS) health plan performance rates from 2015-2017 which demonstrates a continued performance gap. The Committee agreed that while there is little improvement, an important gap remains.

- The measure developer did not provide disparities data since HEDIS data are stratified by type of insurance. While not specified in this measure, this measure can also be stratified by demographic variables in order to assess other health care disparities.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-5; M-8; L-0; I-0** 2b. Validity: **H-2; M-11; L-0; I-0**

<u>Rationale</u>:

- The measure developer used a beta-binominal model to assess the signal-to-noise ratio that showed high reliability. The Committee agreed that the data elements are clearly defined and unlikely to be prone to unreliability.
- To assess the validity of the measure, the developer conducted construct validity testing using the Pearson correlation coefficient to examine the association between using this measure and measure #1932, which both focus on patients with schizophrenia and whether they received care for diabetes. The developer found that there is a statistically significant (0.66) and positive relationship between the two measures.

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3. Feasibility: H-12; M-1; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Standing Committee agreed that given that all data elements are in defined fields in electronic claims and no fees are associated with use, that this measure is feasible.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-13; No Pass-0** 4b. Usability: **H-8; M-5; L-0; I-0**

<u>Rationale</u>:

- This measure is currently used in several programs including the Physician Value-Based Payment Modifier and various NCQA programs.
- The Standing Committee agreed that collecting data on diabetes management in this population is critical public health priority and is essential to improving the health of people with schizophrenia and addressing early mortality. Any unintended consequences are far outweighed by the potential public health benefit.

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5. Related and Competing Measures

- There are no competing measures.
- The measure developer notes the following related measures:

1932: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Mediations (SSD)

1933: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

- The measure developer noted that the specifications are harmonized to the extent possible.

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6. Standing Committee Recommendation for Endorsement: **Y-13**; **N-0**

7. Public and Member Comment

- Four comments were received on this measure during the post-evaluation commenting period. Three comments were in support of the Committee's decision to recommend the measure and one comment involved limiting the measure's scope to individuals with uncomplicated diabetes. Another comment questioned whether the measure should be diagnostically specific while one comment cautioned the use of the measure in regards to diabetes monitoring outside of the acute care setting or beyond the practice scope.
    - Developer response: For this measure, we do not differentiate between complicated and uncomplicated diabetes, as we did not find evidence in the literature or guidelines to support limiting the measure in this way. Evidence suggests that the prevalence of diabetes among patients with schizophrenia is higher than among the general population. Additionally, there is a known relationship between the use of antipsychotic medications and increased risk of metabolic syndrome and diabetes. People with Schizophrenia and are also less likely to receive care for diabetes than the general population. This measure aims to shed light on disparities in care and assess the proper management of diabetes among a high-risk subset of the general population.

      The two measures in question [1934: Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD); 1933: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia] are meant to assess appropriate monitoring of individuals with schizophrenia and either cardiovascular disease or diabetes. Guidelines for the treatment of patients with schizophrenia recommend that laboratory tests to evaluate health status, including glucose and cholesterol, be performed. Evidence suggests that the prevalence of diabetes and cardiovascular disease among patients with schizophrenia is higher than among the general population. Additionally, there is a known relationship between the use of antipsychotic medications and increased cardiac and metabolic effects. Guidelines and evidence do not specify the type of provider that can order and review the laboratory tests required for monitoring in these measures.

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8. Consensus Standards Approval Committee (CSAC) Vote: Y-17; N-0

CSAC Decision: Approved for endorsement on October 23, 2018.

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9. Appeals

No appeals were received.

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Submission | Specifications

Description: The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year.

A lower rate indicates better performance.

Numerator Statement: The number of individuals from the denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year.

Denominator Statement: The denominator includes individuals 18 years and older with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days' supply is 15 or more days. Individuals with cancer or in hospice are excluded.

Exclusions: Individuals with cancer or in hospice at any point during the measurement year are excluded from the denominator.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan

Setting of Care: Other

Type of Measure: Process

Data Source: Claims

Measure Steward: PQA, Inc.

STANDING COMMITTEE MEETING 6/14/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-8; M-7; L-0; I-0**; 1b. Performance Gap: **H-6; M-9; L-0; I-0**

Rationale:

- The measure developer submitted strong evidence for the measure including a CDC guideline, three studies, and a FDA black box warning.
- The performance gap was demonstrated with measure testing results based on 2015 Medicare Part D data indicating a significant performance gap for which 24% of patients had concurrent prescribing.
- Disparities rates were measured via beneficiary level Low-Income Subsidy (LIS) variable for which the measure rate was 29.9% while the rate of the non-LIS population was lower at 19.9%.

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2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-2; M-13; L-0; I-0** 2b. Validity: **H-14; M-1; L-0; I-0**

Rationale:

- Testing was conducted on Medicare and Medicaid data. A beta-binomial model was used to calculate plan-specific reliability scores. The mean reliability score for Medicare is .77 and the mean reliability score for Medicaid is .94.

- The measure developer provided systematic assessment of face validity for the measure score. The measure was reviewed by several PQA expert panels as well as the entire PQA membership. Ninety-three percent of the Quality Metrics Expert Panel recommended the measure for endorsement and, of the 93 PQA member organizations who cast a vote, eighty-nine percent voted in favor of the measure.
- The Standing Committee noted one concern in regards to threats to validity, related to missing data as a result of individuals paying cash for opioids and benzodiazepines resulting in missing claims.

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3. Feasibility: H-10; M-5; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Pilot sites testing the measure indicated that the measure was feasible and results were reported efficiently, accurately, and without difficulty.
- The required data (prescription and medical claims) are readily available in electronic format.
- Measure developer (PQA) retains the rights to measure and can rescind or alter the measure at any time.
- The Standing Committee had no concerns in regards to feasibility.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-15; No Pass-0** 4b. Usability: **H-9; M-6; L-0; I-0**

Rationale:

- The measure was added to the 2018 CMS Medicaid Adult Core Measure set.
- The measure developer anticipates adoption of the measure over time to meet the 25 state threshold for public reporting.

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5. Related and Competing Measures

- This measure is related to:
    - NQF #2940 : Use of Opioids at High Dosage in Persons Without Cancer
    - NQF #2950 : Use of Opioids from Multiple Providers in Persons Without Cancer
    - NQF #2951 : Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
    - Use of Opioids at High Dosage (NCQA)
    - Use of Opioids from Multiple Providers (NCQA)
- The PQA opioid measures (NQF # 2940, 2950, and 2951) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The NCQA opioid measures were developed as an adaptation to existing PQA measures; the NCQA opioid measure denominators are similar to the PQA opioid measures, but have a different area of focus than the concurrent use of opioids and benzodiazepines measure.

6. Standing Committee Recommendation for Endorsement: **Y-15**; **N-0**

7. Public and Member Comment

- Nine comments were received on this measure specific to feasibility and data collection, unintended consequences, and general support. There was one comment that expressed concern about the measure as specified as well as its relation to another newly endorsed measure NQF #3316 *Safe Use of Opioids – Concurrent Prescribing*.

  Developer response: Thank you for the opportunity to respond to these additional comments received regarding the PQA measure #3389 Concurrent Use of Opioids and Benzodiazepines that retrospectively evaluates the performance of health plans using administrative claims data. To clarify, the measure denominator includes individuals 18 years and older with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days' supply is 15 or more days. The numerator is the number of individuals from the denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year. Individuals with cancer or in hospice at any point during the measurement year are excluded from the denominator.

  The measure rationale and exclusions are based on the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain – United States, 2016, that provides a category A recommendation (applies to all persons; most patients should receive the recommended course of action) that prescribers should avoid concurrent prescriptions of opioids and benzodiazepines.1 The CDC guideline states that although there are circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should avoid concurrent prescribing whenever possible. Additional rationale for the measure is the 2016 US Food and Drug Administration Boxed Warnings added to prescription drug labeling for prescription opioid pain and prescription opioid cough medications, and benzodiazepines, based on studies finding that combined use of opioids and benzodiazepines has resulted in serious side effects, including death.2 Since the publication of the CDC prescribing guideline, several retrospective observational studies have been published that add to the growing body of evidence to support the lack of broad therapeutic benefit combined with the increased risk for overdose associated with co-prescribing of these medications.3-5

  Measure exclusions were carefully considered and vetted through PQA's transparent, multi-stakeholder, consensus-based development process. According to the CDC guideline and subject matter expert feedback during the measure development process, few medication situations warrant concurrent use of opioids and benzodiazepines. The measure excludes patients with cancer and those in hospice due to the unique therapeutic goals, ethical considerations, increased opportunities for medical

supervision, and balance of risks and benefits with opioid therapy. Other exclusions were not recommended for the measure, though opioid products that are indicated for medication assisted treatment for opioid use disorder are not included in the measure.

The intent of measure #3389 is to address the known consequences of concurrent prescribing and the risk of adverse events, including severe respiratory depression and death. The performance results from the measure can be used to establish benchmarks and identify opportunities to decrease co-prescribing of opioid and benzodiazepines. As a retrospective population-level measure, it is not intended to serve as a guide for individual patient care decisions. Although a lower rate indicates better performance, the rate is not expected to be zero. We acknowledge that in certain situations, providers may choose to concurrently prescribe opioid and benzodiazepine medications for individual patients due to patient individualization considerations. This performance measure is not intended to preclude such situations.

To date, implementation of measure #3389 includes the Centers for Medicare & Medicaid Services (CMS) reporting within the Medicare Patient Safety reports, addition to the 2018 Medicaid Adult Core Set, and use in Medicaid 1115 Substance Use Disorder Demonstrations, and negative unintended consequences have not been identified. We will monitor for potential unintended consequences based on feedback from measure implementers to ensure that the benefits of the performance measure in facilitating progress toward achieving high-quality healthcare outweigh evidence of unintended negative consequences.

Although measure #3389 does not focus on pain, pain management is a complex topic that is central to the issue of opioid stewardship. Efforts to prevent opioid overdose deaths should comprise a balanced and multi-faceted approach, including strategies that focus on reducing opioid prescribing, limiting use of potentially dangerous drug-drug combinations, and being mindful and vigilant about pain management considerations.

We are aware of the NQF-endorsed measure, #3316e, Safe use of opioids - concurrent prescribing, which was reviewed by the Patient Safety Standing Committee during the Fall 2017 Cycle. Specifically, #3316e evaluates, patients age 18 years and older prescribed two or more opioids or an opioid and benzodiazepine concurrently at discharge from a hospital-based encounter (inpatient or emergency department [ED], including observation stays). The PQA measure #3389 is related to #3316e conceptually because they both focus on concurrent prescribing of opioids and benzodiazepines. However, the measures do not use the same target population (denominator) and the data sources (claims vs. electronic health records), levels of analysis (health plan vs. facility) and settings (ambulatory vs. emergency department, inpatient/hospital) are distinctly different. PQA did not identify any competing measures (i.e., those that

addresses both the same measure focus and the same target population) that would necessitate harmonization of measure elements.

References

1. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. MMWR Recomm Rep. 2016;65(1):1-49. doi:10.15585/mmwr.rr6501e1.

2. US Food and Drug Administration. FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning. August 31, 2016. Available at: http://www.fda.gov/Drugs/DrugSafety/ucm518473.htm. Accessed: November 9, 2016.

3. Sun EC, Dixit A, Humphreys K, et al. Association between concurrent use of prescription opioids and benzodiazepines and overdose: retrospective analysis. BMJ. 2017;356:j760. doi: 10.1136/bmj.j760. PMID: 28292769

4. Gaither JR, Goulet JL, Becker WC, et al. The Association Between Receipt of Guideline-Concordant Long-Term Opioid Therapy and All-Cause Mortality. J Gen Intern Med 2016; 31:492

5. Dasgupta N, Funk MJ, Proescholdbell S, et al. Cohort Study of the Impact of High-Dose Opioid Analgesics on Overdose Mortality. Pain Med 2016; 17:85.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-17; N-0

CSAC Decision: Approved for endorsement on October 23, 2018.

9. Appeals

No appeals were received.

3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Submission | Specifications

Description: The percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

Numerator Statement: Beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year.

Denominator Statement: Number of Medicaid beneficiaries with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.

Exclusions: None.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Population : Regional and State

Setting of Care: Emergency Department and Services, Inpatient/Hospital, Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

STANDING COMMITTEE MEETING 6/14/2018

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-2; M-8; L-2; I-1**; 1b. Performance Gap: **H-7; M-7; L-0; I-0**

Rationale:

- The measure developer submitted a clinical practice guideline and six systematic reviews indicating pharmacotherapy for the treatment of opioid use disorder is proven effective.
- Performance gap is demonstrated with testing results based on 2014 Medicaid Analytic extract data from 16 states. Overall performance rate for pharmacotherapy use was 57.2% and the state-level scores ranged from 13.1% - 76.5% indicating wide variation.
- The Standing Committee discussed the omission of psychosocial support in the measure and agreed that it would be beneficial to include in future versions.
- The Committee questioned how the measure accounted for individuals who are in remission and not on pharmacotherapy. The developer responded that patients in remission tend to be on pharmacotherapy already and that they had excluded the remission cohort of patients in testing but there was minimal change.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-5; M-9; L-0; I-0** 2b. Validity: **H-1; M-10; L-2; I-1**

<u>Rationale</u>:

- Reliability and validity testing was based on Medicaid Analytic extract (MAX) 2014 data that included inpatient, other services, long term care, and drug files. Sixteen states were included in the testing.
- Signal-to-noise reliability analysis for the measure was highly reliable in terms of ability to distinguish the measure's performance in different states.
- Convergent validity was assessed by comparing performance of the measure with two other Healthcare Effectiveness Data and Information Set (HEDIS) alcohol or drug dependence measures. The state-level performances between this measure and the two HEDIS measures have a strong positive correlation – states with high or low substance use disorder rates respectfully tend to have high or low Initiation and engagement of treatment for alcohol and drug rates.
- Face validity was assessed via a multi-stakeholder technical expert panel of 19. Nine of the ten respondents agreed or strongly agreed the performance scores can be used to distinguish good from poor quality of care.
- The measure developer shared with the Committee that two states participating in the measure testing did not have methadone billing codes, so it is possible that there was under reporting.

3. Feasibility: H-6; M-7; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The measure is coded by someone other than the person obtaining original information. This measure requires gathering data from a variety of different data sources and may be complex for certain states to gather.
- All data elements are in defined fields in electronic claims.
- There are no fees or licensing requirements to use this measure, which is in the public domain.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-14; No Pass-0** 4b. Usability: **H-1; M-12; L-1; I-0**

<u>Rationale</u>:

- Adoption of the measure has the potential to improve the quality of care for Medicaid beneficiaries who have an opioid use disorder.
- The Standing Committee discussed unintended consequences for this measure pertaining to the risks of pharmacotherapy such as overdose or dependence and recommended surveillance to detect such harms be paired with the measure.

- CMS is considering implementation plans for this measure. The measure is currently intended for voluntary use by states to monitor and improve the quality of care.

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5. Related and Competing Measures

- No competing measures.
- The measure developer notes related measures stating that the specifications have been harmonized to the extent possible:
    - 3175 : Continuity of Pharmacotherapy for Opioid Use Disorder
    - Evidence of medication-assisted treatment (MAT) among patients with opioid use disorder (OUD) or OD, Steward: OptumLabs

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6. Standing Committee Recommendation for Endorsement: **Y-13**; **N-1**

7. Public and Member Comment

- Nine comments were received on this measure specific to feasibility and data collection, unintended consequences, and general support. One commenter expressed concern with how data collection may interfere with accurately calculating the measure and also cited drug-prescribing trends, state billing guidance, and data workflow as other interfering factors. Another commenter recommended that this measure assess the receipt of medication assisted therapy (MAT) within 30 days of a new OUD diagnosis (or within 30 days of the MAT initiation visit). As currently specified, this measure is a cross sectional analysis that is unsubstantiated by the evidence regarding the importance of MAT initiation. One comment was received noting that the measure is similar to an existing endorsed measure: #3175 *Continuity of Pharmacotherapy for Opioid Use.*
    - Developer response: We acknowledge the validity of this concern. Bundled payment and, more broadly, other alternative payment methodologies is a challenge that likely effects many claims-based measures, and we are not sure how common this is yet. We spoke with our technical expert panel and stakeholders from some of the states represented in the data we used to test the measure about this issue. They indicated that states are implementing ways of identifying services such as medication treatment in their alternate payment systems. The state officials we interviewed all indicated they bill outpatient treatment programs that provide methadone treatment and, with the exception of one state, are able to identify methadone use through claims. It seems likely that states who choose to implement this measure will either already have the ability to identify methadone or, like many of the stakeholders we interviewed, will implement ways of identifying the treatment. We plan as part of measure maintenance to look into how commonly states are using bundled payment for opioid use disorder, and how they identify specific services within bundles.

      NQF #3400 is intended to measure access to OUD pharmacotherapy, meaning it is an indicator of whether Medicaid beneficiaries initiate pharmacotherapy for OUD. While we recognize the commenter's desire to link a MAT initiation visit to receipt of MAT

within a specified time, currently the research evidence does not support a specified period of time after a new diagnosis within which medications should be initiated. We do not exclude patients in remission in the denominator. When we tested the measure in 16 state Medicaid programs, we found that 6.3% of beneficiaries had a diagnosis of opioid dependence in remission, in addition to another OUD diagnosis that would include them in the denominator anyway. Only 1.8% of beneficiaries (ranging by state from 1.2% to 3.4%) had opioid dependence in remission as their sole OUD diagnosis for the year. They were included in the denominator. While this measure is not intended as an OUD maintenance treatment only measure, we tested the sensitivity of the measure to restricting the denominator to maintenance only. To do this, we examined the extent to which we included patients with withdrawal management services (detoxification) in our denominator, and how measure performance changed when we excluded patients with this service. To be conservative, we eliminated all beneficiaries with any evidence of any drug detoxification in claims (10% of the original denominator). These beneficiaries could have had detoxification only or could have had detoxification and maintenance with pharmacotherapy. We found that restricting the denominator moved performance from 57.2% for all states to 58.1%, less than a one percentage point difference. This difference varied by state from 0 to 2.4 percentage points. We view this as a relatively small difference, balanced against the challenges states would have in defining withdrawal management services across settings. Therefore, in order to preserve feasibility of the measure and capture as many beneficiaries as possible, we specified the measure to include all beneficiaries with an OUD diagnosis. In addition, although the use of pharmacotherapy among Medicaid beneficiaries overall is higher than some might expect, our testing found that it ranges widely by state, from 13.1% to 76.0%, indicating room for improvement and importance of measuring. We agree that for young adults who may be seeking non-medical programs, we would not see the extent to which they are not using Medicaid as a source of funds, and thus not evident in claims. This measure is intended for use by Medicaid programs, and is not intended to measure services provided for individuals outside of Medicaid or services other than the described medications. We agree that there's variation in the type of medication Medicaid beneficiaries are able to access for treatment. The measure is specified to report the overall use of any OUD treatment medications in addition to differentiating between the four medications. CMS intends for this measure to be voluntary for Medicaid state programs, and identifying use of different medications is intended to support states in management of OUD, not penalize them for low proportions of specific medications. We agree that this wording creates confusion. "Dispensed" is a better term than "ordered," as this is a claims-based measure. We propose to change the wording when the measure undergoes the annual update.

Measures #3400: Use of pharmacotherapy for opioid use disorder (OUD) and #3175: Continuity of pharmacotherapy for opioid use have been identified as related by the developer. The Behavioral Health and Substance Use Committee will evaluate these measures during the post-comment call and provide guidance and recommendations.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-17; N-0

CSAC Decision: Approved for endorsement on October 23, 2018.

9. Appeals

No appeals were received.

Appendix B: Behavioral Health and Substance Use Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Programs
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Quality Rating System (QRS) (Implemented 2015)
0027	Medical Assistance With Smoking and Tobacco Use Cessation	Medicaid (Implemented 2018) Quality Rating System (QRS) (Implemented 2016)
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Medicare Shared Savings Program (MSSP) (Implemented 2012)
0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Million Hearts (Implemented 2018)
0104e	Adult Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
0105	Antidepressant Medication Management (AMM)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Quality Rating System (QRS) (Implemented 2016) Medicaid (Implemented 2018)
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Quality Rating System (QRS) (Implemented 2016) Medicaid (Implemented 2018)
0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Medicare Shared Savings Program (MSSP) (Implemented 2012) Merit-based Incentive Payment System (MIPS) (Finalized 2016) Medicaid (Implemented 2018)
0418e	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
0560	HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Hospital Compare (Implemented 2013) Inpatient Psychiatric Quality Reporting (Implemented 2013)

[a] Per CMS Measures Inventory Tool as of January 4, 2019.

NQF #	Title	Federal Programs
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Hospital Compare (Implemented 2015) Inpatient Psychiatric Facility Quality Reporting (Implemented 2015) Quality Rating System (QRS) (Implemented 2015) Medicaid (Implemented 2018)
0640	HBIPS-2 Hours of physical restraint use	Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)
0641	HBIPS-3 Hours of seclusion use	Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)
0710e	Depression Remission at Twelve Months (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicare Shared Savings Program (MSSP) (Implemented 2015)
0711	Depression Remission at Six Months	Merit-Based Incentive Payment System (MIPS) Program (Finalized 2016)
0712e	Depression Utilization of the PHQ-9 Tool (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
1365e	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
1651	TOB-1 Tobacco Use Screening	Hospital Compare (Implemented 2016) Inpatient Psychiatric Facility Quality Reporting (Implemented 2016; to be removed 2019)
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	Hospital Compare (Implemented 2016) Inpatient Psychiatric Hospital Facility Reporting (Implemented 2016)
1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Hospital Compare (Implemented 2017) Inpatient Psychiatric Hospital Facility Reporting (Implemented 2017)
1661	SUB-1 Alcohol Use Screening	Hospital Compare (Implemented 2015) Inpatient Psychiatric Facility Quality Reporting (Implemented 2015; to be removed 2019)

NQF #	Title	Federal Programs
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	Hospital Compare (Implemented 2017) Inpatient Psychiatric Facility Quality Reporting (Implemented 2017)
1664	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Inpatient Psychiatric Facility Quality Reporting (Implemented 2017)
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Medicaid (Implemented 2018)
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Medicaid (Implemented 2018)
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Merit-based Incentive Payment System (MIPS) (Finalized 2016)
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Medicaid (Implemented 2018)
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid (Implemented 2018)

Appendix C: Behavioral Health and Substance Use Standing Committee and NQF Staff

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Appendix D: Measure Specifications

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

STEWARD

PCPI

DESCRIPTION

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

TYPE

Process

DATA SOURCE

Electronic Health Records Not Applicable

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Emergency Department and Services, Other, Outpatient Services Behavioral Health Day Treatment

NUMERATOR STATEMENT

Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

NUMERATOR DETAILS

Time Period for Data Collection: At every visit where a new diagnosis or recurrent episode of Major Depressive Disorder is identified [initial evaluation during the episode]

Definition:

Suicide risk assessment - Must include questions about the following:

1) Suicidal ideation

2) Patient's intent of initiating a suicide attempt

AND, if either is present,

3) Patient plans for a suicide attempt

4) Whether the patient has means for completing suicide

GUIDANCE:

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped

to the concept “Intervention, Performed: Suicide Risk Assessment” included in the numerator logic in the attached HQMF in field

S.2a.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

DENOMINATOR STATEMENT

All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

Guidance:

This measure is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of major depressive disorder (MDD); every new or recurrent episode will count separately in the Initial Population.

It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (ie, at the initial evaluation). For the purposes of this measure, an episode of MDD would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for MDD, that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence.

The measure description outlined in the header for this measure states, 'patients aged 18 years and older' while the logic statement states, '>= 17 year(s) at: "Measurement Period"'. The logic statement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure. To ensure all patients with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS 177 covers children and adolescents aged 6 through 17, and CMS 161 covers the adult population aged 18 years and older.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

EXCLUSIONS

None

EXCLUSION DETAILS

Not Applicable

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

If the patient does not meet the numerator, this case represents a quality failure. 140560| 141015| 142428

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0105 Antidepressant Medication Management (AMM)

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of members 18 years of age and older who were treated antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported.

a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

TYPE

Process

DATA SOURCE

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via the Interactive Data Submission System (IDSS) portal.

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

Adults 18 years of age and older who were newly treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.

NUMERATOR DETAILS

a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of treatment with antidepressant medication (Table AMM-C) during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 231-day period following the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

TABLE AMM-C: ANTIDEPRESSANT MEDICATIONS

Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine

Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine

Phenylpiperazine antidepressants: Nefazodone, Trazodone

Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine

SNRI antidepressants : Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine

SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline

Tetracyclic antidepressants: Maprotiline, Mirtazapine

Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine

DENOMINATOR STATEMENT

Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.

DENOMINATOR DETAILS

Step 1: Determine the Index Prescription Start Date (IPSD). Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period (The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year).

Step 2: Required exclusion: Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting

during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Patients who meet any of the following criteria remain in the eligible population:

• An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:

– AMM Stand Alone Visits Value Set with Major Depression Value Set. with or without a telehealth modifier (Telehealth Modifier Value Set).

– AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). .

• Telephone Visits Value Set with Major Depression Value Set.

• An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).

• An acute or nonacute inpatient stay discharge with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges:

First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Second, identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.

Step 3: Test for Negative Medication History. Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 4: Calculate continuous enrollment. Patients must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

TABLE AMM-C: ANTIDEPRESSANT MEDICATIONS

Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine

Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine

Phenylpiperazine antidepressants: Nefazodone, Trazodone

Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine

SNRI antidepressants : Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine

SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline

Tetracyclic antidepressants: Maprotiline, Mirtazapine

Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine

*See corresponding Excel file for value sets referenced above.

EXCLUSIONS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.

Exclude patients who filled a prescription for an antidepressant 105 days prior to the IPSD.

EXCLUSION DETAILS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Patients who meet any of the following criteria remain in the eligible population:

• An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:

– AMM Stand Alone Visits Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

– AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

• Telephone Visits Value Set with Major Depression Value Set.

• An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).

• An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges:

First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Second, identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.

Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

*See corresponding Excel file for value sets referenced above.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

NCQA asks that health plans collect the measure data for each of the three product lines each year (i.e. commercial, Medicare, Medicaid) if applicable.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Determine the eligible population, or denominator.

Step 1a: Determine the Index Prescription Start Date (IPSD). Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period (the 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year).

Step 1b: Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.

Step 1c: Test for Negative Medication History. Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 1d: Calculate continuous enrollment. Exclude patients who are not continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Step 2: Determine the numerators for the two reported rates.

Step 2a (Effective Acute Phase Treatment): Identify at least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Step 2b (Effective Continuation Phase Treatment): Identify at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 232-day period following the IPSD. Continuous treatment allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Step 3: Calculate the two reported rates by dividing both the numerators from steps 2a and 2b by the denominator in step 1d.

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1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

STEWARD

Centers for Medicare and Medicaid Services

DESCRIPTION

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

TYPE

Process

DATA SOURCE

Claims The data source for the measure calculation required the following Medicare files depending on the level of accountability where the measure is being used:

- Denominator tables to determine individual enrollment
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME (durable medical equipment)
- Prescription drug benefit (Part D) claims
- Centers for Medicare and Medicaid Services (CMS) physician and physician specialty tables
- National Plan and Provider Enumeration System (NPPES) database

LEVEL

Clinician : Group/Practice, Health Plan, Population : Regional and State

SETTING

Outpatient Services

NUMERATOR STATEMENT

Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

NUMERATOR DETAILS

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

PDC NUMERATOR

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all antipsychotic medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends

beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

DENOMINATOR STATEMENT

Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

DENOMINATOR DETAILS

Target population meets the following conditions:

1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement period;

2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and,

3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement period.

IDENTIFICATION OF SCHIZOPHRENIA

Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of schizophrenia or schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

CODES USED TO IDENTIFY SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER DIAGNOSIS

Codes used to identify schizophrenia or schizoaffective disorder are included in the attached excel worksheet of codes (NQF_1879_Code Tables_2018_Final.xlsx) under the tab NQF_1879_Schizophrenia.

Table 1: Schizophrenia or Schizoaffective Disorder Diagnosis

ICD-9-CM: 295.xx

ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

CODES USED TO IDENTIFY ENCOUNTER TYPE:

Codes used to identify encounters are under tab NQF_1879_Encounter_types.

Table 2.1: Outpatient Setting

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

Table 2.2: Emergency Department Setting

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

Table 2.3: Non-Acute Inpatient Setting

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

Table 2.4: Acute Inpatient Setting

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

POS: 21, 51

IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR ANTIPSYCHOTIC MEDICATION:

Individuals with at least two prescription drug claims for any of the following oral antipsychotic medications (Table 3: Oral Antipsychotic Medications) or long-acting injectable antipsychotic

medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1879_ Antipsychotics of the attached excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.

TABLE 3: ORAL ANTIPSYCHOTIC MEDICATIONS

The following are oral formulations only.

Typical Antipsychotic Medications:

chlorpromazine

fluphenazine

haloperidol

loxapine

molindone

perphenazine

prochlorperazine

thioridazine

thiothixene

trifluoperazine

Atypical Antipsychotic Medications:

aripiprazole

asenapine

brexpiprazole

cariprazine

clozapine

iloperidone

lurasidone

olanzapine

paliperidone

quetiapine

quetiapine fumarate (Seroquel)

risperidone

ziprasidone

Antipsychotic Combinations:

perphenazine-amitriptyline

TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS

The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Typical Antipsychotic Medications:

fluphenazine decanoate (J2680)

haloperidol decanoate (J1631)

Atypical Antipsychotic Medications:

aripiprazole (J0401)

aripiprazole lauroxil (Aristada)

olanzapine pamoate (J2358)

paliperidone palmitate (J2426)

risperidone microspheres (J2794)

Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B:

fluphenazine decanoate (J2680) – 28 days' supply

haloperidol decanoate (J1631) – 28 days' supply

aripiprazole (J0401) – 28 days' supply

aripiprazole lauroxil (Aristada) - 28 days' supply

olanzapine pamoate (J2358) – 28 days' supply

paliperidone palmitate (J2426) – 28 days' supply

risperidone microspheres (J2794) – 14 days' supply

EXCLUSIONS

Individuals with any diagnosis of dementia during the measurement period.

EXCLUSION DETAILS

Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below tab NQF_1879_Dementia

Table 5: Codes Used to Identify Dementia

ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 292.82, 294.10, 294.11, 294.20, 294.21, 330.1, 331.0, 331.19, 331.82

ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F10.27, F11.122, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Depending on the operational use of the measure, measure results can be stratified by:

- State
- Physician Group*
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

*See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D.

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

CREATE DENOMINATOR:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.

2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.

3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).

4. Of those individuals identified in Step 3, keep individuals who had:

At least two encounters with a diagnosis of schizophrenia of schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

Individuals who had at least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

5. For the individuals identified in Step 4, extract Medicare Part D claims for any antipsychotic medication during the measurement period. Attach the generic name and the drug ID to the dataset.

6. Of the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any antipsychotic medication on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period.

7. Exclude those individuals with a diagnosis of dementia during the measurement period.

Numerator: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

CREATE NUMERATOR:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an antipsychotic medication in the measurement period.

2. Within the medication therapy period, count the days the individual was covered by at least one drug in the antipsychotic medication class based on the prescription drug claim service date and days of supply.

a. Sort and de-duplicate Medicare Part D antipsychotic medication claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.

b. Calculate the number of days covered by antipsychotic drug therapy per individual.

i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the antipsychotic medications. This is the numerator.

PHYSICIAN GROUP ATTRIBUTION:

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPIs) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPI. Valid NPIs have 10 numeric characters (no alpha characters).

2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.

3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.

4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).

5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare

Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)

a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.

b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.

c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

6. Identify TINs that are not solo practices.

a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.

b. Count unique NPIs per TIN.

c. Keep only those TINs having two or more providers.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).

8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.

9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.

a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.

b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.

a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year.

b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:

• A = working-age individual/spouse with an employer group health plan (EGHP)

• B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP

• G = working disabled for any month of the year

c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.

d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.

a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.

b. Exclude claims with no npi_prfrmg.

12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.

a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.

b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.

14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.

15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.

16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*

02—General surgery

03—Allergy/immunology

04—Otolaryngology

05—Anesthesiology

06—Cardiology

07—Dermatology

08—Family practice*

09—Interventional pain management

10—Gastroenterology

11—Internal medicine*

12—Osteopathic manipulative therapy

13—Neurology

14—Neurosurgery

16—Obstetrics/gynecology*

18—Ophthalmology

20—Orthopedic surgery

22—Pathology

24—Plastic and reconstructive surgery

25—Physical medicine and rehabilitation

26—Psychiatry*

28—Colorectal surgery

29—Pulmonary disease

30—Diagnostic radiology
33—Thoracic surgery
34—Urology
37—Nuclear medicine
38—Geriatric medicine*
39—Nephrology
39—Pediatric medicine
40—Hand surgery
44—Infectious disease
46—Endocrinology
50—Nurse practitioner*
66—Rheumatology
70—Multi-specialty clinic or group practice*
72—Pain management
76—Peripheral vascular disease
77—Vascular surgery
78—Cardiac surgery
79—Addiction medicine
81—Critical care (intensivists)
82—Hematology
83—Hematology/oncology
84—Preventive medicine*
85—Maxillofacial surgery
86—Neuropsychiatry*
90—Medical oncology
91—Surgical oncology
92—Radiation oncology
93—Emergency medicine
94—Interventional radiology
97—Physician assistant*
98—Gynecologist/oncologist
99—Unknown physician specialty
Other—NA
*Provider specialty codes specific to this measure

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1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

STEWARD

Centers for Medicare & Medicaid Services

DESCRIPTION

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).

TYPE

Process

DATA SOURCE

Claims For measure calculation in the Medicare product line, the following Medicare files were required:

- Denominator tables
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

For ACO attribution, the following were required:

- Denominator tables for Parts A and B enrollment
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

For physician group attribution, the following were required:

- Non-institutional claims (Part B)—physician carrier/non-DME
- Denominator tables to determine individual enrollment
- Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payor status
- CMS physician and physician specialty tables
- National Plan and Provider Enumeration System (NPPES) database

LEVEL

Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : Regional and State

SETTING

Outpatient Services

NUMERATOR STATEMENT

Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.

NUMERATOR DETAILS

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

PDC NUMERATOR

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all mood stabilizer medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

DENOMINATOR STATEMENT

Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).

DENOMINATOR DETAILS

Target population meets the following conditions:

1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement year;

2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement year; and,

3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement year.

IDENTIFICATION OF BIPOLAR I DISORDER

Individuals with bipolar I disorder are identified by having a diagnosis of bipolar I disorder within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period.

CODES USED TO IDENTIFY BIPOLAR I DISORDER DIAGNOSIS

Codes used to identify bipolar I disorder are included in the attached Excel worksheet of codes (NQF_1880_Code Tables_2018 Final) under the tab NQF_1880_Bipolar_ICD9-10.

TABLE 1. BIPOLAR I DISORDER DIAGNOSIS

ICD-9-CM: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7

ICD-10-CM: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.89, F31.9

CODES USED TO IDENTIFY ENCOUNTER TYPE

Codes used to identify encounters are under tab NQF_1880_Encounter_types.

TABLE 2.1. OUTPATIENT SETTING

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

TABLE 2.2. EMERGENCY DEPARTMENT SETTING

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

TABLE 2.3. NON-ACUTE INPATIENT SETTING

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

TABLE 2.4. ACUTE INPATIENT SETTING

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

POS: 21, 51

IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR MOOD STABILIZER MEDICATION

Individuals with at least two prescription drug claims for any of the following mood stabilizer medications (Table 3: Mood Stabilizer Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1880_Mood_Stabilizers of the attached Excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.

MOOD STABILIZER MEDICATIONS

TABLE 3. MOOD STABILIZER MEDICATIONS

Active ingredients listed below are limited to oral, buccal, sublingual, and translingual formulations only.

Anticonvulsants:

carbamazepine

divalproex sodium

lamotrigine

valproic acid

Atypical Antipsychotics:

aripiprazole

asenapine

cariprazine

lurasidone

olanzapine

quetiapine

quetiapine fumarate (Seroquel)

risperidone

ziprasidone

Phenothiazine/Related Antipsychotics:

chlorpromazine

loxapine succinate

Other Antipsychotics:

olanzapine-fluoxetine

Lithium Salts:

lithium carbonate

lithium citrate

TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS

The following are the long-acting (depot) injectable antipsychotic medications. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Atypical Antipsychotic Medications:

aripiprazole (J0401)

risperidone microspheres (J2794)

Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B:

aripiprazole (J0401) – 28 days' supply

risperidone microspheres (J2794) – 14 days' supply

EXCLUSIONS

Not Applicable

EXCLUSION DETAILS

Not Applicable

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Depending on the operational use of the measure, measure results may be stratified by:

- State
- Accountable Care Organization (ACOs)*
- Plan
- Physician Group**
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

*ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers.

**See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D.

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).

CREATE DENOMINATOR:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.

2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.

3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).

4. Of those individuals identified in Step 3, keep those who had:

At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period.

5. Of the individuals identified in Step 4, extract Medicare Part D claims for a mood stabilizer during the measurement period. Attach the drug ID and the generic name to the dataset.

6. For the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any mood stabilizer on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period.

Numerator: Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.

CREATE NUMERATOR:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for a mood stabilizer medication in the measurement period.

2. Within the medication therapy period, count the days the individual was covered by at least one drug in the mood stabilizer medication class based on the prescription drug claim service date and days of supply.

a. Sort and de-duplicate Medicare Part D claims for mood stabilizers by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic

name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.

b. Calculate the number of days covered by mood stabilizer therapy per individual.

i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

ii. If claims for the same drug (generic name) overlap, then adjust the latest prescription start date to be the day after the previous fill has ended.

iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the mood stabilizers. This is the numerator.

PHYSICIAN GROUP ATTRIBUTION:

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPIs. Valid NPIs have 10 numeric characters (no alpha characters).

2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.

3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.

4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).

5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)

a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.

b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.

c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

6. Identify TINs that are not solo practices.

a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.

b. Count unique NPIs per TIN.

c. Keep only those TINs having two or more providers.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).

8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.

9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.

a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.

b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.

a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year.

b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:

• A = working-age individual/spouse with an employer group health plan (EGHP)

• B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP

• G = working disabled for any month of the year

c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.

d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.

a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.

b. Exclude claims with no npi_prfrmg.

12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.

a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.

b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.

14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.

15. Attribute the individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.

16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*

02—General surgery

03—Allergy/immunology

04—Otolaryngology

05—Anesthesiology

06—Cardiology

07—Dermatology

08—Family practice*

09—Interventional pain management

10—Gastroenterology

11—Internal medicine*

12—Osteopathic manipulative therapy

13—Neurology

14—Neurosurgery

16—Obstetrics/gynecology*

18—Ophthalmology

20—Orthopedic surgery

22—Pathology

24—Plastic and reconstructive surgery

25—Physical medicine and rehabilitation

26—Psychiatry*

28—Colorectal surgery

29—Pulmonary disease

30—Diagnostic radiology

33—Thoracic surgery

34—Urology

36—Nuclear medicine

37—Pediatric medicine

38—Geriatric medicine*

39—Nephrology
40—Hand surgery
44—Infectious disease
46—Endocrinology
50—Nurse practitioner*
66—Rheumatology
70—Multi-specialty clinic or group practice*
72—Pain management
76—Peripheral vascular disease
77—Vascular surgery
78—Cardiac surgery
79—Addiction medicine
81—Critical care (intensivists)
82—Hematology
83—Hematology/oncology
84—Preventive medicine*
85—Maxillofacial surgery
86—Neuropsychiatry*
90—Medical oncology
91—Surgical oncology
92—Radiation oncology
93—Emergency medicine
94—Interventional radiology
97—Physician assistant*
98—Gynecologist/oncologist
99—Unknown physician specialty
Other—NA
*Provider specialty codes specific to this measure

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Not Applicable

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

TYPE

Process

DATA SOURCE

Claims This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

LEVEL

Health Plan, Integrated Delivery System, Population : Regional and State

SETTING

Other, Outpatient Services Any outpatient setting represented with Medicaid claims data

NUMERATOR STATEMENT

Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

NUMERATOR DETAILS

A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

See corresponding Excel document for the Glucose Tests Value Set and the HbA1c Tests Value Set.

DENOMINATOR STATEMENT

Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

DENOMINATOR DETAILS

Follow the steps below to identify the eligible population.

Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.

- At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:
  - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.
  - BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set.
  - BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set.

- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.
- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set.
- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Other Bipolar Disorder Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:

- BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.
- ED Value Set with Schizophrenia Value Set.
- BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria:

- BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set.
- BH Stand Alone Outpatient/PH/IOP Value Set with Other Bipolar Disorder Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Bipolar Disorder Value Set.
- ED Value Set with Bipolar Disorder Value Set.
- ED Value Set with Other Bipolar Disorder Value Set.
- BH ED Value Set with ED POS Value Set with Bipolar Disorder Value Set.
- BH ED Value Set with ED POS Value Set with Other Bipolar Disorder Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Bipolar Disorder Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Other Bipolar Disorder Value Set.

(See corresponding Excel document for the above value sets)

EXCLUSIONS

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients with diabetes during the measurement year or the year prior to the measurement year.

Exclude patients who had no antipsychotic medications dispensed during the measurement year.

EXCLUSION DETAILS

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Diabetes Medications List).

Claim/encounter data: Patients who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years).

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitaglipin

Exclude patients who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.

- Claim/encounter data. An antipsychotic medication (Long-Acting Injections Value Set).
- Pharmacy data. Dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List) on an ambulatory basis.

ANTIPSYCHOTIC MEDICATIONS:

(Antipsychotic Medications List)

Miscellaneous antipsychotic agents:

Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone

Phenothiazine antipsychotics:

Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine

Thioxanthenes:

Thiothixene

Long-acting injections:

Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone

(Antipsychotic Combination Medications List)

Psychotherapeutic combinations:

Fluoxetine-olanzapine, Perphenazine-amitriptyline

See corresponding Excel document for the value sets referenced above.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

None.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year.

Step 2. Search for an exclusion in the patient's history: Exclude patients from the eligible population if they meet the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
- Patients with diabetes during the measurement year or the year prior to the measurement year.
- Patients who had no antipsychotic medications dispensed during the measurement year.

Step 3. Determine the numerator: the number of patients who had a diabetes screening test during the measurement year.

Step 4. Calculate the rate.

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1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

TYPE

Process

DATA SOURCE

Claims This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

LEVEL

Health Plan, Integrated Delivery System, Population : Regional and State

SETTING

Outpatient Services

NUMERATOR STATEMENT

An LDL-C test performed during the measurement year.

NUMERATOR DETAILS

An LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

- See corresponding Excel document for the LDL-C Tests Value Set

The organization may use a calculated or direct LDL.

DENOMINATOR STATEMENT

Patients 18-64 years of age as of the end of the measurement year (e.g., December 31) with a diagnosis of schizophrenia and cardiovascular disease.

DENOMINATOR DETAILS

Follow the steps below to identify the eligible population.

Step 1: Identify patients with schizophrenia as those who met at least one of the following criteria during the measurement year:

• At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:

– BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.

– BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:

– BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.

– BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.

– ED Value Set with Schizophrenia Value Set.

– BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.

– BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.

– BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set

Step 2: Identify patients from step 1 who also have cardiovascular disease. Members are identified as having cardiovascular disease in two ways: by event or by diagnosis. The organization must use both methods to identify the eligible population, but a patient need only be identified by one to be included in the measure.

Event. Any of the following during the year prior to the measurement year meet criteria:

• AMI. Discharged from an inpatient setting with an AMI (AMI Value Set). To identify discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Identify the discharge date for the stay.

• CABG. Members who had CABG (CABG Value Set) in any setting.

• PCI. Members who had PCI (PCI Value Set) in any setting (e.g., inpatient, outpatient, ED).

Diagnosis. Identify members with IVD as those who met at least either 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 outpatient visit (Outpatient Value Set) with a diagnosis of IVD (IVD Value Set).

• At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of IVD (IVD Value Set).

(See corresponding Excel document for the above value sets)

EXCLUSIONS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

EXCLUSION DETAILS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year with a diagnosis of schizophrenia and cardiovascular disease

Step 2. Determine the numerator: the number of patients who had an LDL-C test during the measurement year

Step 3. Calculate the rate.

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1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of patients 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

TYPE

Process

DATA SOURCE

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

LEVEL

Health Plan, Integrated Delivery System, Population : Regional and State

SETTING

Outpatient Services

NUMERATOR STATEMENT

One or more HbA1c tests and one or more LDL-C tests performed during the measurement year.

NUMERATOR DETAILS

An HbA1c test (HbA1c Tests Value Set) and an LDL-C test (LDL-C Tests Value Set) performed during the measurement year (on the same or different dates of service), as identified by claim/encounter or automated laboratory data. The patient must have both tests to be included in the numerator. The organization may use a calculated or direct LDL.

See corresponding Excel document for the LDL-C Tests Value Set and the HbA1c Tests Value Set

DENOMINATOR STATEMENT

Patients age 18-64 years of age as of the end of the measurement year (e.g. December 31) with a schizophrenia and diabetes diagnosis.

DENOMINATOR DETAILS

Follow the steps below to identify the eligible population.

Step 1: Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year:

• At least one acute inpatient encounter, with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:

- BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.

- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:

- BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.

- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.

- ED Value Set with Schizophrenia Value Set.

- BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.

- BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.

- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set.

Step 2 Identify members from step 1 who also have diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member need only be identified by one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.
- At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set).

Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

(See corresponding Excel document for the above value sets)

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitaglipin

EXCLUSIONS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

EXCLUSION DETAILS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Optional exclusion: Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

If a member was identified as a diabetic based on claim or encounter data, as described in step 2 of S.7, the optional exclusions do not apply because the member had a diagnosis of diabetes.

See corresponding Excel document for the value sets referenced above.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

None.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year

Step 2. Search for an optional exclusion in the patient's history: Exclude patients from the eligible population if the eligible population if they meet the following criteria:

- Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
- Exclude patients who do not have a diagnosis of diabetes during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or

steroid-induced diabetes during the measurement year or the year prior to the measurement year.

Step 3. Determine the numerator: the number of patients who have one or more HbA1c tests and one or more LDL-C tests performed during the measurement year.

Step 4. Calculate the rate.

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3389 Concurrent Use of Opioids and Benzodiazepines (COB)

STEWARD

PQA, Inc.

DESCRIPTION

The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year.

A lower rate indicates better performance.

TYPE

Process

DATA SOURCE

Claims Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs)

LEVEL

Health Plan

SETTING

Other The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.

NUMERATOR STATEMENT

The number of individuals from the denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year.

NUMERATOR DETAILS

The number of individuals from the denominator with:

- 2 or more prescription claims for any benzodiazepine with unique dates of service, AND
- Concurrent use of opioids and benzodiazepines for 30 or more cumulative days.

Complete the steps below to identify individuals with concurrent use of opioids and benzodiazepines:

Step 1: From the denominator population, identify individuals with 2 or more prescriptions claims on unique dates of service for any benzodiazepine (Table COB-B, below) during the measurement year.

Step 2: Of the population identified in Step 1, determine the total days of overlap (concurrent use) between the opioid and benzodiazepine prescriptions during the measurement year.

- Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of overlap that occur after the end of the measurement year.

Step 3: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator.

Note: When identifying days' supply for opioids (or benzodiazepines):

- Exclude any days' supply that occur after the end of the measurement year.
- Multiple prescription claims with the same date of service: If multiple prescription claims for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

Table COB-B: Benzodiazepines:

Alprazolam, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, estazolam, flurazepam, lorazepam, midazolam, oxazepam, quazepam, temazepam, triazolam

(note: excludes injectable formulations)

DENOMINATOR STATEMENT

The denominator includes individuals 18 years and older with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days' supply is 15 or more days. Individuals with cancer or in hospice are excluded.

DENOMINATOR DETAILS

The denominator includes individuals 18 years and older by the first day of the measurement year with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days' supply is 15 or more days. Use Table COB-A: Opioids, below, to identify the opioid medications for the measure.

Complete the steps below to determine the denominator:

Step 1: Identify individuals aged 18 years and older as of the first day of the measurement year

Step 2: Of those identified in step 1, identify individuals meeting the continuous enrollment criteria.

- To be continuously enrolled, an individual may have no more than one gap in enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Step 3: Of those identified in step 2, identify individuals with 2 or more prescription claims for opioids on unique dates of service, for which the sum of the days' supply is 15 or more days' supply during the measurement year.

Step 4: Of those identified in step 3, identify individuals where the earliest prescription for an opioid (i.e. Index Prescription Start Date [IPSD]) is 30 or more days from the last day of the measurement year (January 1 through December 2)

Note: When identifying days' supply for opioids:

- Exclude any days' supply that occur after the end of the measurement year.
- Multiple prescription claims with the same date of service: If multiple prescription claims for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

Table COB-A: Opioids:

buprenorphine, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol

(note: excludes injectable formulations; includes prescription opioid cough medications; excludes single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

EXCLUSIONS

Individuals with cancer or in hospice at any point during the measurement year are excluded from the denominator.

EXCLUSION DETAILS

Hospice exclusion: Exclude any individual in hospice during the measurement year. To identify individuals in hospice:

- Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or
- Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid)

Cancer exclusion: Exclude any individuals with cancer during the measurement year. To identify individuals with cancer:

- Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
- For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

The measure is stratified by the following lines of business for the health plan:

- Commercial
- Medicare
- Medicaid

Medicare Plans are further stratified by Low-Income Subsidy (LIS) status.

LIS is a subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency.

The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify LIS status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.

TYPE SCORE

Rate/proportion better quality = lower score

ALGORITHM

A. Target population (denominator):

Step 1: Identify individuals aged 18 years and older as of the first day of the measurement year

Step 2: Of those identified in step 1, identify individuals meeting the continuous enrollment criteria.

- To be continuously enrolled, an individual may have no more than one gap in enrollment of up to 31 days during the measurement year. When enrollment is verified

monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Step 3: Of those identified in step 2, identify individuals with 2 or more prescription claims for opioids on unique dates of service, for which the sum of the days' supply is 15 or more days' supply during the measurement year.

Step 4: Of those identified in step 3, identify individuals where the earliest prescription for an opioid (i.e. Index Prescription Start Date [IPSD]) is 30 or more days from the last day of the measurement year (January 1 through December 2)

Note: When identifying days' supply for opioids:

- Exclude any days' supply that occur after the end of the measurement year.
- Multiple prescription claims with the same date of service: If multiple prescription claims for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

Step 5: Identify individuals with cancer or in hospice during the measurement year.

To identify individuals in hospice:

- Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or
- Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid)

To identify individuals with cancer:

- Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
- For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

Step 6: Exclude individuals with cancer or in hospice (Step 5) from those identified in Step 4. This is the denominator.

B. Numerator Population:

Step 7: From the denominator population (from Step 6), identify individuals with 2 or more prescriptions claims on unique dates of service for any benzodiazepine during the measurement year.

Step 8: Of the population identified in Step 7, determine the total days of overlap (concurrent use) between the opioid and benzodiazepine prescriptions during the measurement year.

- Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of overlap that occur after the end of the measurement year.

Step 9: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator.

Note: When identifying days' supply for opioids (or benzodiazepines):

- Exclude any days' supply that occur after the end of the measurement year.
- Multiple prescription opioid (or benzodiazepine) claims with overlap: For multiple prescription claims for opioids (or benzodiazepines) with overlapping days' supply, count each day in the measurement year only once toward the denominator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines).

C. Measure Rate:

Step 10: Divide the number of individuals in the numerator (Step 9) by the denominator (Step 6) and multiply by 100. This is the measure rate reported as a percentage.

- Report the rates separately by line of business (e.g. Medicare, Medicaid, Commercial). For Medicare, report rates for low-income subsidy (LIS) and non-LIS populations separately.

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3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

STEWARD

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

DESCRIPTION

The percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

TYPE

Process

DATA SOURCE

Claims Medicaid Alpha-MAX 2014 data: eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided.

LEVEL

Population : Regional and State

SETTING

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

NUMERATOR STATEMENT

Beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year.

NUMERATOR DETAILS

Beneficiaries identified as filling a prescription for or were administered or ordered an FDA-approved medication for OUD, during the 12-month measure year, through pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. Only formulations with an OUD indication (not pain management) are included in measure calculation.

The measure will be calculated both overall and stratified by four medications/mode of administration: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. NDC codes listed are codes that were used in testing and are current as of June 2017.

DENOMINATOR STATEMENT

Number of Medicaid beneficiaries with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.

DENOMINATOR DETAILS

Medicaid beneficiaries age 18 through 64, enrolled for full 12 months of measurement year, and had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-9 and ICD-10 codes for OUD are provided in the attached Excel file in required format at S.2b.

EXCLUSIONS

None.

EXCLUSION DETAILS

Not applicable.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

The measure will be calculated both overall and stratified by four medications/mode of administration: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

The NDC pharmacy codes used to identify the FDA-approved medications for OUD are listed in an Excel file attached in S.2b.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Identify denominator

Identify Medicaid beneficiaries age 18 through 64 years with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (primary or other diagnosis) during the measurement year and continuously enrolled during the measurement year. Age is calculated as of January 1 of the measurement year.

Step 2: Identify the numerator as beneficiaries with evidence of at least one prescription filled, or were administered or ordered an FDA-approved medication for the disorder during the measurement year.

The measure will report any medications used in MAT of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

Step 2A: Identify beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year.

Step 2B: Identify beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year.

Step 2C: Identify beneficiaries with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year.

Step 2D: Identify beneficiaries with evidence of at least one prescription for methadone at any point during the measurement year.

Note: Pharmacotherapy for opioid abuse, dependence, or remission prescriptions and procedures, might occur in several files. Similarly, a diagnosis of opioid abuse, dependence, or remission might occur in several files. For example, one claims file may contain injectables while another claims file may contain oral medications. Consequently, pharmacotherapy and opioid abuse, dependence, or remission variables are created separately in each source and then merged by beneficiary ID.

Step 3: Calculate the overall rate by dividing the number of beneficiaries with evidence of at least one prescription (Step 2) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1). Then, calculate rates separately for each of the four medications.

Step 3A: Calculate the buprenorphine prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for buprenorphine during the measurement year (Step 2A) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).

Step 3B: Calculate the oral naltrexone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for oral naltrexone during the measurement year (Step 2B) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).

Step 3C: Calculate the long-acting, injectable naltrexone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for injectable naltrexone during the measurement year (Step 2C) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).

Step 3D: Calculate the methadone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for methadone during the measurement year (Step 2D) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).

Appendix E1: Related and Competing Measures (tabular format)

Comparison of NQF #0104e and NQF #1365e

	0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Steward	Centers for Medicare and Medicaid Services	PCPI
Description	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	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
Type	Process	Process
Data Source	Electronic Health Records Not Applicable No data collection instrument provided Attachment 0104_MDD_SuicideRisk_ValueSets_2017September29.xlsx	Electronic Health Records Not Applicable No data collection instrument provided Attachment EP_EC_CMS177v6_NQF1365_CAMDD_SuicideRisk_ValueSets.xlsx
Level	Clinician : Group/Practice, Clinician : Individual	Clinician : Group/Practice, Clinician : Individual
Setting	Emergency Department and Services, Other, Outpatient Services Behavioral Health Day Treatment	Outpatient Services
Numerator Statement	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	Patient visits with an assessment for suicide risk
Numerator Details	Time Period for Data Collection: At every visit where a new diagnosis or recurrent episode of Major Depressive Disorder is identified [initial evaluation during the episode] Definition: Suicide risk assessment - Must include questions about the following: 1) Suicidal ideation 2) Patient's intent of initiating a suicide attempt AND, if either is present, 3) Patient plans for a suicide attempt 4) Whether the patient has means for completing suicide GUIDANCE: Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept “Intervention, Performed: Suicide Risk Assessment” included in the numerator logic in the attached HQMF in field S.2a. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.	Time Period for Data Collection: At each visit for major depressive disorder during the measurement period. HQMF eCQM developed and is attached to this submission in field S.2a. We have provided the following definitions and/or guidance for convenience; please see HQMF eCQM for complete details related to the specification. NUMERATOR DEFINITION: The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate: 1. Risk (eg, age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (eg, religious belief, concern not to hurt family) that may influence the desire to attempt suicide. 2. Current severity of suicidality. 3. Most severe point of suicidality in episode and lifetime. Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used. NUMERATOR GUIDANCE: A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period. Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed: Suicide Risk Assessment" included in the numerator logic in the HQMF eCQM attached in field S.2a.
Denominator Statement	All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder
Denominator Details	Time Period for Data Collection: 12 consecutive months Guidance: This measure is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of major depressive disorder (MDD); every new or recurrent episode will count separately in the Initial Population. It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (ie, at the initial evaluation). For the purposes of this measure, an episode of MDD would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for MDD, that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence. The measure description outlined in the header for this measure states, 'patients aged 18 years and older' while the logic statement states, '>= 17 year(s) at: "Measurement Period"'. The logic statement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure. To ensure all patients with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS 177 covers children and adolescents aged 6 through 17, and CMS 161 covers the adult population aged 18 years and older. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.	Time Period for Data Collection: 12 consecutive months. HQMF eCQM developed and is attached to this submission in field S.2a. We have provided the following definitions and/or guidance for convenience; please see HQMF eCQM for complete details related to the specification. DENOMINATOR DEFINITION: None DENOMINATOR GUIDANCE: This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment.
Exclusions	None	None
Exclusion Details	Not Applicable	N/A

	0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator If the patient does not meet the numerator, this case represents a quality failure.	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who meet the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator If the patient does not meet the numerator, this case represents a quality failure.
Submission items	5.1 Identified measures: 1365 : Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The guidelines used as evidence in the NQF 1365: Child and Adolescent Major Depressive Disorder (MDD) Suicide Risk Assessment explicitly recommend suicide assessment at every visit for MDD whereas the guidelines used for evidence in this measure do not emphasize this level of assessment frequency. 5b.1 If competing, why superior or rationale for additive value: Both of these measures (0104 and 1365) were developed by PCPI and updated and harmonized with each other on an annual basis. They are not competing because they are used in different patient populations and have different frequencies of suicide assessment based on their respective evidence.	5.1 Identified measures: 0104 : Adult Major Depressive Disorder (MDD): Suicide Risk Assessment 0111 : Bipolar Disorder: Appraisal for risk of suicide 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Our measure addresses a different target population, children and adolescents with MDD, from the related measures that focus on adults with MDD and patients with bipolar disorder. As a result, the recommended frequency of suicide assessment is different in our measure from the other measures. 5b.1 If competing, why superior or rationale for additive value: Because our measure emphasizes a different target population and a different type/frequency of assessment, we feel multiple measures are justified to address suicide risk assessment differently in different high-risk populations.

Comparison of NQF #0105 and NQF #1880

	0105 Antidepressant Medication Management (AMM)	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance
Description	The percentage of members 18 years of age and older who were treated antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months). a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).
Type	Process	Process
Data Source	Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via the Interactive Data Submission System (IDSS) portal. No data collection instrument provided Attachment 0105_AMM_Value_Sets_updated_4.11.18.xlsx	Claims For measure calculation in the Medicare product line, the following Medicare files were required: • Denominator tables • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME • Prescription drug benefit (Part D) claims For ACO attribution, the following were required: • Denominator tables for Parts A and B enrollment • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME

	0105 Antidepressant Medication Management (AMM)	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
		• Prescription drug benefit (Part D) claims For physician group attribution, the following were required: • Non-institutional claims (Part B)—physician carrier/non-DME • Denominator tables to determine individual enrollment • Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payor status • CMS physician and physician specialty tables • National Plan and Provider Enumeration System (NPPES) database No data collection instrument provided Attachment NQF_1880_Code_Tables_2018_Final.xlsx
Level	Health Plan	Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : Regional and State
Setting	Outpatient Services	Outpatient Services
Numerator Statement	Adults 18 years of age and older who were newly treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.	Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.
Numerator Details	a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of treatment with antidepressant medication (Table AMM-C) during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 231-day period following the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. TABLE AMM-C: ANTIDEPRESSANT MEDICATIONS Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine Phenylpiperazine antidepressants: Nefazodone, Trazodone Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine SNRI antidepressants : Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline Tetracyclic antidepressants: Maprotiline, Mirtazapine Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine	The numerator is defined as individuals with a PDC of 0.8 or greater. The PDC is calculated as follows: PDC NUMERATOR The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all mood stabilizer medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended. PDC DENOMINATOR The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.
Denominator Statement	Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.	Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).
Denominator Details	Step 1: Determine the Index Prescription Start Date (IPSD). Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period (The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year). Step 2: Required exclusion: Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Patients who meet any of the following criteria remain in the eligible population: • An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria: – AMM Stand Alone Visits Value Set with Major Depression Value Set. with or without a telehealth modifier (Telehealth Modifier Value Set). – AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). . • Telephone Visits Value Set with Major Depression Value Set. • An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).	Target population meets the following conditions: 1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement year; 2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement year; and, 3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement year. IDENTIFICATION OF BIPOLAR I DISORDER Individuals with bipolar I disorder are identified by having a diagnosis of bipolar I disorder within the inpatient or outpatient claims data. Individuals must have: At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period. CODES USED TO IDENTIFY BIPOLAR I DISORDER DIAGNOSIS Codes used to identify bipolar I disorder are included in the attached Excel worksheet of codes (NQF_1880_Code Tables_2018 Final) under the tab NQF_1880_Bipolar_ICD9-10. TABLE 1. BIPOLAR I DISORDER DIAGNOSIS ICD-9-CM: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7 ICD-10-CM: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70,

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	• An acute or nonacute inpatient stay discharge with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges: First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Second, identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria. Step 3: Test for Negative Medication History. Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD. Step 4: Calculate continuous enrollment. Patients must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD. TABLE AMM-C: ANTIDEPRESSANT MEDICATIONS Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine Phenylpiperazine antidepressants: Nefazodone, Trazodone Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine SNRI antidepressants : Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline Tetracyclic antidepressants: Maprotiline, Mirtazapine Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine *See corresponding Excel file for value sets referenced above.	F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.89, F31.9 CODES USED TO IDENTIFY ENCOUNTER TYPE Codes used to identify encounters are under tab NQF_1880_Encounter_types. TABLE 2.1. OUTPATIENT SETTING Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 TABLE 2.2. EMERGENCY DEPARTMENT SETTING CPT: 99281-99285 UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 23 TABLE 2.3. NON-ACUTE INPATIENT SETTING CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 HCPCS: H0017-H0019, T2048 UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 31, 32, 56 TABLE 2.4. ACUTE INPATIENT SETTING UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH POS: 21, 51 IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR MOOD STABILIZER MEDICATION Individuals with at least two prescription drug claims for any of the following mood stabilizer medications (Table 3: Mood Stabilizer Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1880_Mood_Stabilizers of the attached Excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period. MOOD STABILIZER MEDICATIONS TABLE 3. MOOD STABILIZER MEDICATIONS Active ingredients listed below are limited to oral, buccal, sublingual, and translingual formulations only. Anticonvulsants: carbamazepine divalproex sodium lamotrigine valproic acid Atypical Antipsychotics: aripiprazole asenapine cariprazine lurasidone olanzapine quetiapine quetiapine fumarate (Seroquel) risperidone

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		ziprasidone Phenothiazine/Related Antipsychotics: chlorpromazine loxapine succinate Other Antipsychotics: olanzapine-fluoxetine Lithium Salts: lithium carbonate lithium citrate TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS The following are the long-acting (depot) injectable antipsychotic medications. The route of administration includes all injectable and intramuscular formulations of the medications listed below. Atypical Antipsychotic Medications: aripiprazole (J0401) risperidone microspheres (J2794) Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B: aripiprazole (J0401) – 28 days' supply risperidone microspheres (J2794) – 14 days' supply
Exclusions	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Exclude patients who filled a prescription for an antidepressant 105 days prior to the IPSD.	Not Applicable
Exclusion Details	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set). Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Patients who meet any of the following criteria remain in the eligible population: • An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria: – AMM Stand Alone Visits Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • Telephone Visits Value Set with Major Depression Value Set. • An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set). • An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges: First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Second, identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria. --- Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD. *See corresponding Excel file for value sets referenced above.	Not Applicable
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	NCQA asks that health plans collect the measure data for each of the three product lines each year (i.e. commercial, Medicare, Medicaid) if applicable.	Depending on the operational use of the measure, measure results may be stratified by: • State • Accountable Care Organization (ACOs)* • Plan • Physician Group** • Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years

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		• Race/Ethnicity • Dual Eligibility *ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers. **See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population, or denominator. Step 1a: Determine the Index Prescription Start Date (IPSD). Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period (the 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year). Step 1b: Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Step 1c: Test for Negative Medication History. Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD. Step 1d: Calculate continuous enrollment. Exclude patients who are not continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD. Step 2: Determine the numerators for the two reported rates. Step 2a (Effective Acute Phase Treatment): Identify at least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Step 2b (Effective Continuation Phase Treatment): Identify at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 232-day period following the IPSD. Continuous treatment allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Step 3: Calculate the two reported rates by dividing both the numerators from steps 2a and 2b by the denominator in step 1d.	Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D. Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months). CREATE DENOMINATOR: 1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period. 2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period. 3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only). 4. Of those individuals identified in Step 3, keep those who had: At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period. 5. Of the individuals identified in Step 4, extract Medicare Part D claims for a mood stabilizer during the measurement period. Attach the drug ID and the generic name to the dataset. 6. For the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any mood stabilizer on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period. Numerator: Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications. CREATE NUMERATOR: For the individuals in the denominator, calculate the PDC for each individual according to the following methods: 1. Determine the individual's medication therapy period, defined as the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for a mood stabilizer medication in the measurement period. 2. Within the medication therapy period, count the days the individual was covered by at least one drug in the mood stabilizer medication class based on the prescription drug claim service date and days of supply. a. Sort and de-duplicate Medicare Part D claims for mood stabilizers by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply. b. Calculate the number of days covered by mood stabilizer therapy per individual. i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. ii. If claims for the same drug (generic name) overlap, then adjust the latest prescription start date to be the day after the previous fill has ended. iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date. 3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1. An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf. 4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the mood stabilizers. This is the numerator. PHYSICIAN GROUP ATTRIBUTION: Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project:

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		Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not. I. Identify Physician and Medical Groups 1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPIs. Valid NPIs have 10 numeric characters (no alpha characters). 2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables. 3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty. 4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP). 5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.) a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year. b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code. c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 6. Identify TINs that are not solo practices. a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year. b. Count unique NPIs per TIN. c. Keep only those TINs having two or more providers. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices). 8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs. 9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants. a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty. b. The specialty with the maximum count is assigned to the medical group. II. Identify Individual Sample and Claims 10. Create individual sample. a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year. b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following: • A = working-age individual/spouse with an employer group health plan (EGHP) • B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP • G = working disabled for any month of the year c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C. d. Exclude individuals who enter the Medicare hospice at any point during the measurement year. e. Exclude individuals who died during the measurement year. 11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year. a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245. b. Exclude claims with no npi_prfrmg. 12. Attach medical group TIN to claims by NPI. III. Patient Attribution 13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and

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		specialty codes below). Attribute each individual to at most one medical group TIN for each measure. a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields. b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9. 14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims. 15. Attribute the individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim. 16. Attach the medical group TIN to the denominator and numerator files by individual. Provider Specialties and Specialty Codes Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below: 01—General practice* 02—General surgery 03—Allergy/immunology 04—Otolaryngology 05—Anesthesiology 06—Cardiology 07—Dermatology 08—Family practice* 09—Interventional pain management 10—Gastroenterology 11—Internal medicine* 12—Osteopathic manipulative therapy 13—Neurology 14—Neurosurgery 16—Obstetrics/gynecology* 18—Ophthalmology 20—Orthopedic surgery 22—Pathology 24—Plastic and reconstructive surgery 25—Physical medicine and rehabilitation 26—Psychiatry* 28—Colorectal surgery 29—Pulmonary disease 30—Diagnostic radiology 33—Thoracic surgery 34—Urology 36—Nuclear medicine 37—Pediatric medicine 38—Geriatric medicine* 39—Nephrology 40—Hand surgery 44—Infectious disease 46—Endocrinology 50—Nurse practitioner* 66—Rheumatology 70—Multi-specialty clinic or group practice* 72—Pain management 76—Peripheral vascular disease 77—Vascular surgery 78—Cardiac surgery 79—Addiction medicine 81—Critical care (intensivists) 82—Hematology 83—Hematology/oncology 84—Preventive medicine* 85—Maxillofacial surgery 86—Neuropsychiatry* 90—Medical oncology 91—Surgical oncology 92—Radiation oncology 93—Emergency medicine 94—Interventional radiology 97—Physician assistant* 98—Gynecologist/oncologist 99—Unknown physician specialty Other—NA *Provider specialty codes specific to this measure

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Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: N/A 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease 0542 : Adherence to Chronic Medications 0545 : Adherence to Statins for Individuals with Diabetes Mellitus 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category 0580 : Bipolar antimanic agent 0109 : Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors 0110 : Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use 0111 : Bipolar Disorder: Appraisal for risk of suicide 0112 : Bipolar Disorder: Level-of-function evaluation 0003 : Bipolar Disorder: Assessment for diabetes 1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia 1927 : Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications 1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879) and the NCQA version of the same measure (Adherence to Antipsychotic Medications for Individuals with Schizophrenia), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in all three measures. The methodology used to identify the denominator population is also calculated the same in all three measures, with the exception of the clinical conditions which is the target of the measure. The data collection burden is identical for the measures. The only differences between Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879), and the related NCQA measure are: (1) the clinical codes used to identify the different populations in each measure (NQF #1880 – individuals with bipolar I disorder; NQF #1879 and NCQA measure– individuals with schizophrenia); (2) the medications includes in each measure (NQF #1880-mood stabilizers; NQF #1879 and the NCQA measure– antipsychotics); and, (3) an exclusion for dementia which is included in NQF #1879 and the NCQA measure but not in NQF #1880. The rationale for these difference is due to the different clinical focus of each measure. There is no impact on interpretability since the measures clearly identify the disparate clinical focus. During development the measure developers worked to harmonize this measure with other measures which were NQF-endorsed at the time of development. The section below is from the original submission of the measure for initial endorsement and refers to measures which are no longer NQF-endorsed. We are including this language to demonstrate the efforts of the measure developers to harmonize this measure with other measures. MEASURES WITH WHICH THE MEASURE IS HARMONIZED. The measure has been harmonized where feasible with NQF #0542, #0543, #0545, #0541, #1879, #1927, and #1932 MEASURES WITH WHICH THE MEASURE IS NOT HARMONIZED. The measure specifications of the measure are not harmonized with the following NQF-endorsed measures that have the same measure focus (use of mood stabilizers among patients with Bipolar Disorder): NQF #0580 Bipolar antimanic agent. DIFFERENCES BETWEEN MEASURE 1880 AND MEASURE 0580. One NQF-endorsed measure (NQF #0580) focuses on a similar concept, but differs from this measure in two important ways. First, the NQF-endorsed measure includes individuals with newly diagnosed bipolar disorder and major depressive disorder. However, this measure includes all individuals with bipolar I disorder, not just those who are newly diagnosed, and does not include individuals with major depressive disorder. Second, the NQF-endorsed measure identifies the percentage of eligible individuals who have received at least 1 prescription for a mood-stabilizing agent during the measurement year, while this measure measures the percentage of eligible individuals with a proportion of days covered (PDC) for mood stabilizer medications greater than 0.8 during the measurement year. RATIONALE. This measure is an improved measure that adds value because it measures adherence to mood stabilizer treatment for individuals with bipolar I disorder. In contrast, the NQF measure (NQF# 0580) is linked to a one-time prescription for mood stabilizer treatment. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN. Differences have not been identified concerning the data collection burden between Measure 1880 and Measure 0580. However, interpretability for Measure 1880 (as compared to NQF #0580) is improved because Measure 1880 focuses on adherence rather than a single prescription, and Measure 1880 is harmonized with the majority of adherence measures for other chronic diseases in the NQF portfolio and those that are being publicly reported by CMS. 5b.1 If competing, why superior or rationale for additive value: This measure does not address both the same measure focus and population as another NQF-endorsed measure.

Comparison of NQF #1879, NQF #1880, NQF #0541

	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
Steward	Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services	National Committee for Quality Assurance	Pharmacy Quality Alliance
Description	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).	The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, Statins. A higher score indicates better quality.
Type	Process	Process	Process
Data Source	Claims The data source for the measure calculation required the following Medicare files depending on the level of accountability where the measure is being used: • Denominator tables to determine individual enrollment • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME (durable medical equipment) • Prescription drug benefit (Part D) claims • Centers for Medicare and Medicaid Services (CMS) physician and physician specialty tables • National Plan and Provider Enumeration System (NPPES) database No data collection instrument provided Attachment NQF_1879_Code_Tables_2018_Final.xlsx	Claims For measure calculation in the Medicare product line, the following Medicare files were required: • Denominator tables • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME • Prescription drug benefit (Part D) claims For ACO attribution, the following were required: • Denominator tables for Parts A and B enrollment • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME • Prescription drug benefit (Part D) claims For physician group attribution, the following were required: • Non-institutional claims (Part B)—physician carrier/non-DME • Denominator tables to determine individual enrollment • Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payor status • CMS physician and physician specialty tables • National Plan and Provider Enumeration System (NPPES) database No data collection instrument provided Attachment NQF_1880_Code_Tables_2018_Final.xlsx	Claims Health plan prescription claims data and enrollment data (e.g. Medicare Part D) No data collection instrument provided No data dictionary
Level	Clinician : Group/Practice, Health Plan, Population : Regional and State	Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : Regional and State	Clinician : Group/Practice, Health Plan
Setting	Outpatient Services	Outpatient Services	Outpatient Services
Numerator Statement	Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.	Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.	The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold. Step 1: Determine the patient's treatment period, defined as the index prescription date (date of the first fill of the target medication) to the end of the calendar year, disenrollment, or death. Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.* Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
			Step 4: Count the number of patients who had a PDC 80% or greater and then divide by the total number of eligible patients. *Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of combination product to another combination product where a least one of the drugs from the target therapeutic class is common.
Numerator Details	The numerator is defined as individuals with a PDC of 0.8 or greater. The PDC is calculated as follows: PDC NUMERATOR The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all antipsychotic medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended. PDC DENOMINATOR The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.	The numerator is defined as individuals with a PDC of 0.8 or greater. The PDC is calculated as follows: PDC NUMERATOR The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all mood stabilizer medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended. PDC DENOMINATOR The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.	The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold. Step 1: Determine the patient's treatment period, defined as the index prescription date (date of the first fill of the target medication) to the end of the calendar year, disenrollment, or death. Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.* Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient. Step 4: Count the number of patients who had a PDC 80% or greater and then divide by the total number of eligible patients. *Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of combination product to another combination product where a least one of the drugs from the target therapeutic class is common. RENIN ANGIOTENSIN SYSTEM (RAS) ANTAGONISTS: aliskiren, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan,valsartan, azilsartan, benazepril,captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolopril, amlodipine & benazepril, benazepril & HCTZ, captopril & HCTZ, enalapril & HCTZ, fosinopril & HCTZ, lisinopril & HCTZ, moexipril & HCTZ, perindopril & amlodipine, quinapril & HCTZ, trandolopril & verapamil HCL, candesartan & HCTZ, eprosartan & HCTZ, telmisartan & amilodipine, nebivolol & valsartan, irbesartan & HCTZ, losartan & HCTZ, amlodipine & olmesartan, azlisartan & chlorthalidone, olmesartan & HCTZ, telmisartan & HCTZ, olmesartan & amlodipine & HCTZ, valsartan & HCTZ, amlodipine & valsartan, amlodipine & valsartan & HCTZ, aliskiren & amlodipine, aliskiren & amlodipine & HCTZ, aliskiren & HCTZ, DIABETES MEDICATIONS: (Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV Inhibitors, Incretin Mimetic Agents, Meglitinides, Sodium glucose co-transporter2 (SGLT2) inhibitors and combination products that include these medications) metformin, glipizide & metformin, glyburide & metformin, chlorpropamide, glimepiride, glipizide, glyburide, tolazamide, tolbutamide, pioglitazone, rosiglitazone, rosiglitazone & metformin, rosiglitazone & glimepiride, pioglitazone & metformin, pioglitazone & glimepiride, alogliptin & pioglitazone, sitagliptin, linagliptin,

	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
			saxagliptin, alogliptin, sitagliptin & metformin, saxagliptin & metformin SR, sitagliptin & simvastatin, linagliptin & metformin, alogliptin & metformin, exenatide, liraglutide, nateglinide, repaglinide, repaglinide & metformin, canagliflozin, alogliptin & metformin, empagliflozin & linagliptin, dulaglutide, liraglutide, lisxisenatide, albiglutide, empagliflozin, dapagliflozin, dapagliflozin & metformin, empagliflozin & linagliptin, canagliflozin & metformin, empagliflozin & metformin STATINS: lovastatin, rosuvastatin, fluvastatin, atorvastatin, pravastatin, pitavastatin, simvastatin, niacin & lovastatin, atorvastatin & amlodipine, niacin & simvastatin, sitagliptin & simvastatin, ezetimibe & simvastatin, ezetimibe & atorvastatin
Denominator Statement	Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).	Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).	Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year. For the Diabetes rate only: Exclude any patient with one or more prescriptions for insulin in the treatment period. Exclude any patient with ESRD For RASA rate only: Exclude any patient with one or more prescription claims for sacubitril/valsartan during the treatment period. Exclude any patient with ESRD
Denominator Details	Target population meets the following conditions: 1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement period; 2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and, 3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement period. IDENTIFICATION OF SCHIZOPHRENIA Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have: At least two encounters with a diagnosis of schizophrenia or schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period. CODES USED TO IDENTIFY SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER DIAGNOSIS Codes used to identify schizophrenia or schizoaffective disorder are included in the attached excel worksheet of codes (NQF_1879_Code Tables_2018_Final.xlsx) under the tab NQF_1879_Schizophrenia. Table 1: Schizophrenia or Schizoaffective Disorder Diagnosis ICD-9-CM: 295.xx ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9 CODES USED TO IDENTIFY ENCOUNTER TYPE: Codes used to identify encounters are under tab NQF_1879_Encounter_types. Table 2.1: Outpatient Setting	Target population meets the following conditions: 1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement year; 2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement year; and, 3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement year. IDENTIFICATION OF BIPOLAR I DISORDER Individuals with bipolar I disorder are identified by having a diagnosis of bipolar I disorder within the inpatient or outpatient claims data. Individuals must have: At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period. CODES USED TO IDENTIFY BIPOLAR I DISORDER DIAGNOSIS Codes used to identify bipolar I disorder are included in the attached Excel worksheet of codes (NQF_1880_Code Tables_2018 Final) under the tab NQF_1880_Bipolar_ICD9-10. TABLE 1. BIPOLAR I DISORDER DIAGNOSIS ICD-9-CM: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7 ICD-10-CM: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.89, F31.9 CODES USED TO IDENTIFY ENCOUNTER TYPE Codes used to identify encounters are under tab NQF_1880_Encounter_types.	Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year. (For the Diabetes rate only: Exclude any patient with one or more prescriptions for insulin in the measurement period - See S.10) RENIN ANGIOTENSIN SYSTEM (RAS) ANTAGONISTS: aliskiren, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan,valsartan, azilsartan, benazepril,captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolopril, amlodipine & benazepril, benazepril & HCTZ, captopril & HCTZ, enalapril & HCTZ, fosinopril & HCTZ, lisinopril & HCTZ, moexipril & HCTZ, perindopril & amlodipine, quinapril & HCTZ, trandolopril & verapamil HCL, candesartan & HCTZ, eprosartan & HCTZ, telmisartan & amilodipine, nebivolol & valsartan, irbesartan & HCTZ, losartan & HCTZ, amlodipine & olmesartan, azlisartan & chlorthalidone, olmesartan & HCTZ, telmisartan & HCTZ, olmesartan & amlodipine & HCTZ, valsartan & HCTZ, amlodipine & valsartan, amlodipine & valsartan & HCTZ, aliskiren & amlodipine, aliskiren & amlodipine & HCTZ, aliskiren & HCTZ, DIABETES MEDICATIONS: (Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV Inhibitors, Incretin Mimetic Agents, Meglitinides, Sodium glucose co-transporter2 (SGLT2) inhibitors and combination products that include these medications) metformin, glipizide & metformin, glyburide & metformin, chlorpropamide, glimepiride, glipizide, glyburide, tolazamide, tolbutamide, pioglitazone, rosiglitazone, rosiglitazone & metformin, rosiglitazone & glimepiride, pioglitazone & metformin, pioglitazone & glimepiride, alogliptin & pioglitazone, sitagliptin, linagliptin, saxagliptin, alogliptin, sitagliptin & metformin, saxagliptin & metformin SR, sitagliptin & simvastatin, linagliptin & metformin, alogliptin & metformin,

	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
	Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 Table 2.2: Emergency Department Setting CPT: 99281-99285 UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 23 Table 2.3: Non-Acute Inpatient Setting CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 HCPCS: H0017-H0019, T2048 UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 31, 32, 56 Table 2.4: Acute Inpatient Setting UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH POS: 21, 51 IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR ANTIPSYCHOTIC MEDICATION: Individuals with at least two prescription drug claims for any of the following oral antipsychotic medications (Table 3: Oral Antipsychotic Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1879_ Antipsychotics of the attached excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.	TABLE 2.1. OUTPATIENT SETTING Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 TABLE 2.2. EMERGENCY DEPARTMENT SETTING CPT: 99281-99285 UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 23 TABLE 2.3. NON-ACUTE INPATIENT SETTING CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 HCPCS: H0017-H0019, T2048 UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 31, 32, 56 TABLE 2.4. ACUTE INPATIENT SETTING UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH POS: 21, 51 IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR MOOD STABILIZER MEDICATION Individuals with at least two prescription drug claims for any of the following mood stabilizer medications (Table 3: Mood Stabilizer Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1880_Mood_Stabilizers of the attached Excel workbook. Obsolete drug products are excluded from National Drug	exenatide, liraglutide, nateglinide, repaglinide, repaglinide & metformin, canagliflozin, alogliptin & metformin, empagliflozin & linagliptin, dulaglutide, liraglutide, lisxisenatide, albiglutide, empagliflozin, dapagliflozin, dapagliflozin & metformin, empagliflozin & linagliptin, canagliflozin & metformin, empagliflozin & metformin STATINS: lovastatin, rosuvastatin, fluvastatin, atorvastatin, pravastatin, pitavastatin, simvastatin, niacin & lovastatin, atorvastatin & amlodipine, niacin & simvastatin, sitagliptin & simvastatin, ezetimibe & simvastatin, ezetimibe & atorvastatin

	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
	TABLE 3: ORAL ANTIPSYCHOTIC MEDICATIONS The following are oral formulations only. Typical Antipsychotic Medications: chlorpromazine fluphenazine haloperidol loxapine molindone perphenazine prochlorperazine thioridazine thiothixene trifluoperazine Atypical Antipsychotic Medications: aripiprazole asenapine brexpiprazole cariprazine clozapine iloperidone lurasidone olanzapine paliperidone quetiapine quetiapine fumarate (Seroquel) risperidone ziprasidone Antipsychotic Combinations: perphenazine-amitriptyline TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below. Typical Antipsychotic Medications: fluphenazine decanoate (J2680) haloperidol decanoate (J1631) Atypical Antipsychotic Medications: aripiprazole (J0401) aripiprazole lauroxil (Aristada) olanzapine pamoate (J2358) paliperidone palmitate (J2426) risperidone microspheres (J2794) Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B: fluphenazine decanoate (J2680) – 28 days' supply haloperidol decanoate (J1631) – 28 days' supply aripiprazole (J0401) – 28 days' supply aripiprazole lauroxil (Aristada) - 28 days' supply olanzapine pamoate (J2358) – 28 days' supply paliperidone palmitate (J2426) – 28 days' supply risperidone microspheres (J2794) – 14 days' supply	Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period. MOOD STABILIZER MEDICATIONS TABLE 3. MOOD STABILIZER MEDICATIONS Active ingredients listed below are limited to oral, buccal, sublingual, and translingual formulations only. Anticonvulsants: carbamazepine divalproex sodium lamotrigine valproic acid Atypical Antipsychotics: aripiprazole asenapine cariprazine lurasidone olanzapine quetiapine quetiapine fumarate (Seroquel) risperidone ziprasidone Phenothiazine/Related Antipsychotics: chlorpromazine loxapine succinate Other Antipsychotics: olanzapine-fluoxetine Lithium Salts: lithium carbonate lithium citrate TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS The following are the long-acting (depot) injectable antipsychotic medications. The route of administration includes all injectable and intramuscular formulations of the medications listed below. Atypical Antipsychotic Medications: aripiprazole (J0401) risperidone microspheres (J2794) Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B: aripiprazole (J0401) – 28 days' supply risperidone microspheres (J2794) – 14 days' supply	
Exclusions	Individuals with any diagnosis of dementia during the measurement period.	Not Applicable	Exclusion criteria for the PDC category of Diabetes medications: 1. Patients who have one or more prescriptions for insulin in the treatment period. 2. Patients with ESRD. Patients with ESRD can be identified using RxHCC 121 - Dialysis Status (for payment year 2015) or RxHCC 261 - Dialysis Status (for payment year 2016 or 2017) or by using the ICD codes

	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
			Exclusion criteria for the PDC category of RASA: 1. Patients with ESRD Patients with ESRD can be identified using RxHCC 121 - Dialysis Status (for payment year 2015) or RxHCC 261 - Dialysis Status (for payment year 2016 or 2017) or by using the ICD codes 2. Patients with one or more prescription claims for the medication, sacubitril/valsartan, during the treatment period.
Exclusion Details	Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below tab NQF_1879_Dementia Table 5: Codes Used to Identify Dementia ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 292.82, 294.10, 294.11, 294.20, 294.21, 330.1, 331.0, 331.19, 331.82 ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F10.27, F11.122, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83	Not Applicable	Exclusion details for PDC category of Diabetes medications (one or more prescriptions for insulin): INSULINS: insulin aspart, insulin aspart Protamine & Aspart, insulin detemir, insulin glargine, insulin glulisine, insulin isophane & regular human insulin, insulin isophane (human N), insulin lispro, insulin lispro Protamine & Insulin lispro, insulin regular (human R), Insulin regular (human) inhalation powder, Insulin degludec, Insulin degludec & liraglutide, Insulin glargine & lixisenatide ESRD ICD codes: ESRD ICD9 codes: 585.6 End stage renal disease ESRD ICD10 codes: I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease N18.5 Chronic kidney disease, stage 5 N18.6 End stage renal disease N19 Renal failure, unspecified Z91.15 Patient's noncompliance with renal dialysis Z99.2 Dependence on renal dialysis
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Depending on the operational use of the measure, measure results can be stratified by: • State • Physician Group* • Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years • Race/Ethnicity • Dual Eligibility *See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.	Depending on the operational use of the measure, measure results may be stratified by: • State • Accountable Care Organization (ACOs)* • Plan • Physician Group** • Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years • Race/Ethnicity • Dual Eligibility *ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers. **See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.	None
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D. Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during	Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D. Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications	For EACH PDC rate identify the Denominator: Step 1: Identify the eligible population that is 18 years and older as of the last day of the measurement year and that are continuously enrolled in the drug plan. Step 2: Identify those patients in Step 1 that have filled at least two prescriptions for the target class of medication (either RAS Antagonist, Diabetes medication or Statin)

	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
	the measurement period (12 consecutive months). CREATE DENOMINATOR: 1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period. 2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period. 3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only). 4. Of those individuals identified in Step 3, keep individuals who had: At least two encounters with a diagnosis of schizophrenia of schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR Individuals who had at least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period. 5. For the individuals identified in Step 4, extract Medicare Part D claims for any antipsychotic medication during the measurement period. Attach the generic name and the drug ID to the dataset. 6. Of the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any antipsychotic medication on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period. 7. Exclude those individuals with a diagnosis of dementia during the measurement period. Numerator: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications. CREATE NUMERATOR: For the individuals in the denominator, calculate the PDC for each individual according to the following methods: 1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an antipsychotic medication in the measurement period. 2. Within the medication therapy period, count the days the individual was covered by at least one drug in the antipsychotic medication class based on the prescription drug claim service date and days of supply. a. Sort and de-duplicate Medicare Part D antipsychotic medication claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply. b. Calculate the number of days covered by antipsychotic drug therapy per individual.	during the measurement period (12 consecutive months). CREATE DENOMINATOR: 1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period. 2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period. 3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only). 4. Of those individuals identified in Step 3, keep those who had: At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period. 5. Of the individuals identified in Step 4, extract Medicare Part D claims for a mood stabilizer during the measurement period. Attach the drug ID and the generic name to the dataset. 6. For the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any mood stabilizer on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period. Numerator: Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications. CREATE NUMERATOR: For the individuals in the denominator, calculate the PDC for each individual according to the following methods: 1. Determine the individual's medication therapy period, defined as the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for a mood stabilizer medication in the measurement period. 2. Within the medication therapy period, count the days the individual was covered by at least one drug in the mood stabilizer medication class based on the prescription drug claim service date and days of supply. a. Sort and de-duplicate Medicare Part D claims for mood stabilizers by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply. b. Calculate the number of days covered by mood stabilizer therapy per individual. i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. ii. If claims for the same drug (generic name) overlap, then adjust the latest	For the Diabetes rate only:Step 3: Exclude any patient with one or more prescriptions for insulin in the measurement period. Exclude any patient with ESRD. For the RASA rate only: Exclude any patient with one or more prescription claims for the medication sacubitril/valsartan during the treatment period. Exclude any patient with ESRD For EACH PDC rate calculate the Numerator: Step 1: Determine the patient's treatment period, defined as the index prescription date (first fill of the target medication) to the end of the calendar year, disenrollment, or death. Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.* Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient. Step 4: Count the number of patients who had a PDC greater than 80% and then divide by the total number of eligible patients. *Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the drugs is common.

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	i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended. iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date. 3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1. An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf. 4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the antipsychotic medications. This is the numerator. PHYSICIAN GROUP ATTRIBUTION: Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not. I. Identify Physician and Medical Groups 1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPIs) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPI. Valid NPIs have 10 numeric characters (no alpha characters). 2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables. 3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty. 4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP). 5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.) a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year. b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code. c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs	prescription start date to be the day after the previous fill has ended. iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date. 3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1. An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf. 4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the mood stabilizers. This is the numerator. PHYSICIAN GROUP ATTRIBUTION: Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not. I. Identify Physician and Medical Groups 1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPIs. Valid NPIs have 10 numeric characters (no alpha characters). 2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables. 3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty. 4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP). 5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.) a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year. b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code. c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 6. Identify TINs that are not solo practices.	

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	with percentages greater than or equal to 50%. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 6. Identify TINs that are not solo practices. a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year. b. Count unique NPIs per TIN. c. Keep only those TINs having two or more providers. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices). 8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs. 9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants. a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty. b. The specialty with the maximum count is assigned to the medical group. II. Identify Individual Sample and Claims 10. Create individual sample. a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year. b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following: • A = working-age individual/spouse with an employer group health plan (EGHP) • B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP • G = working disabled for any month of the year c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C. d. Exclude individuals who enter the Medicare hospice at any point during the measurement year. e. Exclude individuals who died during the measurement year. 11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year. a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245. b. Exclude claims with no npi_prfrmg. 12. Attach medical group TIN to claims by NPI. III. Patient Attribution 13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure. a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the	a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year. b. Count unique NPIs per TIN. c. Keep only those TINs having two or more providers. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices). 8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs. 9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants. a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty. b. The specialty with the maximum count is assigned to the medical group. II. Identify Individual Sample and Claims 10. Create individual sample. a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year. b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following: • A = working-age individual/spouse with an employer group health plan (EGHP) • B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP • G = working disabled for any month of the year c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C. d. Exclude individuals who enter the Medicare hospice at any point during the measurement year. e. Exclude individuals who died during the measurement year. 11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year. a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245. b. Exclude claims with no npi_prfrmg. 12. Attach medical group TIN to claims by NPI. III. Patient Attribution 13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure. a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields. b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.	

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	measure-specific specialties, then check additional specialty fields. b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9. 14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims. 15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim. 16. Attach the medical group TIN to the denominator and numerator files by individual. Provider Specialties and Specialty Codes Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below: 01—General practice* 02—General surgery 03—Allergy/immunology 04—Otolaryngology 05—Anesthesiology 06—Cardiology 07—Dermatology 08—Family practice* 09—Interventional pain management 10—Gastroenterology 11—Internal medicine* 12—Osteopathic manipulative therapy 13—Neurology 14—Neurosurgery 16—Obstetrics/gynecology* 18—Ophthalmology 20—Orthopedic surgery 22—Pathology 24—Plastic and reconstructive surgery 25—Physical medicine and rehabilitation 26—Psychiatry* 28—Colorectal surgery 29—Pulmonary disease 30—Diagnostic radiology 33—Thoracic surgery 34—Urology 37—Nuclear medicine 38—Geriatric medicine* 39—Nephrology 39—Pediatric medicine 40—Hand surgery 44—Infectious disease 46—Endocrinology 50—Nurse practitioner* 66—Rheumatology 70—Multi-specialty clinic or group practice* 72—Pain management 76—Peripheral vascular disease 77—Vascular surgery 78—Cardiac surgery 79—Addiction medicine 81—Critical care (intensivists) 82—Hematology 83—Hematology/oncology 84—Preventive medicine* 85—Maxillofacial surgery 86—Neuropsychiatry* 90—Medical oncology 91—Surgical oncology 92—Radiation oncology 93—Emergency medicine 94—Interventional radiology	14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims. 15. Attribute the individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim. 16. Attach the medical group TIN to the denominator and numerator files by individual. Provider Specialties and Specialty Codes Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below: 01—General practice* 02—General surgery 03—Allergy/immunology 04—Otolaryngology 05—Anesthesiology 06—Cardiology 07—Dermatology 08—Family practice* 09—Interventional pain management 10—Gastroenterology 11—Internal medicine* 12—Osteopathic manipulative therapy 13—Neurology 14—Neurosurgery 16—Obstetrics/gynecology* 18—Ophthalmology 20—Orthopedic surgery 22—Pathology 24—Plastic and reconstructive surgery 25—Physical medicine and rehabilitation 26—Psychiatry* 28—Colorectal surgery 29—Pulmonary disease 30—Diagnostic radiology 33—Thoracic surgery 34—Urology 36—Nuclear medicine 37—Pediatric medicine 38—Geriatric medicine* 39—Nephrology 40—Hand surgery 44—Infectious disease 46—Endocrinology 50—Nurse practitioner* 66—Rheumatology 70—Multi-specialty clinic or group practice* 72—Pain management 76—Peripheral vascular disease 77—Vascular surgery 78—Cardiac surgery 79—Addiction medicine 81—Critical care (intensivists) 82—Hematology 83—Hematology/oncology 84—Preventive medicine* 85—Maxillofacial surgery 86—Neuropsychiatry* 90—Medical oncology 91—Surgical oncology 92—Radiation oncology 93—Emergency medicine 94—Interventional radiology 97—Physician assistant* 98—Gynecologist/oncologist 99—Unknown physician specialty Other—NA	

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	97—Physician assistant* 98—Gynecologist/oncologist 99—Unknown physician specialty Other—NA *Provider specialty codes specific to this measure	*Provider specialty codes specific to this measure	
Submission items	5.1 Identified measures: 0544 : Use and Adherence to Antipsychotics among members with Schizophrenia 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease 0542 : Adherence to Chronic Medications 0545 : Adherence to Statins for Individuals with Diabetes Mellitus 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category 0569 : ADHERENCE TO STATINS 1880 : Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in both measures. The methodology used to identify the denominator population is also calculated the same in both measures with the exception of the clinical conditions which is the target of the measure. The medications included in both measures are specific to the clinical condition targeted in the measure. 5b.1 If competing, why superior or rationale for additive value: The Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NCQA) measure is used for HEDIS reporting and is harmonized with the NQF #1879 in condition, target population, methodology, and medications. The HEDIS measure is only used in Medicaid health plans and therefore is restricted to adults age 18-64. During development the measure developers identified another competing measure which eventually lost NQF endorsement. The section below is from the original submission of the measures for initial endorsement and compares this measure (#1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia) to a previously NQF-endorsed measure (#0544 Use and Adherence to Antipsychotics among Members with Schizophrenia). Measure 1879 (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) has both the same measure focus and essentially the same target population as Measure 0544 (Use and Adherence to Antipsychotics among Members with Schizophrenia), which is no longer endorsed after the measure's time-limited endorsement (TLE) status expired. Measure 1879 is superior to the existing Measure 0544 because it represents a more valid and efficient approach to measuring medication adherence to antipsychotic medications. In addition, as discussed above in Section 5a.2, Measure 1879 is harmonized with several other adherence measures in the NQF portfolio. Key differences in measure validity and efficiency are addressed in the sections below. VALIDITY The Proportion of Days Covered (PDC), which is the method used to calculate adherence in Measure 1879, has several advantages over the Medication Possession	5.1 Identified measures: 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease 0542 : Adherence to Chronic Medications 0545 : Adherence to Statins for Individuals with Diabetes Mellitus 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category 0580 : Bipolar antimanic agent 0109 : Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors 0110 : Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use 0111 : Bipolar Disorder: Appraisal for risk of suicide 0112 : Bipolar Disorder: Level-of-function evaluation 0003 : Bipolar Disorder: Assessment for diabetes 1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia 1927 : Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications 1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879) and the NCQA version of the same measure (Adherence to Antipsychotic Medications for Individuals with Schizophrenia), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in all three measures. The methodology used to identify the denominator population is also calculated the same in all three measures, with the exception of the clinical conditions which is the target of the measure. The data collection burden is identical for the measures. The only differences between Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879), and the related NCQA measure are: (1) the clinical codes used to identify the different populations in each measure (NQF #1880 – individuals with bipolar I disorder; NQF #1879 and NCQA measure– individuals with schizophrenia); (2) the medications includes in each measure (NQF #1880- mood stabilizers; NQF #1879 and the NCQA measure– antipsychotics); and, (3) an exclusion for dementia which is included in NQF #1879 and the NCQA measure but not in NQF #1880. The rationale for these difference is due to the different clinical focus of each measure. There is no impact on interpretability since the measures clearly identify the disparate clinical focus. During development the measure developers worked to harmonize this measure with other measures which were NQF-endorsed at the time of development.	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:

	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
	Ratio (MPR), which is used in Measure 0544. First, the PDC was found to be more conservative compared to the Medication Possession Ratio (MPR) and was preferred in clinical scenarios in which there is the potential for more than one drug to be used within a drug class concomitantly (e.g., antipsychotics). This clinical situation applies directly to Measure 1879. Martin et al. (2009) demonstrated this in a study published in the Annals of Pharmacotherapy by comparing the methodology for drugs that are commonly switched, where the MPR was 0.690, truncated MPR was 0.624, and PDC was 0.562 and found significant differences between the values for adherence ($p < 0.001$). Martin et al (2009) also compared drugs with therapeutic duplication where the PDC was 0.669, truncated MPR was 0.774, and MPR was 1.238, and again obtained significant differences ($p < 0.001$). These findings were partially replicated by testing results from FMQAI (now HSAG) of Measure 1879 where MPR produced a higher measure rate (as compared to PDC) as shown below. Adherence to Antipsychotic Medications for Individuals with Schizophrenia Method Measure Rate Comparison of MPR and PDC Method Measure Rate MPR 74.4% PDC 70.0% Based on initial draft measure specifications and data from a 100% sample of Medicare fee-for-service beneficiaries with Part D coverage in Florida and Rhode Island, using 2008 Medicare Parts A, B, and D data. Additional differences between Measure 1879 and TLE 0544 related to validity include the following concerns: Denominator: The measure denominator requires at least two antipsychotic medication prescriptions; whereas, the NQF TLE measure (NQF# 0544) does not require any antipsychotic medication prescriptions in the measure denominator. In 0544, an MPR of "0" is assigned to those without any antipsychotic medication prescriptions, which may falsely lower measure rates, specifically in scenarios where the prescriber has made the decision not to prescribe antipsychotic medications for an individual diagnosed with schizophrenia. Exclusion related to a diagnosis of dementia: Measure 1879 excludes individuals with a diagnosis of dementia during the measurement year which is not considered in Measure 0544. Antipsychotic medications are currently labeled with a Food and Drug Administration (FDA) Black Box warning that states, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients." The Technical Expert Panel, which reviewed the measure, recommended excluding these individuals from the measure denominator, since continued adherence to antipsychotic medications in this subpopulation may increase mortality and not represent quality of care. (Please see Section 2b3.2 that provides descriptive results of testing related to exclusions.) EFFICIENCY Measure 1879 requires only one year of administrative claims data, rather than two years of data which is required for TLE 0544.	The section below is from the original submission of the measure for initial endorsement and refers to measures which are no longer NQF-endorsed. We are including this language to demonstrate the efforts of the measure developers to harmonize this measure with other measures. MEASURES WITH WHICH THE MEASURE IS HARMONIZED. The measure has been harmonized where feasible with NQF #0542, #0543, #0545, #0541, #1879, #1927, and #1932 MEASURES WITH WHICH THE MEASURE IS NOT HARMONIZED. The measure specifications of the measure are not harmonized with the following NQF-endorsed measures that have the same measure focus (use of mood stabilizers among patients with Bipolar Disorder): NQF #0580 Bipolar antimanic agent. DIFFERENCES BETWEEN MEASURE 1880 AND MEASURE 0580. One NQF-endorsed measure (NQF #0580) focuses on a similar concept, but differs from this measure in two important ways. First, the NQF-endorsed measure includes individuals with newly diagnosed bipolar disorder and major depressive disorder. However, this measure includes all individuals with bipolar I disorder, not just those who are newly diagnosed, and does not include individuals with major depressive disorder. Second, the NQF-endorsed measure identifies the percentage of eligible individuals who have received at least 1 prescription for a mood-stabilizing agent during the measurement year, while this measure measures the percentage of eligible individuals with a proportion of days covered (PDC) for mood stabilizer medications greater than 0.8 during the measurement year. RATIONALE. This measure is an improved measure that adds value because it measures adherence to mood stabilizer treatment for individuals with bipolar I disorder. In contrast, the NQF measure (NQF# 0580) is linked to a one-time prescription for mood stabilizer treatment. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN. Differences have not been identified concerning the data collection burden between Measure 1880 and Measure 0580. However, interpretability for Measure 1880 (as compared to NQF #0580) is improved because Measure 1880 focuses on adherence rather than a single prescription, and Measure 1880 is harmonized with the majority of adherence measures for other chronic diseases in the NQF portfolio and those that are being publicly reported by CMS. 5b.1 If competing, why superior or rationale for additive value: This measure does not address both the same measure focus and population as another NQF-endorsed measure.	

	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
	The Technical Expert Panel that reviewed Measure 1879 indicated that the burden of requiring two years of administrative claims data would not meaningfully modify measure rates and would potentially result in the unnecessary exclusion of individuals for which adherence should be assessed but for which only 1 year of claims data were available. Additional rationale for this TEP recommendation was related to an increased length of the continuous enrollment criteria to specify the measure use with two years of data. FMQAI's (now HSAG) empirical analysis of a related adherence measure (NQF 0542 – Adherence to Chronic Medications) using 2007 and 2008 Medicare Part D data for beneficiaries in Florida and Rhode Island validated this concern and indicated that approximately 10% of the eligible population would be excluded from the measure if the enrollment criteria required two years of administrative claims data as opposed to one year.		

Comparison of NQF #1880, NQF #0541, NQF #1879 and NQF #1932

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
Steward	National Committee for Quality Assurance	Pharmacy Quality Alliance	Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services	National Committee for Quality Assurance
Description	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).	The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, Statins. A higher score indicates better quality.	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Type	Process	Process	Process	Process
Data Source	Claims For measure calculation in the Medicare product line, the following Medicare files were required: • Denominator tables • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME • Prescription drug benefit (Part D) claims For ACO attribution, the following were required: • Denominator tables for Parts A and B enrollment • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME • Prescription drug benefit (Part D) claims For physician group attribution, the following were required: • Non-institutional claims (Part B)—physician carrier/non-DME	Claims Health plan prescription claims data and enrollment data (e.g. Medicare Part D) No data collection instrument provided No data dictionary	Claims The data source for the measure calculation required the following Medicare files depending on the level of accountability where the measure is being used: • Denominator tables to determine individual enrollment • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME (durable medical equipment) • Prescription drug benefit (Part D) claims • Centers for Medicare and Medicaid Services (CMS) physician and physician specialty tables • National Plan and Provider Enumeration System (NPPES) database No data collection instrument provided Attachment NQF_1879_Code_Tables_2018_Final.xlsx	Claims This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system. No data collection instrument provided Attachment 1932_SSD_Value_Sets.xlsx

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	• Denominator tables to determine individual enrollment • Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payor status • CMS physician and physician specialty tables • National Plan and Provider Enumeration System (NPPES) database No data collection instrument provided Attachment NQF_1880_Code_Tables_2018_Final.xlsx			
Level	Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : Regional and State	Clinician : Group/Practice, Health Plan	Clinician : Group/Practice, Health Plan, Population : Regional and State	Health Plan, Integrated Delivery System, Population : Regional and State
Setting	Outpatient Services	Outpatient Services	Outpatient Services	Other, Outpatient Services Any outpatient setting represented with Medicaid claims data
Numerator Statement	Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.	The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold. Step 1: Determine the patient's treatment period, defined as the index prescription date (date of the first fill of the target medication) to the end of the calendar year, disenrollment, or death. Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.* Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient. Step 4: Count the number of patients who had a PDC 80% or greater and then divide by the total number of eligible patients. *Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of combination product to another combination product where a least one of the drugs from the target therapeutic class is common.	Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.	Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.
Numerator Details	The numerator is defined as individuals with a PDC of 0.8 or greater. The PDC is calculated as follows: PDC NUMERATOR The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for	The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold. Step 1: Determine the patient's treatment period, defined as	The numerator is defined as individuals with a PDC of 0.8 or greater. The PDC is calculated as follows: PDC NUMERATOR The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all antipsychotic medications. The period covered by	A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. See corresponding Excel document for the Glucose Tests

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	all mood stabilizer medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended. PDC DENOMINATOR The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.	the index prescription date (date of the first fill of the target medication) to the end of the calendar year, disenrollment, or death. Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.* Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient. Step 4: Count the number of patients who had a PDC 80% or greater and then divide by the total number of eligible patients. *Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of combination product to another combination product where a least one of the drugs from the target therapeutic class is common. RENIN ANGIOTENSIN SYSTEM (RAS) ANTAGONISTS: aliskiren, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan,valsartan, azilsartan, benazepril,captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolopril, amlodipine & benazepril, benazepril & HCTZ, captopril & HCTZ, enalapril & HCTZ, fosinopril & HCTZ, lisinopril & HCTZ, moexipril & HCTZ, perindopril & amlodipine, quinapril & HCTZ, trandolopril & verapamil HCL, candesartan & HCTZ, eprosartan & HCTZ, telmisartan & amilodipine, nebivolol & valsartan, irbesartan & HCTZ, losartan & HCTZ, amlodipine & olmesartan, azlisartan & chlorthalidone, olmesartan & HCTZ, telmisartan & HCTZ, olmesartan & amlodipine & HCTZ, valsartan & HCTZ, amlodipine & valsartan, amlodipine & valsartan & HCTZ, aliskiren & amlodipine, aliskiren & amlodipine & HCTZ, aliskiren & HCTZ, DIABETES MEDICATIONS: (Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV Inhibitors, Incretin Mimetic Agents, Meglitinides, Sodium glucose co-transporter2 (SGLT2) inhibitors and combination products that include these medications) metformin, glipizide & metformin, glyburide &	the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended. PDC DENOMINATOR The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.	Value Set and the HbA1c Tests Value Set.

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
		metformin, chlorpropamide, glimepiride, glipizide, glyburide, tolazamide, tolbutamide, pioglitazone, rosiglitazone, rosiglitazone & metformin, rosiglitazone & glimepiride, pioglitazone & metformin, pioglitazone & glimepiride, alogliptin & pioglitazone, sitagliptin, linagliptin, saxagliptin, alogliptin, sitagliptin & metformin, saxagliptin & metformin SR, sitagliptin & simvastatin, linagliptin & metformin, alogliptin & metformin, exenatide, liraglutide, nateglinide, repaglinide, repaglinide & metformin, canagliflozin, alogliptin & metformin, empagliflozin & linagliptin, dulaglutide, liraglutide, lisxisenatide, albiglutide, empagliflozin, dapagliflozin, dapagliflozin & metformin, empagliflozin & linagliptin, canagliflozin & metformin, empagliflozin & metformin STATINS: lovastatin, rosuvastatin, fluvastatin, atorvastatin, pravastatin, pitavastatin, simvastatin, niacin & lovastatin, atorvastatin & amlodipine, niacin & simvastatin, sitagliptin & simvastatin, ezetimibe & simvastatin, ezetimibe & atorvastatin		
Denominator Statement	Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).	Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year. For the Diabetes rate only: Exclude any patient with one or more prescriptions for insulin in the treatment period. Exclude any patient with ESRD For RASA rate only: Exclude any patient with one or more prescription claims for sacubitril/valsartan during the treatment period. Exclude any patient with ESRD	Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).	Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.
Denominator Details	Target population meets the following conditions: 1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement year; 2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement year; and, 3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement year. IDENTIFICATION OF BIPOLAR I DISORDER Individuals with bipolar I disorder are identified by having a diagnosis of bipolar I disorder within the inpatient	Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year. (For the Diabetes rate only: Exclude any patient with one or more prescriptions for insulin in the measurement period - See S.10) RENIN ANGIOTENSIN SYSTEM (RAS) ANTAGONISTS: aliskiren, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan,valsartan, azilsartan, benazepril,captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolopril, amlodipine & benazepril, benazepril & HCTZ, captopril & HCTZ, enalapril & HCTZ, fosinopril & HCTZ, lisinopril & HCTZ, moexipril & HCTZ, perindopril & amlodipine, quinapril & HCTZ,	Target population meets the following conditions: 1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement period; 2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and, 3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement period. IDENTIFICATION OF SCHIZOPHRENIA Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have: At least two encounters with a diagnosis of schizophrenia or	Follow the steps below to identify the eligible population. Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year. • At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria: - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set. - BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set. - BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set. - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	or outpatient claims data. Individuals must have: At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period. CODES USED TO IDENTIFY BIPOLAR I DISORDER DIAGNOSIS Codes used to identify bipolar I disorder are included in the attached Excel worksheet of codes (NQF_1880_Code Tables_2018 Final) under the tab NQF_1880_Bipolar_ICD9-10. TABLE 1. BIPOLAR I DISORDER DIAGNOSIS ICD-9-CM: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7 ICD-10-CM: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.89, F31.9 CODES USED TO IDENTIFY ENCOUNTER TYPE Codes used to identify encounters are under tab NQF_1880_Encounter_types. TABLE 2.1. OUTPATIENT SETTING Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72	trandolopril & verapamil HCL, candesartan & HCTZ, eprosartan & HCTZ, telmisartan & amilodipine, nebivolol & valsartan, irbesartan & HCTZ, losartan & HCTZ, amlodipine & olmesartan, azlisartan & chlorthalidone, olmesartan & HCTZ, telmisartan & HCTZ, olmesartan & amlodipine & HCTZ, valsartan & HCTZ, amlodipine & valsartan, amlodipine & valsartan & HCTZ, aliskiren & amlodipine, aliskiren & amlodipine & HCTZ, aliskiren & HCTZ, DIABETES MEDICATIONS: (Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV Inhibitors, Incretin Mimetic Agents, Meglitinides, Sodium glucose co-transporter2 (SGLT2) inhibitors and combination products that include these medications) metformin, glipizide & metformin, glyburide & metformin, chlorpropamide, glimepiride, glipizide, glyburide, tolazamide, tolbutamide, pioglitazone, rosiglitazone, rosiglitazone & metformin, rosiglitazone & glimepiride, pioglitazone & metformin, pioglitazone & glimepiride, alogliptin & pioglitazone, sitagliptin, linagliptin, saxagliptin, alogliptin, sitagliptin & metformin, saxagliptin & metformin SR, sitagliptin & simvastatin, linagliptin & metformin, alogliptin & metformin, exenatide, liraglutide, nateglinide, repaglinide, repaglinide & metformin, canagliflozin, alogliptin & metformin, empagliflozin & linagliptin, dulaglutide, liraglutide, lisxisenatide, albiglutide, empagliflozin, dapagliflozin, dapagliflozin & metformin, empagliflozin & linagliptin, canagliflozin & metformin, empagliflozin & metformin STATINS: lovastatin, rosuvastatin, fluvastatin, atorvastatin, pravastatin, pitavastatin, simvastatin, niacin & lovastatin, atorvastatin & amlodipine, niacin & simvastatin, sitagliptin & simvastatin, ezetimibe & simvastatin, ezetimibe & atorvastatin	schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period. CODES USED TO IDENTIFY SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER DIAGNOSIS Codes used to identify schizophrenia or schizoaffective disorder are included in the attached excel worksheet of codes (NQF_1879_Code Tables_2018_Final.xlsx) under the tab NQF_1879_Schizophrenia. Table 1: Schizophrenia or Schizoaffective Disorder Diagnosis ICD-9-CM: 295.xx ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9 CODES USED TO IDENTIFY ENCOUNTER TYPE: Codes used to identify encounters are under tab NQF_1879_Encounter_types. Table 2.1: Outpatient Setting Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 Table 2.2: Emergency Department Setting CPT: 99281-99285 UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 23 Table 2.3: Non-Acute Inpatient Setting CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 HCPCS: H0017-H0019, T2048	- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set. - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Other Bipolar Disorder Value Set. • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: - BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set. - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set. - ED Value Set with Schizophrenia Value Set. - BH ED Value Set with ED POS Value Set with Schizophrenia Value Set. - BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set. - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set. • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria: - BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set. - BH Stand Alone Outpatient/PH/IOP Value Set with Other Bipolar Disorder Value Set. - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set. - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Bipolar Disorder Value Set. - ED Value Set with Bipolar Disorder Value Set. - ED Value Set with Other Bipolar Disorder Value Set. - BH ED Value Set with ED POS Value Set with Bipolar Disorder Value Set. - BH ED Value Set with ED POS Value Set with Other Bipolar Disorder Value Set. - BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set. - BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set.

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	TABLE 2.2. EMERGENCY DEPARTMENT SETTING CPT: 99281-99285 UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 23 TABLE 2.3. NON-ACUTE INPATIENT SETTING CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 HCPCS: H0017-H0019, T2048 UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 31, 32, 56 TABLE 2.4. ACUTE INPATIENT SETTING UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH POS: 21, 51 IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR MOOD STABILIZER MEDICATION Individuals with at least two prescription drug claims for any of the following mood stabilizer medications (Table 3: Mood Stabilizer Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1880_Mood_Stabilizers of the attached Excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.		UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 31, 32, 56 Table 2.4: Acute Inpatient Setting UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH POS: 21, 51 IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR ANTIPSYCHOTIC MEDICATION: Individuals with at least two prescription drug claims for any of the following oral antipsychotic medications (Table 3: Oral Antipsychotic Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1879_ Antipsychotics of the attached excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period. TABLE 3: ORAL ANTIPSYCHOTIC MEDICATIONS The following are oral formulations only. Typical Antipsychotic Medications: chlorpromazine fluphenazine haloperidol loxapine molindone perphenazine prochlorperazine thioridazine thiothixene trifluoperazine Atypical Antipsychotic Medications: aripiprazole asenapine brexpiprazole cariprazine clozapine iloperidone lurasidone olanzapine paliperidone quetiapine quetiapine fumarate (Seroquel) risperidone ziprasidone	- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Bipolar Disorder Value Set. - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Other Bipolar Disorder Value Set. (See corresponding Excel document for the above value sets)

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	MOOD STABILIZER MEDICATIONS TABLE 3. MOOD STABILIZER MEDICATIONS Active ingredients listed below are limited to oral, buccal, sublingual, and translingual formulations only. Anticonvulsants: carbamazepine divalproex sodium lamotrigine valproic acid Atypical Antipsychotics: aripiprazole asenapine cariprazine lurasidone olanzapine quetiapine quetiapine fumarate (Seroquel) risperidone ziprasidone Phenothiazine/Related Antipsychotics: chlorpromazine loxapine succinate Other Antipsychotics: olanzapine-fluoxetine Lithium Salts: lithium carbonate lithium citrate TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS The following are the long-acting (depot) injectable antipsychotic medications. The route of administration includes all injectable and intramuscular formulations of the medications listed below. Atypical Antipsychotic Medications: aripiprazole (J0401) risperidone microspheres (J2794) Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B: aripiprazole (J0401) – 28 days' supply risperidone microspheres (J2794) – 14 days' supply		Antipsychotic Combinations: perphenazine-amitriptyline TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below. Typical Antipsychotic Medications: fluphenazine decanoate (J2680) haloperidol decanoate (J1631) Atypical Antipsychotic Medications: aripiprazole (J0401) aripiprazole lauroxil (Aristada) olanzapine pamoate (J2358) paliperidone palmitate (J2426) risperidone microspheres (J2794) Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B: fluphenazine decanoate (J2680) – 28 days' supply haloperidol decanoate (J1631) – 28 days' supply aripiprazole (J0401) – 28 days' supply aripiprazole lauroxil (Aristada) - 28 days' supply olanzapine pamoate (J2358) – 28 days' supply paliperidone palmitate (J2426) – 28 days' supply risperidone microspheres (J2794) – 14 days' supply	
Exclusions	Not Applicable	Exclusion criteria for the PDC category of Diabetes medications: 1. Patients who have one or more prescriptions for insulin in the treatment period. 2. Patients with ESRD. Patients with ESRD can be identified using RxHCC 121 - Dialysis Status (for payment year 2015) or RxHCC 261 - Dialysis Status (for payment year 2016 or 2017) or by using the ICD codes Exclusion criteria for the PDC category of RASA:	Individuals with any diagnosis of dementia during the measurement period.	Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients with diabetes during the measurement year or the year prior to the measurement year. Exclude patients who had no antipsychotic medications dispensed during the measurement year.

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
		1. Patients with ESRD Patients with ESRD can be identified using RxHCC 121 - Dialysis Status (for payment year 2015) or RxHCC 261 - Dialysis Status (for payment year 2016 or 2017) or by using the ICD codes 2. Patients with one or more prescription claims for the medication, sacubitril/valsartan, during the treatment period.		
Exclusion Details	Not Applicable	Exclusion details for PDC category of Diabetes medications (one or more prescriptions for insulin): INSULINS: insulin aspart, insulin aspart Protamine & Aspart, insulin detemir, insulin glargine, insulin glulisine, insulin isophane & regular human insulin, insulin isophane (human N), insulin lispro, insulin lispro Protamine & Insulin lispro, insulin regular (human R), Insulin regular (human) inhalation powder, Insulin degludec, Insulin degludec & liraglutide, Insulin glargine & lixisenatide ESRD ICD codes: ESRD ICD9 codes: 585.6 End stage renal disease ESRD ICD10 codes: I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease N18.5 Chronic kidney disease, stage 5 N18.6 End stage renal disease N19 Renal failure, unspecified Z91.15 Patient's noncompliance with renal dialysis Z99.2 Dependence on renal dialysis	Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below tab NQF_1879_Dementia Table 5: Codes Used to Identify Dementia ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 292.82, 294.10, 294.11, 294.20, 294.21, 330.1, 331.0, 331.19, 331.82 ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F10.27, F11.122, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83	Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set). Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Diabetes Medications List). Claim/encounter data: Patients who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years). - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. - At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List): Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations:

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
				Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled Meglitinides: Nateglinide, Repaglinide Glucagon-like peptide-1 (GLP1) agonists: Dulaglutide, Exenatide, Liraglutide, Albiglutide Sodium glucose cotransporter 2 (SGLT2) inhibitor: Canagliflozin, Dapagliflozin, Empagliflozin Sulfonylureas: Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone Dipeptidyl peptidase-4 (DDP-4) inhibitors: Alogliptin, Linagliptin, Saxagliptin, Sitaglipin --- Exclude patients who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. - Claim/encounter data. An antipsychotic medication (Long-Acting Injections Value Set). - Pharmacy data. Dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List) on an ambulatory basis. ANTIPSYCHOTIC MEDICATIONS: (Antipsychotic Medications List) Miscellaneous antipsychotic agents: Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine,

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
				Quetiapine fumarate, Risperidone, Ziprasidone Phenothiazine antipsychotics: Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine Thioxanthenes: Thiothixene Long-acting injections: Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone (Antipsychotic Combination Medications List) Psychotherapeutic combinations: Fluoxetine-olanzapine, Perphenazine-amitriptyline See corresponding Excel document for the value sets referenced above.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Depending on the operational use of the measure, measure results may be stratified by: • State • Accountable Care Organization (ACOs)* • Plan • Physician Group** • Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years • Race/Ethnicity • Dual Eligibility *ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers. **See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.	None	Depending on the operational use of the measure, measure results can be stratified by: • State • Physician Group* • Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years • Race/Ethnicity • Dual Eligibility *See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.	None.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D. Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months). CREATE DENOMINATOR: 1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period. 2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a	For EACH PDC rate identify the Denominator: Step 1: Identify the eligible population that is 18 years and older as of the last day of the measurement year and that are continuously enrolled in the drug plan. Step 2: Identify those patients in Step 1 that have filled at least two prescriptions for the target class of medication (either RAS Antagonist, Diabetes medication or Statin) For the Diabetes rate only:Step 3: Exclude any patient with one or more prescriptions for insulin in the measurement period. Exclude any patient with ESRD. For the RASA rate only: Exclude any patient with one or more prescription claims for the medication sacubitril/valsartan during the treatment period. Exclude any patient with ESRD	Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D. Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months). CREATE DENOMINATOR: 1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period. 2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until	Step1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year. Step 2. Search for an exclusion in the patient's history: Exclude patients from the eligible population if they meet the following criteria: - Patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. - Patients with diabetes during the measurement year or the year prior to the measurement year. - Patients who had no antipsychotic medications dispensed during the measurement year. Step 3. Determine the numerator: the number of patients who had a diabetes

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period. 3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only). 4. Of those individuals identified in Step 3, keep those who had: At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period. 5. Of the individuals identified in Step 4, extract Medicare Part D claims for a mood stabilizer during the measurement period. Attach the drug ID and the generic name to the dataset. 6. For the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any mood stabilizer on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period. Numerator: Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications. CREATE NUMERATOR: For the individuals in the denominator, calculate the PDC for each individual according to the following methods: 1. Determine the individual's medication therapy period, defined as the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for a mood stabilizer medication in the measurement period. 2. Within the medication therapy period, count the days the individual was covered by at least one drug in the mood stabilizer medication class based on the prescription drug claim	For EACH PDC rate calculate the Numerator: Step 1: Determine the patient's treatment period, defined as the index prescription date (first fill of the target medication) to the end of the calendar year, disenrollment, or death. Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.* Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient. Step 4: Count the number of patients who had a PDC greater than 80% and then divide by the total number of eligible patients. *Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the drugs is common.	their death date if they died during the measurement period. 3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only). 4. Of those individuals identified in Step 3, keep individuals who had: At least two encounters with a diagnosis of schizophrenia of schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR Individuals who had at least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period. 5. For the individuals identified in Step 4, extract Medicare Part D claims for any antipsychotic medication during the measurement period. Attach the generic name and the drug ID to the dataset. 6. Of the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any antipsychotic medication on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period. 7. Exclude those individuals with a diagnosis of dementia during the measurement period. Numerator: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications. CREATE NUMERATOR: For the individuals in the denominator, calculate the PDC for each individual according to the following methods: 1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an antipsychotic medication in the measurement period. 2. Within the medication therapy period, count the days the individual was covered by at least one drug in the antipsychotic medication class based on the prescription drug claim service date and days of supply. a. Sort and de-duplicate Medicare Part D antipsychotic medication claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the	screening test during the measurement year. Step 4. Calculate the rate.

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	service date and days of supply. a. Sort and de-duplicate Medicare Part D claims for mood stabilizers by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply. b. Calculate the number of days covered by mood stabilizer therapy per individual. i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. ii. If claims for the same drug (generic name) overlap, then adjust the latest prescription start date to be the day after the previous fill has ended. iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date. 3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1. An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf. 4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the mood stabilizers. This is the numerator. PHYSICIAN GROUP ATTRIBUTION: Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not. I. Identify Physician and Medical Groups		same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply. b. Calculate the number of days covered by antipsychotic drug therapy per individual. i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended. iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date. 3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1. An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf. 4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the antipsychotic medications. This is the numerator. PHYSICIAN GROUP ATTRIBUTION: Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not. I. Identify Physician and Medical Groups 1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPIs) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPI. Valid NPIs have 10 numeric characters (no alpha characters). 2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables. 3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty. 4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).	

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	1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPIs. Valid NPIs have 10 numeric characters (no alpha characters). 2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables. 3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty. 4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP). 5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.) a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year. b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code. c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 6. Identify TINs that are not solo practices. a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year. b. Count unique NPIs per TIN. c. Keep only those TINs having two or more providers. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).		5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.) a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year. b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code. c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 6. Identify TINs that are not solo practices. a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year. b. Count unique NPIs per TIN. c. Keep only those TINs having two or more providers. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices). 8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs. 9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants. a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty. b. The specialty with the maximum count is assigned to the medical group. II. Identify Individual Sample and Claims 10. Create individual sample. a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year. b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:	

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs. 9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants. a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty. b. The specialty with the maximum count is assigned to the medical group. II. Identify Individual Sample and Claims 10. Create individual sample. a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year. b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following: • A = working-age individual/spouse with an employer group health plan (EGHP) • B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP • G = working disabled for any month of the year c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C. d. Exclude individuals who enter the Medicare hospice at any point during the measurement year. e. Exclude individuals who died during the measurement year. 11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year. a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245. b. Exclude claims with no npi_prfrmg. 12. Attach medical group TIN to claims by NPI. III. Patient Attribution 13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure. a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the		• A = working-age individual/spouse with an employer group health plan (EGHP) • B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP • G = working disabled for any month of the year c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C. d. Exclude individuals who enter the Medicare hospice at any point during the measurement year. e. Exclude individuals who died during the measurement year. 11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year. a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245. b. Exclude claims with no npi_prfrmg. 12. Attach medical group TIN to claims by NPI. III. Patient Attribution 13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure. a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields. b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9. 14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims. 15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim. 16. Attach the medical group TIN to the denominator and numerator files by individual. Provider Specialties and Specialty Codes Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below: 01—General practice* 02—General surgery 03—Allergy/immunology 04—Otolaryngology 05—Anesthesiology 06—Cardiology 07—Dermatology 08—Family practice* 09—Interventional pain management	

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	measure-specific specialties, then check additional specialty fields. b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9. 14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims. 15. Attribute the individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim. 16. Attach the medical group TIN to the denominator and numerator files by individual. Provider Specialties and Specialty Codes Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below: 01—General practice* 02—General surgery 03—Allergy/immunology 04—Otolaryngology 05—Anesthesiology 06—Cardiology 07—Dermatology 08—Family practice* 09—Interventional pain management 10—Gastroenterology 11—Internal medicine* 12—Osteopathic manipulative therapy 13—Neurology 14—Neurosurgery 16—Obstetrics/gynecology* 18—Ophthalmology 20—Orthopedic surgery 22—Pathology 24—Plastic and reconstructive surgery 25—Physical medicine and rehabilitation 26—Psychiatry* 28—Colorectal surgery 29—Pulmonary disease 30—Diagnostic radiology 33—Thoracic surgery 34—Urology 36—Nuclear medicine 37—Pediatric medicine 38—Geriatric medicine* 39—Nephrology 40—Hand surgery 44—Infectious disease 46—Endocrinology 50—Nurse practitioner* 66—Rheumatology 70—Multi-specialty clinic or group practice* 72—Pain management 76—Peripheral vascular disease		10—Gastroenterology 11—Internal medicine* 12—Osteopathic manipulative therapy 13—Neurology 14—Neurosurgery 16—Obstetrics/gynecology* 18—Ophthalmology 20—Orthopedic surgery 22—Pathology 24—Plastic and reconstructive surgery 25—Physical medicine and rehabilitation 26—Psychiatry* 28—Colorectal surgery 29—Pulmonary disease 30—Diagnostic radiology 33—Thoracic surgery 34—Urology 37—Nuclear medicine 38—Geriatric medicine* 39—Nephrology 39—Pediatric medicine 40—Hand surgery 44—Infectious disease 46—Endocrinology 50—Nurse practitioner* 66—Rheumatology 70—Multi-specialty clinic or group practice* 72—Pain management 76—Peripheral vascular disease 77—Vascular surgery 78—Cardiac surgery 79—Addiction medicine 81—Critical care (intensivists) 82—Hematology 83—Hematology/oncology 84—Preventive medicine* 85—Maxillofacial surgery 86—Neuropsychiatry* 90—Medical oncology 91—Surgical oncology 92—Radiation oncology 93—Emergency medicine 94—Interventional radiology 97—Physician assistant* 98—Gynecologist/oncologist 99—Unknown physician specialty Other—NA *Provider specialty codes specific to this measure	

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	77—Vascular surgery 78—Cardiac surgery 79—Addiction medicine 81—Critical care (intensivists) 82—Hematology 83—Hematology/oncology 84—Preventive medicine* 85—Maxillofacial surgery 86—Neuropsychiatry* 90—Medical oncology 91—Surgical oncology 92—Radiation oncology 93—Emergency medicine 94—Interventional radiology 97—Physician assistant* 98—Gynecologist/oncologist 99—Unknown physician specialty Other—NA *Provider specialty codes specific to this measure			
Submission items	5.1 Identified measures: 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease 0542 : Adherence to Chronic Medications 0545 : Adherence to Statins for Individuals with Diabetes Mellitus 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category 0580 : Bipolar antimanic agent 0109 : Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors 0110 : Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use 0111 : Bipolar Disorder: Appraisal for risk of suicide 0112 : Bipolar Disorder: Level-of-function evaluation 0003 : Bipolar Disorder: Assessment for diabetes 1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia 1927 : Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications 1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879) and the NCQA version of the same measure (Adherence to Antipsychotic Medications for Individuals with Schizophrenia), where	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:	5.1 Identified measures: 0544 : Use and Adherence to Antipsychotics among members with Schizophrenia 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease 0542 : Adherence to Chronic Medications 0545 : Adherence to Statins for Individuals with Diabetes Mellitus 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category 0569 : ADHERENCE TO STATINS 1880 : Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in both measures. The methodology used to identify the denominator population is also calculated the same in both measures with the exception of the clinical conditions which is the target of the measure. The medications included in both measures are specific to the clinical condition targeted in the measure. 5b.1 If competing, why superior or rationale for additive value: The Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NCQA) measure is used for HEDIS reporting and is harmonized with the NQF #1879 in condition, target population, methodology, and medications. The HEDIS measure is only used in Medicaid health plans and therefore is restricted to adults age 18-64. During development the measure developers identified another competing measure which eventually lost NQF endorsement. The section below is from the	5.1 Identified measures: 1933 : Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) 1934 : Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: N/A 5b.1 If competing, why superior or rationale for additive value: N/A

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in all three measures. The methodology used to identify the denominator population is also calculated the same in all three measures, with the exception of the clinical conditions which is the target of the measure. The data collection burden is identical for the measures. The only differences between Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879), and the related NCQA measure are: (1) the clinical codes used to identify the different populations in each measure (NQF #1880 – individuals with bipolar I disorder; NQF #1879 and NCQA measure– individuals with schizophrenia); (2) the medications includes in each measure (NQF #1880- mood stabilizers; NQF #1879 and the NCQA measure– antipsychotics); and, (3) an exclusion for dementia which is included in NQF #1879 and the NCQA measure but not in NQF #1880. The rationale for these difference is due to the different clinical focus of each measure. There is no impact on interpretability since the measures clearly identify the disparate clinical focus. During development the measure developers worked to harmonize this measure with other measures which were NQF-endorsed at the time of development. The section below is from the original submission of the measure for initial endorsement and refers to measures which are no longer NQF-endorsed. We are including this language to demonstrate the efforts of the measure developers to harmonize this measure with other measures. MEASURES WITH WHICH THE MEASURE IS HARMONIZED. The measure has been harmonized where feasible with NQF #0542, #0543, #0545, #0541, #1879, #1927, and #1932 MEASURES WITH WHICH THE MEASURE IS NOT HARMONIZED. The measure specifications of the measure are not harmonized with the following NQF-endorsed measures that have the same measure focus (use of mood stabilizers among patients with Bipolar Disorder): NQF #0580 Bipolar antimanic agent. DIFFERENCES BETWEEN MEASURE 1880 AND MEASURE 0580. One		original submission of the measures for initial endorsement and compares this measure (#1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia) to a previously NQF-endorsed measure (#0544 Use and Adherence to Antipsychotics among Members with Schizophrenia). Measure 1879 (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) has both the same measure focus and essentially the same target population as Measure 0544 (Use and Adherence to Antipsychotics among Members with Schizophrenia), which is no longer endorsed after the measure's time-limited endorsement (TLE) status expired. Measure 1879 is superior to the existing Measure 0544 because it represents a more valid and efficient approach to measuring medication adherence to antipsychotic medications. In addition, as discussed above in Section 5a.2, Measure 1879 is harmonized with several other adherence measures in the NQF portfolio. Key differences in measure validity and efficiency are addressed in the sections below. VALIDITY The Proportion of Days Covered (PDC), which is the method used to calculate adherence in Measure 1879, has several advantages over the Medication Possession Ratio (MPR), which is used in Measure 0544. First, the PDC was found to be more conservative compared to the Medication Possession Ratio (MPR) and was preferred in clinical scenarios in which there is the potential for more than one drug to be used within a drug class concomitantly (e.g., antipsychotics). This clinical situation applies directly to Measure 1879. Martin et al. (2009) demonstrated this in a study published in the Annals of Pharmacotherapy by comparing the methodology for drugs that are commonly switched, where the MPR was 0.690, truncated MPR was 0.624, and PDC was 0.562 and found significant differences between the values for adherence ($p < 0.001$). Martin et al (2009) also compared drugs with therapeutic duplication where the PDC was 0.669, truncated MPR was 0.774, and MPR was 1.238, and again obtained significant differences ($p < 0.001$). These findings were partially replicated by testing results from FMQAI (now HSAG) of Measure 1879 where MPR produced a higher measure rate (as compared to PDC) as shown below. Adherence to Antipsychotic Medications for Individuals with Schizophrenia Method Measure Rate Comparison of MPR and PDC Method Measure Rate MPR 74.4% PDC 70.0% Based on initial draft measure specifications and data from a 100% sample of Medicare fee-for-service beneficiaries	

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	NQF-endorsed measure (NQF #0580) focuses on a similar concept, but differs from this measure in two important ways. First, the NQF-endorsed measure includes individuals with newly diagnosed bipolar disorder and major depressive disorder. However, this measure includes all individuals with bipolar I disorder, not just those who are newly diagnosed, and does not include individuals with major depressive disorder. Second, the NQF-endorsed measure identifies the percentage of eligible individuals who have received at least 1 prescription for a mood-stabilizing agent during the measurement year, while this measure measures the percentage of eligible individuals with a proportion of days covered (PDC) for mood stabilizer medications greater than 0.8 during the measurement year. RATIONALE. This measure is an improved measure that adds value because it measures adherence to mood stabilizer treatment for individuals with bipolar I disorder. In contrast, the NQF measure (NQF# 0580) is linked to a one-time prescription for mood stabilizer treatment. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN. Differences have not been identified concerning the data collection burden between Measure 1880 and Measure 0580. However, interpretability for Measure 1880 (as compared to NQF #0580) is improved because Measure 1880 focuses on adherence rather than a single prescription, and Measure 1880 is harmonized with the majority of adherence measures for other chronic diseases in the NQF portfolio and those that are being publicly reported by CMS. 5b.1 If competing, why superior or rationale for additive value: This measure does not address both the same measure focus and population as another NQF-endorsed measure.		with Part D coverage in Florida and Rhode Island, using 2008 Medicare Parts A, B, and D data. Additional differences between Measure 1879 and TLE 0544 related to validity include the following concerns: Denominator: The measure denominator requires at least two antipsychotic medication prescriptions; whereas, the NQF TLE measure (NQF# 0544) does not require any antipsychotic medication prescriptions in the measure denominator. In 0544, an MPR of "0" is assigned to those without any antipsychotic medication prescriptions, which may falsely lower measure rates, specifically in scenarios where the prescriber has made the decision not to prescribe antipsychotic medications for an individual diagnosed with schizophrenia. Exclusion related to a diagnosis of dementia: Measure 1879 excludes individuals with a diagnosis of dementia during the measurement year which is not considered in Measure 0544. Antipsychotic medications are currently labeled with a Food and Drug Administration (FDA) Black Box warning that states, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients." The Technical Expert Panel, which reviewed the measure, recommended excluding these individuals from the measure denominator, since continued adherence to antipsychotic medications in this subpopulation may increase mortality and not represent quality of care. (Please see Section 2b3.2 that provides descriptive results of testing related to exclusions.) EFFICIENCY Measure 1879 requires only one year of administrative claims data, rather than two years of data which is required for TLE 0544. The Technical Expert Panel that reviewed Measure 1879 indicated that the burden of requiring two years of administrative claims data would not meaningfully modify measure rates and would potentially result in the unnecessary exclusion of individuals for which adherence should be assessed but for which only 1 year of claims data were available. Additional rationale for this TEP recommendation was related to an increased length of the continuous enrollment criteria to specify the measure use with two years of data. FMQAI's (now HSAG) empirical analysis of a related adherence measure (NQF 0542 – Adherence to Chronic Medications) using 2007 and 2008 Medicare Part D data for	

	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
			beneficiaries in Florida and Rhode Island validated this concern and indicated that approximately 10% of the eligible population would be excluded from the measure if the enrollment criteria required two years of administrative claims data as opposed to one year.	

Comparison of NQF #1932, NQF #1933 and NQF #1934

	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance	National Committee for Quality Assurance
Description	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	The percentage of patients 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.	The percentage of patients 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
Type	Process	Process	Process
Data Source	Claims This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system. No data collection instrument provided Attachment 1932_SSD_Value_Sets.xlsx	Claims This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system. No data collection instrument provided Attachment 1933_SMC_Value_Sets.xlsx	Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system. No data collection instrument provided Attachment 1934_SMD_Value_Sets.xlsx
Level	Health Plan, Integrated Delivery System, Population : Regional and State	Health Plan, Integrated Delivery System, Population : Regional and State	Health Plan, Integrated Delivery System, Population : Regional and State
Setting	Other, Outpatient Services Any outpatient setting represented with Medicaid claims data	Outpatient Services	Outpatient Services
Numerator Statement	Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.	An LDL-C test performed during the measurement year.	One or more HbA1c tests and one or more LDL-C tests performed during the measurement year.
Numerator Details	A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. See corresponding Excel document for the Glucose Tests Value Set and the HbA1c Tests Value Set.	An LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. - See corresponding Excel document for the LDL-C Tests Value Set The organization may use a calculated or direct LDL.	An HbA1c test (HbA1c Tests Value Set) and an LDL-C test (LDL-C Tests Value Set) performed during the measurement year (on the same or different dates of service), as identified by claim/encounter or automated laboratory data. The patient must have both tests to be included in the numerator. The organization may use a calculated or direct LDL. See corresponding Excel document for the LDL-C Tests Value Set and the HbA1c Tests Value Set
Denominator Statement	Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.	Patients 18-64 years of age as of the end of the measurement year (e.g., December 31) with a diagnosis of schizophrenia and cardiovascular disease.	Patients age 18-64 years of age as of the end of the measurement year (e.g. December 31) with a schizophrenia and diabetes diagnosis.
Denominator Details	Follow the steps below to identify the eligible population. Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year. • At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria: - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set. - BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set. - BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set. - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.	Follow the steps below to identify the eligible population. Step 1: Identify patients with schizophrenia as those who met at least one of the following criteria during the measurement year: • At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria: – BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set. – BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set. • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:	Follow the steps below to identify the eligible population. Step 1: Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year: • At least one acute inpatient encounter, with any diagnosis of schizophrenia. Either of the following code combinations meets criteria: - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set. - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set. • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: - BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.

	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
	- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set. - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Other Bipolar Disorder Value Set. • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: - BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set. - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set. - ED Value Set with Schizophrenia Value Set. - BH ED Value Set with ED POS Value Set with Schizophrenia Value Set. - BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set. - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set. • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria: - BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set. - BH Stand Alone Outpatient/PH/IOP Value Set with Other Bipolar Disorder Value Set. - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set. - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Bipolar Disorder Value Set. - ED Value Set with Bipolar Disorder Value Set. - ED Value Set with Other Bipolar Disorder Value Set. - BH ED Value Set with ED POS Value Set with Bipolar Disorder Value Set. - BH ED Value Set with ED POS Value Set with Other Bipolar Disorder Value Set. - BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set. - BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set. - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Bipolar Disorder Value Set. - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Other Bipolar Disorder Value Set. (See corresponding Excel document for the above value sets)	– BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set. – BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set. – ED Value Set with Schizophrenia Value Set. – BH ED Value Set with ED POS Value Set with Schizophrenia Value Set. – BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set. – BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set Step 2: Identify patients from step 1 who also have cardiovascular disease. Members are identified as having cardiovascular disease in two ways: by event or by diagnosis. The organization must use both methods to identify the eligible population, but a patient need only be identified by one to be included in the measure. Event. Any of the following during the year prior to the measurement year meet criteria: • AMI. Discharged from an inpatient setting with an AMI (AMI Value Set). To identify discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. • CABG. Members who had CABG (CABG Value Set) in any setting. • PCI. Members who had PCI (PCI Value Set) in any setting (e.g., inpatient, outpatient, ED). Diagnosis. Identify members with IVD as those who met at least either 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 outpatient visit (Outpatient Value Set) with a diagnosis of IVD (IVD Value Set). • At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of IVD (IVD Value Set). (See corresponding Excel document for the above value sets)	- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set. - ED Value Set with Schizophrenia Value Set. - BH ED Value Set with ED POS Value Set with Schizophrenia Value Set. - BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set. - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set. Step 2 Identify members from step 1 who also have diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member need only be identified by one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. • At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set). Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List). (See corresponding Excel document for the above value sets) PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List): Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations: Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled Meglitinides: Nateglinide, Repaglinide Glucagon-like peptide-1 (GLP1) agonists: Dulaglutide, Exenatide, Liraglutide, Albiglutide Sodium glucose cotransporter 2 (SGLT2) inhibitor: Canagliflozin, Dapagliflozin, Empagliflozin Sulfonylureas:

	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
			Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone Dipeptidyl peptidase-4 (DDP-4) inhibitors: Alogliptin, Linagliptin, Saxagliptin, Sitaglipin
Exclusions	Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients with diabetes during the measurement year or the year prior to the measurement year. Exclude patients who had no antipsychotic medications dispensed during the measurement year.	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
Exclusion Details	Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set). Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Diabetes Medications List). Claim/encounter data: Patients who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years). - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. - At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List): Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations: Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin,	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set). Optional exclusion: Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. If a member was identified as a diabetic based on claim or encounter data, as described in step 2 of S.7, the optional exclusions do not apply because the member had a diagnosis of diabetes. See corresponding Excel document for the value sets referenced above.

	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
	Metformin-sitagliptin, Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled Meglitinides: Nateglinide, Repaglinide Glucagon-like peptide-1 (GLP1) agonists: Dulaglutide, Exenatide, Liraglutide, Albiglutide Sodium glucose cotransporter 2 (SGLT2) inhibitor: Canagliflozin, Dapagliflozin, Empagliflozin Sulfonylureas: Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone Dipeptidyl peptidase-4 (DDP-4) inhibitors: Alogliptin, Linagliptin, Saxagliptin, Sitaglipin --- Exclude patients who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. - Claim/encounter data. An antipsychotic medication (Long-Acting Injections Value Set). - Pharmacy data. Dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List) on an ambulatory basis. ANTIPSYCHOTIC MEDICATIONS: (Antipsychotic Medications List) Miscellaneous antipsychotic agents: Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone Phenothiazine antipsychotics: Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine Thioxanthenes: Thiothixene Long-acting injections: Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone (Antipsychotic Combination Medications List) Psychotherapeutic combinations: Fluoxetine-olanzapine, Perphenazine-amitriptyline See corresponding Excel document for the value sets referenced above.		
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	None.	N/A	None.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year. Step 2. Search for an exclusion in the patient's history: Exclude patients from the	Step 1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year with a diagnosis of schizophrenia and cardiovascular disease	Step 1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year Step 2. Search for an optional exclusion in the patient's history: Exclude patients from the

	1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
	eligible population if they meet the following criteria: - Patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. - Patients with diabetes during the measurement year or the year prior to the measurement year. - Patients who had no antipsychotic medications dispensed during the measurement year. Step 3. Determine the numerator: the number of patients who had a diabetes screening test during the measurement year. Step 4. Calculate the rate.	Step 2. Determine the numerator: the number of patients who had an LDL-C test during the measurement year Step 3. Calculate the rate.	eligible population if the eligible population if they meet the following criteria: - Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. - Exclude patients who do not have a diagnosis of diabetes during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes during the measurement year or the year prior to the measurement year. Step 3. Determine the numerator: the number of patients who have one or more HbA1c tests and one or more LDL-C tests performed during the measurement year. Step 4. Calculate the rate.
Submission items	5.1 Identified measures: 1933 : Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) 1934 : Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: N/A 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: 1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) 1934 : Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: N/A 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: 1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) 1933 : Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: N/A 5b.1 If competing, why superior or rationale for additive value: N/A

Comparison of NQF #3389 and NQF#2940, NQF #2950, and NQF #2951

	3389 Concurrent Use of Opioids and Benzodiazepines (COB)	2940 Use of Opioids at High Dosage in Persons Without Cancer	2950 Use of Opioids from Multiple Providers in Persons Without Cancer	2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
Steward	PQA, Inc.	Pharmacy Quality Alliance	Pharmacy Quality Alliance	Pharmacy Quality Alliance
Description	The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year. A lower rate indicates better performance.	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.
Type	Process	Process	Process	Process
Data Source	Claims Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs) No data collection instrument provided Attachment PQA_ICD_Code_Cancer_Value_Set_Feb_2018.xlsx	Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information. No data collection instrument provided Attachment Cancer_Exclusion_RxHCC-_ICD-9_and_10_Codes.xlsx	Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information. No data collection instrument provided Attachment Cancer_Exclusion_RxHCC-_ICD-9_and_10_Codes-635969250747751020.xlsx	Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information. No data collection instrument provided Attachment Cancer_Exclusion_RxHCC-_ICD-9_and_10_Codes-635969265833553126.xlsx
Level	Health Plan	Health Plan, Other, Population : Regional and State	Health Plan, Other, Population : Regional and State	Health Plan, Other, Population : Regional and State
Setting	Other The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.	Other, Outpatient Services The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.	Other, Outpatient Services The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.	Other, Outpatient Services The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.
Numerator Statement	The number of individuals from the denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year.	Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer* *MED calculation is included in S.6 Numerator Details	Any member in the denominator who received opioid prescription claims from 4 or more prescribers AND 4 or more pharmacies.	Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer* AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies. *MED calculation is included in S.6 Numerator Details

	3389 Concurrent Use of Opioids and Benzodiazepines (COB)	2940 Use of Opioids at High Dosage in Persons Without Cancer	2950 Use of Opioids from Multiple Providers in Persons Without Cancer	2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
Numerator Details	The number of individuals from the denominator with: • 2 or more prescription claims for any benzodiazepine with unique dates of service, AND • Concurrent use of opioids and benzodiazepines for 30 or more cumulative days. Complete the steps below to identify individuals with concurrent use of opioids and benzodiazepines: Step 1: From the denominator population, identify individuals with 2 or more prescriptions claims on unique dates of service for any benzodiazepine (Table COB-B, below) during the measurement year. Step 2: Of the population identified in Step 1, determine the total days of overlap (concurrent use) between the opioid and benzodiazepine prescriptions during the measurement year. • Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of overlap that occur after the end of the measurement year. Step 3: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator. Note: When identifying days' supply for opioids (or benzodiazepines): • Exclude any days' supply that occur after the end of the measurement year. • Multiple prescription claims with the same date of service: If multiple prescription claims for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. Table COB-B: Benzodiazepines: Alprazolam, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, estazolam, flurazepam, lorazepam, midazolam, oxazepam, quazepam, temazepam, triazolam (note: excludes injectable formulations)	Any member in the denominator with opioid prescription claims greater than 120mg MED for 90 consecutive days or longer* (See Table Opioids-A: Opioid Medications) *Identifying members with prescription opioids that exceeded the MED threshold: To identify members with prescription opioids that exceeded the MED threshold, each claim is to be converted into the MED using the appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MED for each day's claims then are summed to determine the total MED for that day. For each member in the denominator: 1. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations: • # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply) • MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor) 2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. 3. Identify the days where the MED threshold is exceeded. 4. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Table Opioid-A: Opioid Medications (MED conversion factor) buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dihydrocodeine (0.25) fentanyl buccal or SL tablets, or lozenze/troche (0.13) fentanyl film or oral spray (0.18) fentanyl nasal spray (0.16) fentanyl patch (7.2) hydrocodone (1) hydromorphone (4) levorphanol (11) meperidine (0.1) methadone (3) morphine (1) opium (1) oxycodone (1.5) oxymorphone (3) pentazocine (0.37) tapentadol (0.4) tramadol (0.1) *Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., BunavailTM, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys® (fentanyl transdermal patch) is also excluded as it is only for inpatient use; It is also only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)	For each member in the denominator: 1. Calculate the number of unique pharmacy providers associated with an opioid prescription claim. 2. Calculate the number of unique prescribers associated with an opioid prescription claim. 3. Any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.	Any member in the denominator with opioid prescription claims greater than 120mg MED for 90 consecutive days or longer* AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies(See Table Opioids-A: Opioid Medications) *Identifying members with prescription opioids that exceeded the MED threshold: To identify members with prescription opioids that exceeded the MED threshold, each claim is to be converted into the MED using the appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MED for each day's claims then are summed to determine the total MED for that day. For each member in the denominator: 1. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations: • # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply) • MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor) 2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. 3. Identify the days where the MED threshold is exceeded. 4. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. 5. From the members meeting the criteria for the MED component of the numerator (4), calculate the number of unique pharmacy providers associated with an opioid prescription claim. 6. From the members meeting the criteria for the MED component of the numerator (4), calculate the number of unique prescribers associated with an opioid prescription claim. 7. From the members meeting the criteria for the MED component of the numerator (4), any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator. Table Opioid-A: Opioid Medications (MED conversion factor)

	3389 Concurrent Use of Opioids and Benzodiazepines (COB)	2940 Use of Opioids at High Dosage in Persons Without Cancer	2950 Use of Opioids from Multiple Providers in Persons Without Cancer	2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
				buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dihydrocodeine (0.25) fentanyl buccal or SL tablets, or lozenze/troche (0.13) fentanyl film or oral spray (0.18) fentanyl nasal spray (0.16) fentanyl patch (7.2) hydrocodone (1) hydromorphone (4) levorphanol (11) meperidine (0.1) methadone (3) morphine (1) opium (1) oxycodone (1.5) oxymorphone (3) pentazocine (0.37) tapentadol (0.4) tramadol (0.1) *Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., BunavailTM, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys® (fentanyl transdermal patch) is also excluded as it is only for inpatient use; It is also only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)
Denominator Statement	The denominator includes individuals 18 years and older with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days' supply is 15 or more days. Individuals with cancer or in hospice are excluded.	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.
Denominator Details	The denominator includes individuals 18 years and older by the first day of the measurement year with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days' supply is 15 or more days. Use Table COB-A: Opioids, below, to identify the opioid medications for the measure. Complete the steps below to determine the denominator: Step 1: Identify individuals aged 18 years and older as of the first day of the measurement year Step 2: Of those identified in step 1, identify individuals meeting the continuous enrollment criteria. • To be continuously enrolled, an individual may have no more than one gap in enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). Step 3: Of those identified in step 2, identify individuals with 2 or more prescription claims for opioids on unique dates of service, for which the sum of the days' supply is 15	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15. Table Opioid-A: Opioid Medications buprenorphine butorphanol codeine dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15. Table Opioid-A: Opioid Medications buprenorphine butorphanol codeine dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15. Table Opioid-A: Opioid Medications buprenorphine butorphanol codeine dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol

	3389 Concurrent Use of Opioids and Benzodiazepines (COB)	2940 Use of Opioids at High Dosage in Persons Without Cancer	2950 Use of Opioids from Multiple Providers in Persons Without Cancer	2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	or more days' supply during the measurement year. Step 4: Of those identified in step 3, identify individuals where the earliest prescription for an opioid (i.e. Index Prescription Start Date [IPSD]) is 30 or more days from the last day of the measurement year (January 1 through December 2) Note: When identifying days' supply for opioids: • Exclude any days' supply that occur after the end of the measurement year. • Multiple prescription claims with the same date of service: If multiple prescription claims for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. Table COB-A: Opioids: buprenorphine, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (note: excludes injectable formulations; includes prescription opioid cough medications; excludes single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).			
Exclusions	Individuals with cancer or in hospice at any point during the measurement year are excluded from the denominator.	Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.	Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016; (see list in S.11 and S.2b); or a hospice indicator from the enrollment database.	Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.
Exclusion Details	Hospice exclusion: Exclude any individual in hospice during the measurement year. To identify individuals in hospice: • Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or • Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid) Cancer exclusion: Exclude any individuals with cancer during the measurement year. To identify individuals with cancer: • Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened	Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19 ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b	Hospice Exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer Exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19 ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b	Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19 ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b

	3389 Concurrent Use of Opioids and Benzodiazepines (COB)	2940 Use of Opioids at High Dosage in Persons Without Cancer	2950 Use of Opioids from Multiple Providers in Persons Without Cancer	2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. • For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html			
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	The measure is stratified by the following lines of business for the health plan: • Commercial • Medicare • Medicaid Medicare Plans are further stratified by Low-Income Subsidy (LIS) status. LIS is a subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency. The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify LIS status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.	The measure is stratified by the following lines of business for the health plan: Commercial Medicare Medicaid Medicare Plans are further stratified by Low Income Subsidy status Definition: Medicare Low Income Subsidy (LIS) - A subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency. The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name correspond with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.	The measure is stratified by the following lines of business for the health plan: Commercial Medicare Medicaid Medicare Plans are further stratified by Low Income Subsidy status Definition: Medicare Low Income Subsidy (LIS) A subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency. The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name correspond with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.	The measure is stratified by the following lines of business for the health plan: Commercial Medicare Medicaid Medicare Plans are further stratified by Low Income Subsidy status Definition: Medicare Low Income Subsidy (LIS) A subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency. The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name correspond with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.
Type Score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score
Algorithm	A. Target population (denominator): Step 1: Identify individuals aged 18 years and older as of the first day of the measurement year Step 2: Of those identified in step 1, identify individuals	Step One: Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.	Step One: Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the	Step One: Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the

	3389 Concurrent Use of Opioids and Benzodiazepines (COB)	2940 Use of Opioids at High Dosage in Persons Without Cancer	2950 Use of Opioids from Multiple Providers in Persons Without Cancer	2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	meeting the continuous enrollment criteria. • To be continuously enrolled, an individual may have no more than one gap in enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). Step 3: Of those identified in step 2, identify individuals with 2 or more prescription claims for opioids on unique dates of service, for which the sum of the days' supply is 15 or more days' supply during the measurement year. Step 4: Of those identified in step 3, identify individuals where the earliest prescription for an opioid (i.e. Index Prescription Start Date [IPSD]) is 30 or more days from the last day of the measurement year (January 1 through December 2) Note: When identifying days' supply for opioids: • Exclude any days' supply that occur after the end of the measurement year. • Multiple prescription claims with the same date of service: If multiple prescription claims for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. Step 5: Identify individuals with cancer or in hospice during the measurement year. To identify individuals in hospice: • Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or • Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid) To identify individuals with cancer: • Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. • For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition	Step Two: Calculate the numerator by: For each member in the denominator: a. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations: • # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply) • MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor) b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. c. Identify the days where the MED threshold is exceeded. d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Step Three: Divide the number of members that met the criteria in numerator (Step Two d.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.	sum of the days supply is greater than or equal to 15. Step Two: Calculate the numerator by: a. Calculate the number of unique pharmacy providers associated with an opioid prescription claim. b. Calculate the number of unique prescribers associated with an opioid prescription claim. c. Any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator. Step Three: Divide the number of members that met the criteria in numerator (Step Two c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.	sum of the days supply is greater than or equal to 15. Step Two: Calculate the numerator by: For each member in the denominator: a. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations: • # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply) • MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor) b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. c. Identify the days where the MED threshold is exceeded. d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Step Three: From those members meeting the MED component in (Step 2d.) identify those members who received opioids from 4 or more prescribers AND 4 or more pharmacies. a. Calculate the number of unique pharmacy providers associated with an opioid prescription claim. b. Calculate the number of unique prescribers associated with an opioid prescription claim. c. Any member from Step 2d with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator. Step Four: Divide the number of members that met the criteria in numerator (Step Three c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.

	3389 Concurrent Use of Opioids and Benzodiazepines (COB)	2940 Use of Opioids at High Dosage in Persons Without Cancer	2950 Use of Opioids from Multiple Providers in Persons Without Cancer	2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html Step 6: Exclude individuals with cancer or in hospice (Step 5) from those identified in Step 4. This is the denominator. B. Numerator Population: Step 7: From the denominator population (from Step 6), identify individuals with 2 or more prescriptions claims on unique dates of service for any benzodiazepine during the measurement year. Step 8: Of the population identified in Step 7, determine the total days of overlap (concurrent use) between the opioid and benzodiazepine prescriptions during the measurement year. • Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of overlap that occur after the end of the measurement year. Step 9: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator. Note: When identifying days' supply for opioids (or benzodiazepines): • Exclude any days' supply that occur after the end of the measurement year. • Multiple prescription opioid (or benzodiazepine) claims with overlap: For multiple prescription claims for opioids (or benzodiazepines) with overlapping days' supply, count each day in the measurement year only once toward the denominator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines). C. Measure Rate: Step 10: Divide the number of individuals in the numerator (Step 9) by the denominator (Step 6) and multiply by 100. This is the measure rate reported as a percentage. • Report the rates separately by line of business (e.g. Medicare, Medicaid, Commercial). For Medicare, report rates for low-income			

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	subsidy (LIS) and non-LIS populations separately.			
Submission items	5.1 Identified measures: 2940 : Use of Opioids at High Dosage in Persons Without Cancer 2950 : Use of Opioids from Multiple Providers in Persons Without Cancer 2951 : Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The PQA opioid measures (NQF # 2940, 2950, and 2951) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The NCQA opioid measures were developed as an adaptation to existing PQA measures; the NCQA opioid measure denominators are similar to the PQA opioid measures, but have a different area of focus than the concurrent use of opioids and benzodiazepines measure. 5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that addresses both the same measure focus and the same target population).	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: N/A

Comparison of NQF #3400 and NQF# 3175

	3400 Use of pharmacotherapy for opioid use disorder (OUD)	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
Steward	PCPI	University of Southern California
Description	The percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.	Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment
Type	Process	Process
Data Source	Claims Medicaid Alpha-MAX 2014 data: eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided. No data collection instrument provided Attachment NQF_Value_Sets_SUD-4_FINAL_SUD_team.01.24.18.xlsx	Claims, Electronic Health Data For measure calculation, the following files from the Truven MarketScan® Commercial Database were used: • Enrollment data • Drug claims • Medical claims We used data from these files (including data from Standard Quarterly Updates) for calendar years 2010-2015. This database has long been a commonly used data source to study patterns of commercially insured patients. The database contains fully adjudicated, patient-level claims. All records in these files were used as input to identify individuals that met the measure's eligibility criteria. We present detailed results in the MIF for 2013-2014, as we have the most data for this time period, but we include measure scores for each of the two-year periods within 2010-2015. The final analytic file for 2013-2014 contained a total of 43,812 episodes. No data collection instrument provided Attachment NQF_3175_OUD_Code_Lists_1-12-17_To_NQF.xlsx
Level	Population : Regional and State	Health Plan, Population : Regional and State
Setting	Emergency Department and Services, Inpatient/Hospital, Outpatient Services	Outpatient Services

	3400 Use of pharmacotherapy for opioid use disorder (OUD)	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
Numerator Statement	Beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year.	Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days
Numerator Details	Beneficiaries identified as filling a prescription for or were administered or ordered an FDA-approved medication for OUD, during the 12-month measure year, through pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. Only formulations with an OUD indication (not pain management) are included in measure calculation. The measure will be calculated both overall and stratified by four medications/mode of administration: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. NDC codes listed are codes that were used in testing and are current as of June 2017.	The measure numerator is calculated based on commercial claims data for rolling two-year periods from 2010 to 2015: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. The measure numerator is defined as individuals in the denominator with at least 180 days of "continuous pharmacotherapy" with an OUD medication. Continuous pharmacotherapy for OUD is identified on the basis of the days covered by the days' supply of all prescription claims for any OUD medication (see list below) or number of days for which the drug was dispensed in a physician office or treatment center with the exceptions noted in this paragraph. The period of continuous pharmacotherapy starts on the day the first claim for an OUD medication is filled/supplied (index date) and lasts through the days' supply of the last claim for an OUD medication. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period. For claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If two or more prescription claims occur on the same day or overlap, the surplus based on the days' supplies accumulates over all prescriptions. However, if another claim is submitted after a claim for an injectable OUD medication or an oral OUD medication that is dispensed in an office or treatment center, the surplus from the day's supply for the injectable or office-dispensed medication is not retained. An individual is considered to have continuous pharmacotherapy with OUD medication if there is no treatment gap of more than seven days. A gap is defined as a period during which the individual does not have oral OUD medication available based on the days' supply, or is more than 7 days overdue for having an injection of an extended-release OUD medication. OUD medications were identified using National Drug Codes (NDCs) for the following: • Buprenorphine • Naltrexone (oral) • Buprenorphine and Naloxone And HCPCS codes for the following: • Buprenorphine or Buprenorphine/naloxone, oral • Methadone administration • Naltrexone (extended-release injectable) The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-dispensed oral medications (methadone and buprenorphine/naloxone) are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office and is therefore identified based on either NDC or HCPCS codes. Justification of Measure Definition: We define treatment continuity as (1) receiving at least 180 days of treatment and (2) no gaps in medication use of more than 7 days. Our definition of minimum duration is based on the fact that the FDA registration trials for OUD drugs studied the effect of treatment over three to six months (US FDAa, undated; US FDAb, undated), and we have no evidence for effectiveness of shorter durations. In addition, several recommendations support a minimum six-month treatment period as the risk of relapse is the highest in the first 6-12 months after start of opioid abstinence (US FDAa, undated; US FDAb, undated; US DHHS, 2015). Longer treatment duration is associated with better outcomes compared to shorter treatments and the best outcomes have been observed among patients in long-term methadone maintenance programs ("Effective medical treatment of opiate addiction", 1998; Gruber et al., 2008; Moos et al., 1999; NIDA, 1999; Ouimette et al., 1998; Peles et al., 2013). Studies with long-term follow-up suggest that ongoing pharmacotherapy is associated with improved odds of opioid abstinence (Hser et al., 2015; Weiss et al., 2015). We did not specify a maximum duration of treatment, as no upper limit for duration of treatment has been empirically established (US DHHS, 2015). We opted for using a treatment gap of more than seven days in our definition, given that the measure includes three active ingredients with different pharmacological profiles. There is substantial evidence for an elevated mortality risk immediately after treatment cessation (Cornish et al., 2010; Cousins et al., 2016; Davoli et al, 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016). Research suggests that methadone tolerance is lost

	3400 Use of pharmacotherapy for opioid use disorder (OUD)	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
		after three days and this three-day threshold has been used in other observational methadone studies and in developing a United Kingdom treatment guideline which recommends revaluating patients for intoxication and withdrawal after a three-day methadone treatment gap (Cousins et al., 2016; Cousins et al., 2011; "Drug Misuse and Dependence—Guidelines on Clinical Management", 1999). Across all the medications, the mortality risk is highest in the first four weeks out of treatment, with many studies showing an increase in mortality in days 1-14 after treatment cessation. Citations Cornish R, Macleod J, Strang J, Vickerman P, Hickman M. Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. BMJ. 2010;341:c5475. Cousins G, Teljeur C, Motterlini N, McCowan C, Dimitrov BD, Fahey T. Risk of drug-related mortality during periods of transition in methadone maintenance treatment: a cohort study. J Subst Abuse Treat 2011; 41: 252–60. Cousins G, Boland F, Courtney B, Barry J, Lyons S, Fahey T. Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study. Addiction. 2016;111(1):73-82. Davoli M, Bargagli AM, Perucci CA, et al. Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multisite prospective cohort study. Addiction. 2007;102:1954-9. Degenhardt L, Randall D, Hall W, Law M, Butler T, Burns L. Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: risk factors and lives saved. Drug and alcohol dependence. 2009;105:9-15. "Drug Misuse and Dependence—Guidelines on Clinical Management." Scottish Office Department of Health, Welsh Office, Social Services Northern Ireland. London: Stationery Office, 1999. Effective medical treatment of opiate addiction. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. JAMA.1998;280:1936-1943. Gibson AE, Degenhardt LJ. Mortality related to pharmacotherapies for opioid dependence: a comparative analysis of coronial records. Drug Alcohol Rev. 2007; 26(4), 405-410. Gruber VA, Delucchi KL, Kielstein A, Batki SL. A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. Drug and Alcohol Dependence. 2008;94(1-3):199-206. Hser YI, Evans E, Grella C, Ling W, Anglin D. Long-term course of opioid addiction. Harvard Review of Psychiatry. 2015;23(2):76-89. Moos RH, Finney JW, Ouimette PC, Suchinsky RT. A comparative evaluation of substance abuse treatment: I. Treatment orientation, amount of care, and 1-year outcomes. Alcohol Clin Exp Res. 1999;23(3):529-36. National Institute on Drug Abuse (NIDA). Principles of Drug Addiction Treatment: A Research-Based Guide. NIH Publication No. 99–4180. Rockville, MD: NIDA, 1999, reprinted 2000 Ouimette PC, Moos RH, Finney JW. Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. J Stud Alcohol. 1998;59:513-522 Peles E, Schreiber S, Adelson M. Opiate-dependent patients on a waiting list for methadone maintenance treatment are at high risk for mortality until treatment entry. J Addict Med. 2013;7(3):177-82.. Pierce M, Bird SM, Hickman M, Marsden J, Dunn G, Jones A, et al. Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. Addiction. 2016;111:298-308. U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. Review of Medication-Assisted Treatment Guidelines and Measures for Opioid and Alcohol Use. Washington, DC, 2015. Accessed November 9, 2016 at: https://aspe.hhs.gov/sites/default/files/pdf/205171/MATguidelines.pdf U.S. Food and Drug Administration (FDA) (a). REVIA Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2013/018932s017lbl.pdf U.S. Food and Drug Administration (FDA) (b). VIVITROL Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/021897lbl.pdf Weiss RD; Potter JS; Griffin ML, et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. Drug and Alcohol Dependence. 2015;150:112-119.

	3400 Use of pharmacotherapy for opioid use disorder (OUD)	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
Denominator Statement	Number of Medicaid beneficiaries with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.	Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication
Denominator Details	Medicaid beneficiaries age 18 through 64, enrolled for full 12 months of measurement year, and had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-9 and ICD-10 codes for OUD are provided in the attached Excel file in required format at S.2b.	The measure denominator is calculated for rolling two-year periods from 2010 to 2015: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. The denominator includes individuals 18-64 years of age during their treatment period who had a diagnosis code of OUD during an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department encounter at any time during the measurement period. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period. The diagnosis codes used to identify individuals with OUD included: • ICD-9: 304.0x, 305.5x • ICD-10: F11.xxx These codes and descriptions are contained in the sheets called "ICD-9 Diagnosis Codes" and "ICD-10 Diagnosis Codes" in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b. OUD medications were identified using National Drug Codes (NDCs) for the following: • Buprenorphine • Naltrexone (oral) • Buprenorphine and Naloxone And HCPCS codes for the following: • Buprenorphine or Buprenorphine/naloxone, oral • Methadone administration • Naltrexone (extended-release injectable) The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-or treatment-center dispensed oral medications (methadone and buprenorphine) are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office/treatment center and is therefore identified based on either NDC or HCPCS codes.
Exclusions	None.	There are no denominator exclusions.
Exclusion Details	Not applicable.	There are no denominator exclusions.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	The measure will be calculated both overall and stratified by four medications/mode of administration: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone. The NDC pharmacy codes used to identify the FDA-approved medications for OUD are listed in an Excel file attached in S.2b.	Measure results may be stratified by: • Age – Divided into four categories: 18-34, 35-44, 45-54, 55-64 years • Gender: Male, Female • State • Health plan
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step 1: Identify denominator Identify Medicaid beneficiaries age 18 through 64 years with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (primary or other diagnosis) during the measurement year and continuously enrolled during the measurement year. Age is calculated as of January 1 of the measurement year. Step 2: Identify the numerator as beneficiaries with evidence of at least one prescription filled, or were administered or ordered an FDA-approved medication for the disorder during the measurement year. The measure will report any medications used in MAT of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone. Step 2A: Identify beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year. Step 2B: Identify beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year. Step 2C: Identify beneficiaries with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year. Step 2D: Identify beneficiaries with evidence of at least one prescription for methadone at any point during the measurement year. Note: Pharmacotherapy for opioid abuse, dependence, or remission prescriptions and procedures, might occur in several	The measure score is calculated for rolling two-year periods from 2010 to 2015. The steps described below are repeated for five rolling two-year periods: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. We present detailed results in the MIF for 2013-2014, as we have the most data for this time period, but we include measure scores for each of the two-year periods within 2010-2015. DENOMINATOR: Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication CREATE DENOMINATOR: 1. For each two-year period, identify individuals who are 18-64 years of age for the duration of the first year during which they appear in the period. 2. Of individuals identified in Step 1, keep those who had at least one encounter with any diagnosis (primary or secondary) of OUD in an outpatient setting, acute inpatient setting, or emergency department setting at any time during the two-year measurement period. The OUD diagnosis codes with descriptions are contained in the sheets called "ICD-9 Diagnosis Codes" and "ICD-10 Diagnosis Codes" in the Excel file called "NQF 3175 OUD Code Lists", which is attached to this form under Item S.2b. 3. Of individuals identified in Step 2, keep those who have at least one claim with a National Drug Code (NDC) for any of the following oral OUD medications during the two-year period with a date at least 180 days before the end of the final calendar year of the measurement period: • Buprenorphine • Naltrexone (oral) • Buprenorphine and Naloxone Or a HCPCS code for any of the following OUD medications:

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	files. Similarly, a diagnosis of opioid abuse, dependence, or remission might occur in several files. For example, one claims file may contain injectables while another claims file may contain oral medications. Consequently, pharmacotherapy and opioid abuse, dependence, or remission variables are created separately in each source and then merged by beneficiary ID. Step 3: Calculate the overall rate by dividing the number of beneficiaries with evidence of at least one prescription (Step 2) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1). Then, calculate rates separately for each of the four medications. Step 3A: Calculate the buprenorphine prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for buprenorphine during the measurement year (Step 2A) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1). Step 3B: Calculate the oral naltrexone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for oral naltrexone during the measurement year (Step 2B) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1). Step 3C: Calculate the long-acting, injectable naltrexone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for injectable naltrexone during the measurement year (Step 2C) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1). Step 3D: Calculate the methadone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for methadone during the measurement year (Step 2D) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).	• Buprenorphine or Buprenorphine/naloxone, oral • Methadone administration • Naltrexone (extended-release injectable) Claims for oral medications with negative, missing, or zero days' supply were not included. The NDCs for the oral medications and the HCPCS codes for the injectable and office- or treatment center-dispensed medications are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists," which is attached to this form under Item S.2b. 4. Of individuals identified in Step 3, keep individuals who were continuously enrolled in a commercial health plan captured by our data for at least 6 months after the month with the first OUD medication claim in the measurement period, with no gap in enrollment. Individuals who are not enrolled for 6 months, including those who die during the period, are not eligible and are not included in the analysis. This is the denominator. NUMERATOR: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days CREATE NUMERATOR: For the individuals in the denominator, identify those who have at least 180 days of continuous pharmacotherapy with an OUD medication without a gap of more than seven days using the following method: 1. Determine the number of days for the PDC denominator. The start date is the service date (fill date) of the first prescription or injection/dispensing claim for an OUD medication in the two-year measurement period. The end date is defined as the earliest of: • The date on which the individual exhausts their days' supply, including any pre-existing surplus, following their final claim (assuming daily use). • The individual's death date. • December 31st of the second year in the two-year period. 2. For each individual: Count the days during the observation period for which the individual was covered by at least one OUD medication based on the prescription drug or injection/dispensing claim service dates and days' supply. 2a. Sort OUD medication claims by individual's ID and service date. Scan the claims in order, calculating a rolling surplus which accumulates any remaining days' supply from other prior or same-day fills. 2b. Naltrexone injections contribute 30 days' supply unless another claim is found sooner, in which case the Naltrexone injection covers only the days up to the next claim. 2c. Methadone and buprenorphine/naloxone supply is determined by the start and end dates on the outpatient claims with the codes for in-office/treatment center dispensation of methadone (H0020) and buprenorphine/naloxone (J0571-J0575). 2d. Claims for Naltrexone injections and for licensed treatment center-dispensed methadone and office-dispensed buprenorphine/naloxone are not added to the surplus supply and only one such claim per day is counted. 2e. For claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. 3. Determine treatment gaps as periods, in which the individual has exhausted his/her available supply, defined as the days' supply from the most recent previous fill/dispensing and any pre-existing surplus available before that fill/dispensing. 4. Of the individuals in Step 2, count the number of individuals who have a period of 180 days or greater from the start date of the first claim for OUD medication to the end date of the last claim for OUD medication within the two-year period and who do not have a gap of more than seven days without OUD medication available. This is the numerator. CALCULATE MEASURE SCORE: 1. Calculate the measure score by dividing the numerator by the denominator. 2. Calculate the measure score for each state. The state code on the claim record is used to identify individuals in each state. The measure score is then reported for each state that has at least 20 individuals in the denominator. 3. Calculate the measure score for each health plan. Health plan membership is approximated based on a combination of two variables found on the claim record, industry type and Metropolitan Statistical Area (MSA). A health plan identifier is assigned based on each unique combination of industry and MSA. The health plan identifier is used to group individuals into health plans. The measure score is then reported for each health plan that has at least 20 individuals in the denominator.
Submission items	5.1 Identified measures: 3175 : Continuity of Pharmacotherapy for Opioid Use Disorder 5a.1 Are specs completely harmonized? Yes	5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

	3400 Use of pharmacotherapy for opioid use disorder (OUD)	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
	5a.2 If not completely harmonized, identify difference, rationale, impact: Not Applicable. 5b.1 If competing, why superior or rationale for additive value: Not Applicable.	1664 : SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The target population of the proposed measure is related to the two measures listed above (NQF 0004 and NQF 1664). Differences among the three measures, along with the rationale and impact, are discussed below in the text box for Item 5b.1. The text box for this item (5a.2) would not accommodate the length of our response. 5b.1 If competing, why superior or rationale for additive value: There are no competing measures that address both the same measure focus and the same target population as the proposed measure. RESPONSE TO ITEM 5A.2 The information below is the response to Item 5a.2, describing the differences, rationale, and impact on interpretability and data collection burden for the two NQF-endorsed RELATED measures which were identified. (We have inserted it here because the text box under Item 5a.2 would not accept this volume of formatted text.) The target population of the proposed measure is related to the two NQF-endorsed measures listed above (NQF 0004 and NQF 1664). The proposed measure focuses on continuity of pharmacotherapy for patients with OUD. NQF 0004 focuses on treatment initiation and engagement of patients with a new episode of OUD or other substance use disorders, including alcohol use disorder (AUD). NQF 1664 focuses on 0UD and other drug use disorders among hospital discharges. Differences among the three measures, along with the rationale and impact are discussed below. Diagnoses Included in Denominator Definition • Proposed measure: Diagnosis of OUD • NQF 0004: Diagnosis of alcohol or other drug dependence • NQF 1664: Diagnosis of AUD or another substance use disorder • Rationale and impact of focusing on only OUD: There are different medications for treatment of OUD and AUD, and there are no FDA-approved medications for treatment of other substance use disorders. In addition, the conceptual issues related to continuity of pharmacotherapy differ between OUD and AUD, so developing separate measures for the two disorders is required. The impact of this is a more narrowly focused measure that provides information specific to individuals with OUD. Age Range • Proposed measure: Patients 18-64 years of age • NQF 0004: Patients aged 13 years of age and older • NQF 1664: Patients 18 years of age and older • Rationale and impact of limiting to individuals 18-64 years of age: Medications for treatment of OUD have not been approved by the FDA for adolescent patients 13-17 years of age; therefore, the proposed measure is restricted to adults 18-64 years of age. Data Source • Proposed measure: Electronic claims data • NQF 0004: Administrative claims, electronic clinical data • NQF 1664: Electronic clinical data, paper medical records • Rationale and impact of using electronic claims data: Electronic claims data are timely, accessible, and relatively inexpensive to use for analyses of a large number of patients. Using a single source of data expedites the calculation of the measure, and will provide feedback to providers sooner. Inpatient vs. Outpatient • Proposed measure: Inpatient and outpatient • NQF 0004: Inpatient and outpatient • NQF 1664: Inpatient discharges • Rationale and impact of using inpatient and outpatient records to identify patients: A large majority of patients with OUD are not admitted to a hospital, so using inpatient and outpatient data leads to more complete identification of the population eligible for treatment. Process of Care Included in Numerator Definition • Proposed measure: Continuity of pharmacotherapy for OUD • NQF 0004: Inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization for adults with a new episode of AUD, OUD, or other substance use disorders • NQF 1664: Medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment • Rationale and impact of the process of care included in the numerator definition: Successful pharmacotherapy of OUD requires continuity over at least a 180-day period. Therefore, providing feedback to providers about continuity of OUD pharmacotherapy

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		has the potential to improve continuity rates by increasing provider awareness, and motivating health plans and insurers to develop educational material and programs about pharmacotherapy for OUD for both providers and patients.

Appendix E2: Related and Competing Measures (narrative format)

Comparison of NQF #0104e and NQF #1365e

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Steward

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Centers for Medicare and Medicaid Services

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

PCPI

Description

0104e 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

1365e 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

Type

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Process

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Process

Data Source

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Electronic Health Records Not Applicable

No data collection instrument provided Attachment 0104_MDD_SuicideRisk_ValueSets_2017September29.xlsx

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Electronic Health Records Not Applicable

No data collection instrument provided Attachment EP_EC_CMS177v6_NQF1365_CAMDD_SuicideRisk_ValueSets.xlsx

Level

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Clinician : Group/Practice, Clinician : Individual

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Clinician : Group/Practice, Clinician : Individual

Setting

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Emergency Department and Services, Other, Outpatient Services Behavioral Health Day Treatment

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Outpatient Services

Numerator Statement

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Patient visits with an assessment for suicide risk

Numerator Details

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Time Period for Data Collection: At every visit where a new diagnosis or recurrent episode of Major Depressive Disorder is identified [initial evaluation during the episode]

Definition:

Suicide risk assessment - Must include questions about the following:

1) Suicidal ideation

2) Patient's intent of initiating a suicide attempt

AND, if either is present,

3) Patient plans for a suicide attempt

4) Whether the patient has means for completing suicide

GUIDANCE:

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped

to the concept “Intervention, Performed: Suicide Risk Assessment” included in the numerator logic in the attached HQMF in field

S.2a.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Time Period for Data Collection: At each visit for major depressive disorder during the measurement period.

HQMF eCQM developed and is attached to this submission in field S.2a.

We have provided the following definitions and/or guidance for convenience; please see HQMF eCQM for complete details related to the specification.

NUMERATOR DEFINITION:

The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate:

1. Risk (eg, age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (eg, religious belief, concern not to hurt family) that may influence the desire to attempt suicide.

2. Current severity of suicidality.

3. Most severe point of suicidality in episode and lifetime.

Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used.

NUMERATOR GUIDANCE:

A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period.

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed: Suicide Risk Assessment" included in the numerator logic in the HQMF eCQM attached in field S.2a.

Denominator Statement

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder

Denominator Details

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Time Period for Data Collection: 12 consecutive months

Guidance:

This measure is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of major depressive disorder (MDD); every new or recurrent episode will count separately in the Initial Population.

It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (ie, at the initial evaluation). For the purposes of this measure, an episode of MDD would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for MDD, that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence.

The measure description outlined in the header for this measure states, 'patients aged 18 years and older' while the logic statement states, '>= 17 year(s) at: "Measurement Period"'. The logic statement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure. To ensure all

patients with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS 177 covers children and adolescents aged 6 through 17, and CMS 161 covers the adult population aged 18 years and older.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Time Period for Data Collection: 12 consecutive months.

HQMF eCQM developed and is attached to this submission in field S.2a.

We have provided the following definitions and/or guidance for convenience; please see HQMF eCQM for complete details related to the specification.

DENOMINATOR DEFINITION:

None

DENOMINATOR GUIDANCE:

This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment.

Exclusions

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

None

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

None

Exclusion Details

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Not Applicable

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

N/A

Risk Adjustment

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

No risk adjustment or risk stratification

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

No risk adjustment or risk stratification

Stratification

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

Type Score

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Rate/proportion better quality = higher score

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Rate/proportion better quality = higher score

Algorithm

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

If the patient does not meet the numerator, this case represents a quality failure.

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

To calculate performance rates:

1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address).

2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.

3) From the patients within the denominator, find the patients who meet the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

If the patient does not meet the numerator, this case represents a quality failure.

Submission items

0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

5.1 Identified measures: 1365 : Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The guidelines used as evidence in the NQF 1365: Child and Adolescent Major Depressive Disorder (MDD) Suicide Risk Assessment explicitly recommend suicide assessment at every visit for MDD whereas the guidelines used for evidence in this measure do not emphasize this level of assessment frequency.

5b.1 If competing, why superior or rationale for additive value: Both of these measures (0104 and 1365) were developed by PCPI and updated and harmonized with each other on an annual basis. They are not competing because they are used in different patient populations and have different frequencies of suicide assessment based on their respective evidence.

1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

5.1 Identified measures: 0104 : Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

0111 : Bipolar Disorder: Appraisal for risk of suicide

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Our measure addresses a different target population, children and adolescents with MDD, from the related measures that focus on adults with MDD and patients with bipolar disorder. As a result, the recommended frequency of suicide assessment is different in our measure from the other measures.

5b.1 If competing, why superior or rationale for additive value: Because our measure emphasizes a different target population and a different type/frequency of assessment, we feel multiple measures are justified to address suicide risk assessment differently in different high-risk populations.

Comparison of NQF #0105 and NQF #1880

0105 Antidepressant Medication Management (AMM)

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Steward

0105 Antidepressant Medication Management (AMM)

National Committee for Quality Assurance

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

National Committee for Quality Assurance

Description

0105 Antidepressant Medication Management (AMM)

The percentage of members 18 years of age and older who were treated antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported.

a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).

Type

0105 Antidepressant Medication Management (AMM)

Process

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Process

Data Source

0105 Antidepressant Medication Management (AMM)

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via the Interactive Data Submission System (IDSS) portal.

No data collection instrument provided Attachment 0105_AMM_Value_Sets_updated_4.11.18.xlsx

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Claims For measure calculation in the Medicare product line, the following Medicare files were required:

- Denominator tables
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

For ACO attribution, the following were required:

• Denominator tables for Parts A and B enrollment

• Prescription drug benefit (Part D) coverage tables

• Beneficiary file

• Institutional claims (Part A)

• Non-institutional claims (Part B)—physician carrier/non-DME

• Prescription drug benefit (Part D) claims

For physician group attribution, the following were required:

• Non-institutional claims (Part B)—physician carrier/non-DME

• Denominator tables to determine individual enrollment

• Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payor status

• CMS physician and physician specialty tables

• National Plan and Provider Enumeration System (NPPES) database

No data collection instrument provided Attachment NQF_1880_Code_Tables_2018_Final.xlsx

Level

0105 Antidepressant Medication Management (AMM)

Health Plan

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : Regional and State

Setting

0105 Antidepressant Medication Management (AMM)

Outpatient Services

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Outpatient Services

Numerator Statement

0105 Antidepressant Medication Management (AMM)

Adults 18 years of age and older who were newly treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.

Numerator Details

0105 Antidepressant Medication Management (AMM)

a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of treatment with antidepressant medication (Table AMM-C) during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 231-day period following the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

TABLE AMM-C: ANTIDEPRESSANT MEDICATIONS

Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine

Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine

Phenylpiperazine antidepressants: Nefazodone, Trazodone

Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine

SNRI antidepressants : Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine

SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline

Tetracyclic antidepressants: Maprotiline, Mirtazapine

Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

PDC NUMERATOR

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all mood stabilizer medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

Denominator Statement

0105 Antidepressant Medication Management (AMM)

Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).

Denominator Details

0105 Antidepressant Medication Management (AMM)

Step 1: Determine the Index Prescription Start Date (IPSD). Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period (The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year).

Step 2: Required exclusion: Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Patients who meet any of the following criteria remain in the eligible population:

• An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:

– AMM Stand Alone Visits Value Set with Major Depression Value Set. with or without a telehealth modifier (Telehealth Modifier Value Set).

– AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). .

• Telephone Visits Value Set with Major Depression Value Set.

• An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).

• An acute or nonacute inpatient stay discharge with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges:

First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Second, identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.

Step 3: Test for Negative Medication History. Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 4: Calculate continuous enrollment. Patients must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

TABLE AMM-C: ANTIDEPRESSANT MEDICATIONS

Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine

Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine

Phenylpiperazine antidepressants: Nefazodone, Trazodone

Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine

SNRI antidepressants : Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine

SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline

Tetracyclic antidepressants: Maprotiline, Mirtazapine

Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine

*See corresponding Excel file for value sets referenced above.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Target population meets the following conditions:

1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement year;

2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement year; and,

3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement year.

IDENTIFICATION OF BIPOLAR I DISORDER

Individuals with bipolar I disorder are identified by having a diagnosis of bipolar I disorder within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period.

CODES USED TO IDENTIFY BIPOLAR I DISORDER DIAGNOSIS

Codes used to identify bipolar I disorder are included in the attached Excel worksheet of codes (NQF_1880_Code Tables_2018 Final) under the tab NQF_1880_Bipolar_ICD9-10.

TABLE 1. BIPOLAR I DISORDER DIAGNOSIS

ICD-9-CM: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7

ICD-10-CM: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.89, F31.9

CODES USED TO IDENTIFY ENCOUNTER TYPE

Codes used to identify encounters are under tab NQF_1880_Encounter_types.

TABLE 2.1. OUTPATIENT SETTING

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

TABLE 2.2. EMERGENCY DEPARTMENT SETTING

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

TABLE 2.3. NON-ACUTE INPATIENT SETTING

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

TABLE 2.4. ACUTE INPATIENT SETTING

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

POS: 21, 51

IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR MOOD STABILIZER MEDICATION

Individuals with at least two prescription drug claims for any of the following mood stabilizer medications (Table 3: Mood Stabilizer Medications) or long-acting injectable

antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1880_Mood_Stabilizers of the attached Excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.

MOOD STABILIZER MEDICATIONS

TABLE 3. MOOD STABILIZER MEDICATIONS

Active ingredients listed below are limited to oral, buccal, sublingual, and translingual formulations only.

Anticonvulsants:

carbamazepine

divalproex sodium

lamotrigine

valproic acid

Atypical Antipsychotics:

aripiprazole

asenapine

cariprazine

lurasidone

olanzapine

quetiapine

quetiapine fumarate (Seroquel)

risperidone

ziprasidone

Phenothiazine/Related Antipsychotics:

chlorpromazine

loxapine succinate

Other Antipsychotics:

olanzapine-fluoxetine

Lithium Salts:

lithium carbonate

lithium citrate

TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS

The following are the long-acting (depot) injectable antipsychotic medications. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Atypical Antipsychotic Medications:

aripiprazole (J0401)

risperidone microspheres (J2794)

Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B:

aripiprazole (J0401) – 28 days' supply

risperidone microspheres (J2794) – 14 days' supply

Exclusions

0105 Antidepressant Medication Management (AMM)

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.

Exclude patients who filled a prescription for an antidepressant 105 days prior to the IPSD.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Not Applicable

Exclusion Details

0105 Antidepressant Medication Management (AMM)

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Patients who meet any of the following criteria remain in the eligible population:

• An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:

– AMM Stand Alone Visits Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

– AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

• Telephone Visits Value Set with Major Depression Value Set.

• An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).

• An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges:

First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Second, identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.

Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

*See corresponding Excel file for value sets referenced above.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Not Applicable

Risk Adjustment

0105 Antidepressant Medication Management (AMM)

No risk adjustment or risk stratification

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

No risk adjustment or risk stratification

Stratification

0105 Antidepressant Medication Management (AMM)

NCQA asks that health plans collect the measure data for each of the three product lines each year (i.e. commercial, Medicare, Medicaid) if applicable.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Depending on the operational use of the measure, measure results may be stratified by:

- State
- Accountable Care Organization (ACOs)*
- Plan
- Physician Group**
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

*ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers.

**See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.

Type Score

0105 Antidepressant Medication Management (AMM)

Rate/proportion better quality = higher score

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Rate/proportion better quality = higher score

Algorithm

0105 Antidepressant Medication Management (AMM)

Step 1: Determine the eligible population, or denominator.

Step 1a: Determine the Index Prescription Start Date (IPSD). Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the

Intake Period (the 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year).

Step 1b: Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.

Step 1c: Test for Negative Medication History. Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 1d: Calculate continuous enrollment. Exclude patients who are not continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Step 2: Determine the numerators for the two reported rates.

Step 2a (Effective Acute Phase Treatment): Identify at least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Step 2b (Effective Continuation Phase Treatment): Identify at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 232-day period following the IPSD. Continuous treatment allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Step 3: Calculate the two reported rates by dividing both the numerators from steps 2a and 2b by the denominator in step 1d.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D.

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).

CREATE DENOMINATOR:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.

2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.

3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).

4. Of those individuals identified in Step 3, keep those who had:

At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period.

5. Of the individuals identified in Step 4, extract Medicare Part D claims for a mood stabilizer during the measurement period. Attach the drug ID and the generic name to the dataset.

6. For the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any mood stabilizer on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period.

Numerator: Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.

CREATE NUMERATOR:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for a mood stabilizer medication in the measurement period.

2. Within the medication therapy period, count the days the individual was covered by at least one drug in the mood stabilizer medication class based on the prescription drug claim service date and days of supply.

a. Sort and de-duplicate Medicare Part D claims for mood stabilizers by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.

b. Calculate the number of days covered by mood stabilizer therapy per individual.

i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

ii. If claims for the same drug (generic name) overlap, then adjust the latest prescription start date to be the day after the previous fill has ended.

iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the mood stabilizers. This is the numerator.

PHYSICIAN GROUP ATTRIBUTION:

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPIs. Valid NPIs have 10 numeric characters (no alpha characters).

2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.

3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.

4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).

5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)

a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.

b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.

c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

6. Identify TINs that are not solo practices.

a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.

b. Count unique NPIs per TIN.

c. Keep only those TINs having two or more providers.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).

8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.

9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.

a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.

b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.

a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year.

b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:

• A = working-age individual/spouse with an employer group health plan (EGHP)

• B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP

• G = working disabled for any month of the year

c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.

d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.

a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.

b. Exclude claims with no npi_prfrmg.

12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.

a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.

b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.

14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.

15. Attribute the individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.

16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*
02—General surgery
03—Allergy/immunology
04—Otolaryngology
05—Anesthesiology
06—Cardiology
07—Dermatology
08—Family practice*
09—Interventional pain management
10—Gastroenterology
11—Internal medicine*
12—Osteopathic manipulative therapy
13—Neurology
14—Neurosurgery
16—Obstetrics/gynecology*
18—Ophthalmology
20—Orthopedic surgery
22—Pathology
24—Plastic and reconstructive surgery
25—Physical medicine and rehabilitation
26—Psychiatry*
28—Colorectal surgery
29—Pulmonary disease
30—Diagnostic radiology
33—Thoracic surgery
34—Urology
36—Nuclear medicine
37—Pediatric medicine
38—Geriatric medicine*
39—Nephrology
40—Hand surgery
44—Infectious disease
46—Endocrinology
50—Nurse practitioner*
66—Rheumatology
70—Multi-specialty clinic or group practice*
72—Pain management
76—Peripheral vascular disease
77—Vascular surgery

78—Cardiac surgery

79—Addiction medicine

81—Critical care (intensivists)

82—Hematology

83—Hematology/oncology

84—Preventive medicine*

85—Maxillofacial surgery

86—Neuropsychiatry*

90—Medical oncology

91—Surgical oncology

92—Radiation oncology

93—Emergency medicine

94—Interventional radiology

97—Physician assistant*

98—Gynecologist/oncologist

99—Unknown physician specialty

Other—NA

*Provider specialty codes specific to this measure

Submission items

0105 Antidepressant Medication Management (AMM)

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: N/A

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

5.1 Identified measures: 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease

0542 : Adherence to Chronic Medications

0545 : Adherence to Statins for Individuals with Diabetes Mellitus

0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

0580 : Bipolar antimanic agent

0109 : Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors

0110 : Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

0111 : Bipolar Disorder: Appraisal for risk of suicide

0112 : Bipolar Disorder: Level-of-function evaluation

0003 : Bipolar Disorder: Assessment for diabetes

1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia

1927 : Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications

1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879) and the NCQA version of the same measure (Adherence to Antipsychotic Medications for Individuals with Schizophrenia), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in all three measures. The methodology used to identify the denominator population is also calculated the same in all three measures, with the exception of the clinical conditions which is the target of the measure. The data collection burden is identical for the measures. The only differences between Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879), and the related NCQA measure are: (1) the clinical codes used to identify the different populations in each measure (NQF #1880 – individuals with bipolar I disorder; NQF #1879 and NCQA measure– individuals with schizophrenia); (2) the medications includes in each measure (NQF #1880- mood stabilizers; NQF #1879 and the NCQA measure– antipsychotics); and, (3) an exclusion for dementia which is included in NQF #1879 and the NCQA measure but not in NQF #1880. The rationale for these difference is due to the different clinical focus of each measure. There is no impact on interpretability since the measures clearly identify the disparate clinical focus. During development the measure developers worked to harmonize this measure with other measures which were NQF-endorsed at the time of development. The section below is from the original submission of the measure for initial endorsement and refers to measures which are no longer NQF-endorsed. We are including this language to demonstrate the efforts of the measure developers to harmonize this measure with other measures. MEASURES WITH WHICH THE MEASURE IS HARMONIZED. The measure has been harmonized where feasible with NQF #0542, #0543, #0545, #0541, #1879, #1927, and #1932 MEASURES WITH WHICH THE MEASURE IS NOT HARMONIZED. The measure specifications of the measure are not harmonized with the following NQF-endorsed measures that have the same measure focus (use of mood stabilizers among patients with Bipolar Disorder): NQF #0580 Bipolar antimanic agent. DIFFERENCES BETWEEN MEASURE 1880 AND MEASURE 0580. One NQF-endorsed measure (NQF #0580) focuses on a similar concept, but differs from this measure in two important ways. First, the NQF-endorsed measure includes individuals with newly diagnosed bipolar disorder and major depressive disorder. However, this measure includes all individuals with bipolar I disorder, not just those who are newly diagnosed, and does not include individuals with major depressive disorder. Second, the NQF-endorsed measure identifies the percentage of eligible individuals who have received at least 1 prescription for a mood-stabilizing agent during the measurement year, while this measure measures the percentage of eligible individuals with a proportion of days covered (PDC) for mood stabilizer medications greater than 0.8 during the measurement year. RATIONALE. This measure is an improved measure that adds value because it measures adherence to mood stabilizer treatment for individuals with bipolar I disorder. In contrast, the NQF measure (NQF# 0580) is linked to a one-time prescription for mood stabilizer treatment.

IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN. Differences have not been identified concerning the data collection burden between Measure 1880 and Measure 0580. However, interpretability for Measure 1880 (as compared to NQF #0580) is improved because Measure 1880 focuses on adherence rather than a single prescription, and Measure 1880 is harmonized with the majority of adherence measures for other chronic diseases in the NQF portfolio and those that are being publicly reported by CMS.

5b.1 If competing, why superior or rationale for additive value: This measure does not address both the same measure focus and population as another NQF-endorsed measure.

Comparison of NQF #1879, NQF #1880, NQF #0541

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Steward

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

National Committee for Quality Assurance

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Pharmacy Quality Alliance

Description

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, Statins.

A higher score indicates better quality.

Type

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Process

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Process

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Process

Data Source

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Claims The data source for the measure calculation required the following Medicare files depending on the level of accountability where the measure is being used:

- Denominator tables to determine individual enrollment
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME (durable medical equipment)
- Prescription drug benefit (Part D) claims
- Centers for Medicare and Medicaid Services (CMS) physician and physician specialty tables
- National Plan and Provider Enumeration System (NPPES) database

No data collection instrument provided Attachment NQF_1879_Code_Tables_2018_Final.xlsx

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Claims For measure calculation in the Medicare product line, the following Medicare files were required:

- Denominator tables
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

For ACO attribution, the following were required:

- Denominator tables for Parts A and B enrollment
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

For physician group attribution, the following were required:

- Non-institutional claims (Part B)—physician carrier/non-DME
- Denominator tables to determine individual enrollment

• Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payor status

• CMS physician and physician specialty tables

• National Plan and Provider Enumeration System (NPPES) database

No data collection instrument provided Attachment NQF_1880_Code_Tables_2018_Final.xlsx

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Claims Health plan prescription claims data and enrollment data (e.g. Medicare Part D)

No data collection instrument provided No data dictionary

Level

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Clinician : Group/Practice, Health Plan, Population : Regional and State

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : Regional and State

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Clinician : Group/Practice, Health Plan

Setting

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Outpatient Services

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Outpatient Services

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Outpatient Services

Numerator Statement

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.

Step 1: Determine the patient's treatment period, defined as the index prescription date (date of the first fill of the target medication) to the end of the calendar year, disenrollment, or death.

Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*

Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4: Count the number of patients who had a PDC 80% or greater and then divide by the total number of eligible patients.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of combination product to another combination product where a least one of the drugs from the target therapeutic class is common.

Numerator Details

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

PDC NUMERATOR

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all antipsychotic medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

PDC NUMERATOR

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all mood stabilizer medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim

with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.

Step 1: Determine the patient's treatment period, defined as the index prescription date (date of the first fill of the target medication) to the end of the calendar year, disenrollment, or death.

Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*

Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4: Count the number of patients who had a PDC 80% or greater and then divide by the total number of eligible patients.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of combination product to another combination product where a least one of the drugs from the target therapeutic class is common.

RENIN ANGIOTENSIN SYSTEM (RAS) ANTAGONISTS: aliskiren, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan,valsartan, azilsartan, benazepril,captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolopril, amlodipine & benazepril, benazepril & HCTZ, captopril & HCTZ, enalapril & HCTZ, fosinopril & HCTZ, lisinopril & HCTZ, moexipril & HCTZ, perindopril & amlodipine, quinapril & HCTZ, trandolopril & verapamil HCL, candesartan & HCTZ, eprosartan & HCTZ, telmisartan & amilodipine, nebivolol & valsartan, irbesartan & HCTZ, losartan & HCTZ, amlodipine & olmesartan, azlisartan & chlorthalidone, olmesartan & HCTZ, telmisartan & HCTZ, olmesartan & amlodipine & HCTZ, valsartan & HCTZ, amlodipine & valsartan, amlodipine & valsartan & HCTZ, aliskiren & amlodipine, aliskiren & amlodipine & HCTZ, aliskiren & HCTZ,

DIABETES MEDICATIONS: (Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV Inhibitors, Incretin Mimetic Agents, Meglitinides, Sodium glucose co-transporter2 (SGLT2) inhibitors and combination products that include these medications)

metformin, glipizide & metformin, glyburide & metformin, chlorpropamide, glimepiride, glipizide, glyburide, tolazamide, tolbutamide, pioglitazone, rosiglitazone, rosiglitazone & metformin, rosiglitazone & glimepiride, pioglitazone & metformin, pioglitazone & glimepiride, alogliptin & pioglitazone, sitagliptin, linagliptin, saxagliptin, alogliptin, sitagliptin & metformin, saxagliptin & metformin SR, sitagliptin & simvastatin, linagliptin & metformin, alogliptin & metformin, exenatide, liraglutide, nateglinide, repaglinide, repaglinide & metformin, canagliflozin, alogliptin & metformin, empagliflozin & linagliptin, dulaglutide, liraglutide, lisxisenatide, albiglutide, empagliflozin, dapagliflozin, dapagliflozin

& metformin, empagliflozin & linagliptin, canagliflozin & metformin, empagliflozin & metformin

STATINS: lovastatin, rosuvastatin, fluvastatin, atorvastatin, pravastatin, pitavastatin, simvastatin, niacin & lovastatin, atorvastatin & amlodipine, niacin & simvastatin, sitagliptin & simvastatin, ezetimibe & simvastatin, ezetimibe & atorvastatin

Denominator Statement

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year.

For the Diabetes rate only: Exclude any patient with one or more prescriptions for insulin in the treatment period. Exclude any patient with ESRD

For RASA rate only: Exclude any patient with one or more prescription claims for sacubitril/valsartan during the treatment period. Exclude any patient with ESRD

Denominator Details

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Target population meets the following conditions:

1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement period;

2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and,

3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement period.

IDENTIFICATION OF SCHIZOPHRENIA

Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of schizophrenia or schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

CODES USED TO IDENTIFY SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER DIAGNOSIS

Codes used to identify schizophrenia or schizoaffective disorder are included in the attached excel worksheet of codes (NQF_1879_Code Tables_2018_Final.xlsx) under the tab NQF_1879_Schizophrenia.

Table 1: Schizophrenia or Schizoaffective Disorder Diagnosis

ICD-9-CM: 295.xx

ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

CODES USED TO IDENTIFY ENCOUNTER TYPE:

Codes used to identify encounters are under tab NQF_1879_Encounter_types.

Table 2.1: Outpatient Setting

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

Table 2.2: Emergency Department Setting

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

Table 2.3: Non-Acute Inpatient Setting

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

Table 2.4: Acute Inpatient Setting

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

POS: 21, 51

IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR ANTIPSYCHOTIC MEDICATION:

Individuals with at least two prescription drug claims for any of the following oral antipsychotic medications (Table 3: Oral Antipsychotic Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1879_ Antipsychotics of the attached excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.

TABLE 3: ORAL ANTIPSYCHOTIC MEDICATIONS

The following are oral formulations only.

Typical Antipsychotic Medications:

chlorpromazine

fluphenazine

haloperidol

loxapine

molindone

perphenazine

prochlorperazine

thioridazine

thiothixene

trifluoperazine

Atypical Antipsychotic Medications:

aripiprazole

asenapine

brexpiprazole

cariprazine

clozapine

iloperidone

lurasidone

olanzapine

paliperidone

quetiapine

quetiapine fumarate (Seroquel)

risperidone

ziprasidone

Antipsychotic Combinations:

perphenazine-amitriptyline

TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS

The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Typical Antipsychotic Medications:

fluphenazine decanoate (J2680)

haloperidol decanoate (J1631)

Atypical Antipsychotic Medications:

aripiprazole (J0401)

aripiprazole lauroxil (Aristada)

olanzapine pamoate (J2358)

paliperidone palmitate (J2426)

risperidone microspheres (J2794)

Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B:

fluphenazine decanoate (J2680) – 28 days' supply

haloperidol decanoate (J1631) – 28 days' supply

aripiprazole (J0401) – 28 days' supply

aripiprazole lauroxil (Aristada) - 28 days' supply

olanzapine pamoate (J2358) – 28 days' supply

paliperidone palmitate (J2426) – 28 days' supply

risperidone microspheres (J2794) – 14 days' supply

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Target population meets the following conditions:

1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement year;

2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement year; and,

3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement year.

IDENTIFICATION OF BIPOLAR I DISORDER

Individuals with bipolar I disorder are identified by having a diagnosis of bipolar I disorder within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period.

CODES USED TO IDENTIFY BIPOLAR I DISORDER DIAGNOSIS

Codes used to identify bipolar I disorder are included in the attached Excel worksheet of codes (NQF_1880_Code Tables_2018 Final) under the tab NQF_1880_Bipolar_ICD9-10.

TABLE 1. BIPOLAR I DISORDER DIAGNOSIS

ICD-9-CM: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7

ICD-10-CM: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.89, F31.9

CODES USED TO IDENTIFY ENCOUNTER TYPE

Codes used to identify encounters are under tab NQF_1880_Encounter_types.

TABLE 2.1. OUTPATIENT SETTING

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

TABLE 2.2. EMERGENCY DEPARTMENT SETTING

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

TABLE 2.3. NON-ACUTE INPATIENT SETTING

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

TABLE 2.4. ACUTE INPATIENT SETTING

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

POS: 21, 51

IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR MOOD STABILIZER MEDICATION

Individuals with at least two prescription drug claims for any of the following mood stabilizer medications (Table 3: Mood Stabilizer Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1880_Mood_Stabilizers of the attached Excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.

MOOD STABILIZER MEDICATIONS

TABLE 3. MOOD STABILIZER MEDICATIONS

Active ingredients listed below are limited to oral, buccal, sublingual, and translingual formulations only.

Anticonvulsants:

carbamazepine

divalproex sodium

lamotrigine

valproic acid

Atypical Antipsychotics:

aripiprazole

asenapine

cariprazine

lurasidone

olanzapine

quetiapine

quetiapine fumarate (Seroquel)

risperidone

ziprasidone

Phenothiazine/Related Antipsychotics:

chlorpromazine

loxapine succinate

Other Antipsychotics:

olanzapine-fluoxetine

Lithium Salts:

lithium carbonate

lithium citrate

TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS

The following are the long-acting (depot) injectable antipsychotic medications. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Atypical Antipsychotic Medications:

aripiprazole (J0401)

risperidone microspheres (J2794)

Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B:

aripiprazole (J0401) – 28 days' supply

risperidone microspheres (J2794) – 14 days' supply

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year.

(For the Diabetes rate only: Exclude any patient with one or more prescriptions for insulin in the measurement period - See S.10)

RENIN ANGIOTENSIN SYSTEM (RAS) ANTAGONISTS: aliskiren, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan,valsartan, azilsartan, benazepril,captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolopril, amlodipine & benazepril, benazepril & HCTZ, captopril & HCTZ, enalapril & HCTZ, fosinopril & HCTZ, lisinopril & HCTZ, moexipril & HCTZ, perindopril & amlodipine, quinapril & HCTZ, trandolopril & verapamil HCL, candesartan & HCTZ, eprosartan & HCTZ, telmisartan & amilodipine, nebivolol & valsartan, irbesartan & HCTZ, losartan & HCTZ, amlodipine & olmesartan, azlisartan & chlorthalidone, olmesartan & HCTZ, telmisartan & HCTZ, olmesartan & amlodipine & HCTZ, valsartan & HCTZ, amlodipine & valsartan, amlodipine & valsartan & HCTZ, aliskiren & amlodipine, aliskiren & amlodipine & HCTZ, aliskiren & HCTZ,

DIABETES MEDICATIONS: (Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV Inhibitors, Incretin Mimetic Agents, Meglitinides, Sodium glucose co-transporter2 (SGLT2) inhibitors and combination products that include these medications)

metformin, glipizide & metformin, glyburide & metformin, chlorpropamide, glimepiride, glipizide, glyburide, tolazamide, tolbutamide, pioglitazone, rosiglitazone, rosiglitazone & metformin, rosiglitazone & glimepiride, pioglitazone & metformin, pioglitazone & glimepiride, alogliptin & pioglitazone, sitagliptin, linagliptin, saxagliptin, alogliptin, sitagliptin & metformin, saxagliptin & metformin SR, sitagliptin & simvastatin, linagliptin & metformin, alogliptin & metformin, exenatide, liraglutide, nateglinide, repaglinide, repaglinide & metformin, canagliflozin, alogliptin & metformin, empagliflozin & linagliptin, dulaglutide, liraglutide, lisxisenatide, albiglutide, empagliflozin, dapagliflozin, dapagliflozin & metformin, empagliflozin & linagliptin, canagliflozin & metformin, empagliflozin & metformin

STATINS: lovastatin, rosuvastatin, fluvastatin, atorvastatin, pravastatin, pitavastatin, simvastatin, niacin & lovastatin, atorvastatin & amlodipine, niacin & simvastatin, sitagliptin & simvastatin, ezetimibe & simvastatin, ezetimibe & atorvastatin

Exclusions

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with any diagnosis of dementia during the measurement period.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Not Applicable

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Exclusion criteria for the PDC category of Diabetes medications:

1. Patients who have one or more prescriptions for insulin in the treatment period.

2. Patients with ESRD.

Patients with ESRD can be identified using RxHCC 121 - Dialysis Status (for payment year 2015) or RxHCC 261 - Dialysis Status (for payment year 2016 or 2017) or by using the ICD codes

Exclusion criteria for the PDC category of RASA:

1. Patients with ESRD

Patients with ESRD can be identified using RxHCC 121 - Dialysis Status (for payment year 2015) or RxHCC 261 - Dialysis Status (for payment year 2016 or 2017) or by using the ICD codes

2. Patients with one or more prescription claims for the medication, sacubitril/valsartan, during the treatment period.

Exclusion Details

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below tab NQF_1879_Dementia

Table 5: Codes Used to Identify Dementia

ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 292.82, 294.10, 294.11, 294.20, 294.21, 330.1, 331.0, 331.19, 331.82

ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F10.27, F11.122, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Not Applicable

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Exclusion details for PDC category of Diabetes medications (one or more prescriptions for insulin):

INSULINS: insulin aspart, insulin aspart Protamine & Aspart, insulin detemir, insulin glargine, insulin glulisine, insulin isophane & regular human insulin, insulin isophane (human N), insulin lispro, insulin lispro Protamine & Insulin lispro, insulin regular (human R), Insulin regular (human) inhalation powder, Insulin degludec, Insulin degludec & liraglutide, Insulin glargine & lixisenatide

ESRD ICD codes:

ESRD ICD9 codes:

585.6 End stage renal disease

ESRD ICD10 codes:

I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease

I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease

N18.5 Chronic kidney disease, stage 5

N18.6 End stage renal disease

N19 Renal failure, unspecified

Z91.15 Patient's noncompliance with renal dialysis

Z99.2 Dependence on renal dialysis

Risk Adjustment

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

No risk adjustment or risk stratification

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

No risk adjustment or risk stratification

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

No risk adjustment or risk stratification

Stratification

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Depending on the operational use of the measure, measure results can be stratified by:

- State
- Physician Group*
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

*See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Depending on the operational use of the measure, measure results may be stratified by:

- State
- Accountable Care Organization (ACOs)*
- Plan
- Physician Group**
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

*ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers.

**See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

None

Type Score

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Rate/proportion better quality = higher score

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Rate/proportion better quality = higher score

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Rate/proportion better quality = higher score

Algorithm

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D.

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug

claims for antipsychotic medications during the measurement period (12 consecutive months).

CREATE DENOMINATOR:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.

2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.

3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).

4. Of those individuals identified in Step 3, keep individuals who had:

At least two encounters with a diagnosis of schizophrenia of schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

Individuals who had at least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

5. For the individuals identified in Step 4, extract Medicare Part D claims for any antipsychotic medication during the measurement period. Attach the generic name and the drug ID to the dataset.

6. Of the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any antipsychotic medication on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period.

7. Exclude those individuals with a diagnosis of dementia during the measurement period.

Numerator: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

CREATE NUMERATOR:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an antipsychotic medication in the measurement period.

2. Within the medication therapy period, count the days the individual was covered by at least one drug in the antipsychotic medication class based on the prescription drug claim service date and days of supply.

a. Sort and de-duplicate Medicare Part D antipsychotic medication claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug

(generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.

b. Calculate the number of days covered by antipsychotic drug therapy per individual.

i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the antipsychotic medications. This is the numerator.

PHYSICIAN GROUP ATTRIBUTION:

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPIs) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPI. Valid NPIs have 10 numeric characters (no alpha characters).

2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.

3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.

4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).

5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)

a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.

b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.

c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

6. Identify TINs that are not solo practices.

a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.

b. Count unique NPIs per TIN.

c. Keep only those TINs having two or more providers.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).

8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.

9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.

a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.

b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.

a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year.

b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:

• A = working-age individual/spouse with an employer group health plan (EGHP)

• B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP

• G = working disabled for any month of the year

c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.

d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.

a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.

b. Exclude claims with no npi_prfrmg.

12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.

a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.

b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.

14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.

15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.

16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*

02—General surgery

03—Allergy/immunology

04—Otolaryngology

05—Anesthesiology

06—Cardiology

07—Dermatology

08—Family practice*

09—Interventional pain management

10—Gastroenterology

11—Internal medicine*

12—Osteopathic manipulative therapy

13—Neurology

14—Neurosurgery

16—Obstetrics/gynecology*

18—Ophthalmology

20—Orthopedic surgery

22—Pathology

24—Plastic and reconstructive surgery

25—Physical medicine and rehabilitation

26—Psychiatry*

28—Colorectal surgery

29—Pulmonary disease

30—Diagnostic radiology

33—Thoracic surgery

34—Urology

37—Nuclear medicine

38—Geriatric medicine*

39—Nephrology

39—Pediatric medicine

40—Hand surgery

44—Infectious disease

46—Endocrinology

50—Nurse practitioner*

66—Rheumatology

70—Multi-specialty clinic or group practice*

72—Pain management

76—Peripheral vascular disease

77—Vascular surgery

78—Cardiac surgery

79—Addiction medicine

81—Critical care (intensivists)

82—Hematology

83—Hematology/oncology

84—Preventive medicine*

85—Maxillofacial surgery

86—Neuropsychiatry*

90—Medical oncology

91—Surgical oncology

92—Radiation oncology

93—Emergency medicine

94—Interventional radiology

97—Physician assistant*

98—Gynecologist/oncologist

99—Unknown physician specialty

Other—NA

*Provider specialty codes specific to this measure

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D.

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).

CREATE DENOMINATOR:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.

2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.

3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).

4. Of those individuals identified in Step 3, keep those who had:

At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period.

5. Of the individuals identified in Step 4, extract Medicare Part D claims for a mood stabilizer during the measurement period. Attach the drug ID and the generic name to the dataset.

6. For the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any mood stabilizer on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period.

Numerator: Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.

CREATE NUMERATOR:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for a mood stabilizer medication in the measurement period.

2. Within the medication therapy period, count the days the individual was covered by at least one drug in the mood stabilizer medication class based on the prescription drug claim service date and days of supply.

a. Sort and de-duplicate Medicare Part D claims for mood stabilizers by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.

b. Calculate the number of days covered by mood stabilizer therapy per individual.

i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

ii. If claims for the same drug (generic name) overlap, then adjust the latest prescription start date to be the day after the previous fill has ended.

iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the mood stabilizers. This is the numerator.

PHYSICIAN GROUP ATTRIBUTION:

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPIs. Valid NPIs have 10 numeric characters (no alpha characters).

2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.

3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.

4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).

5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)

a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.

b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.

c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

6. Identify TINs that are not solo practices.

a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.

b. Count unique NPIs per TIN.

c. Keep only those TINs having two or more providers.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).

8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.

9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.

a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.

b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.

a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year.

b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:

• A = working-age individual/spouse with an employer group health plan (EGHP)

• B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP

• G = working disabled for any month of the year

c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.

d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.

a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.

b. Exclude claims with no npi_prfrmg.

12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.

a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.

b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.

14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.

15. Attribute the individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.

16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*

02—General surgery

03—Allergy/immunology

04—Otolaryngology

05—Anesthesiology

06—Cardiology

07—Dermatology

08—Family practice*

09—Interventional pain management

10—Gastroenterology

11—Internal medicine*

12—Osteopathic manipulative therapy

13—Neurology

14—Neurosurgery

16—Obstetrics/gynecology*

18—Ophthalmology

20—Orthopedic surgery

22—Pathology

24—Plastic and reconstructive surgery

25—Physical medicine and rehabilitation

26—Psychiatry*

28—Colorectal surgery

29—Pulmonary disease

30—Diagnostic radiology

33—Thoracic surgery

34—Urology

36—Nuclear medicine

37—Pediatric medicine

38—Geriatric medicine*

39—Nephrology

40—Hand surgery

44—Infectious disease

46—Endocrinology

50—Nurse practitioner*

66—Rheumatology

70—Multi-specialty clinic or group practice*

72—Pain management

76—Peripheral vascular disease

77—Vascular surgery

78—Cardiac surgery

79—Addiction medicine

81—Critical care (intensivists)

82—Hematology

83—Hematology/oncology

84—Preventive medicine*

85—Maxillofacial surgery

86—Neuropsychiatry*

90—Medical oncology

91—Surgical oncology

92—Radiation oncology

93—Emergency medicine

94—Interventional radiology

97—Physician assistant*

98—Gynecologist/oncologist

99—Unknown physician specialty

Other—NA

*Provider specialty codes specific to this measure

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

For EACH PDC rate identify the Denominator:

Step 1: Identify the eligible population that is 18 years and older as of the last day of the measurement year and that are continuously enrolled in the drug plan.

Step 2: Identify those patients in Step 1 that have filled at least two prescriptions for the target class of medication (either RAS Antagonist, Diabetes medication or Statin)

For the Diabetes rate only:Step 3: Exclude any patient with one or more prescriptions for insulin in the measurement period. Exclude any patient with ESRD.

For the RASA rate only: Exclude any patient with one or more prescription claims for the medication sacubitril/valsartan during the treatment period. Exclude any patient with ESRD

For EACH PDC rate calculate the Numerator:

Step 1: Determine the patient's treatment period, defined as the index prescription date (first fill of the target medication) to the end of the calendar year, disenrollment, or death.

Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*

Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4: Count the number of patients who had a PDC greater than 80% and then divide by the total number of eligible patients.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the drugs is common.

Submission items

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

5.1 Identified measures: 0544 : Use and Adherence to Antipsychotics among members with Schizophrenia

0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease

0542 : Adherence to Chronic Medications

0545 : Adherence to Statins for Individuals with Diabetes Mellitus

0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

0569 : ADHERENCE TO STATINS

1880 : Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in both measures. The methodology used to identify the denominator population is also calculated the same in both measures with the exception of the clinical conditions which is the target of the measure. The medications included in both measures are specific to the clinical condition targeted in the measure.

5b.1 If competing, why superior or rationale for additive value: The Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NCQA) measure is used for HEDIS reporting and is harmonized with the NQF #1879 in condition, target population, methodology, and medications. The HEDIS measure is only used in Medicaid health plans and therefore is restricted to adults age 18-64.

During development the measure developers identified another competing measure which eventually lost NQF endorsement. The section below is from the original submission of the measures for initial endorsement and compares this measure (#1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia) to a previously NQF-endorsed measure (#0544 Use and Adherence to Antipsychotics among Members with Schizophrenia).

Measure 1879 (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) has both the same measure focus and essentially the same target population as Measure 0544 (Use and Adherence to Antipsychotics among Members with Schizophrenia), which is no longer endorsed after the measure's time-limited endorsement (TLE) status expired. Measure 1879 is superior to the existing Measure 0544 because it represents a more valid and efficient approach to measuring medication adherence to antipsychotic medications. In addition, as discussed above in Section 5a.2, Measure 1879 is harmonized with several other adherence measures in the NQF portfolio. Key differences in measure validity and efficiency are addressed in the sections below.

VALIDITY

The Proportion of Days Covered (PDC), which is the method used to calculate adherence in Measure 1879, has several advantages over the Medication Possession Ratio (MPR), which is used in Measure 0544. First, the PDC was found to be more conservative compared to the Medication Possession Ratio (MPR) and was preferred in clinical scenarios in which there is the potential for more than one drug to be used within a drug class concomitantly (e.g., antipsychotics). This clinical situation applies directly to Measure 1879. Martin et al. (2009) demonstrated this in a study published in the Annals of Pharmacotherapy by comparing the methodology for drugs that are commonly switched, where the MPR was 0.690, truncated MPR was 0.624, and PDC was 0.562 and found significant differences between the values for adherence ($p < 0.001$). Martin et al (2009) also compared drugs with therapeutic duplication where the PDC was 0.669, truncated MPR was 0.774, and MPR was 1.238, and again obtained significant differences ($p < 0.001$). These findings were partially replicated by testing results from FMQAI (now HSAG) of Measure 1879 where MPR produced a higher measure rate (as compared to PDC) as shown below.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Method Measure Rate

Comparison of MPR and PDC

Method Measure Rate

MPR 74.4%

PDC 70.0%

Based on initial draft measure specifications and data from a 100% sample of Medicare fee-for-service beneficiaries

with Part D coverage in Florida and Rhode Island, using 2008 Medicare Parts A, B, and D data.

Additional differences between Measure 1879 and TLE 0544 related to validity include the following concerns:

Denominator: The measure denominator requires at least two antipsychotic medication prescriptions; whereas, the NQF TLE measure (NQF# 0544) does not require any antipsychotic medication prescriptions in the measure denominator. In 0544, an MPR of "0" is assigned to those without any antipsychotic medication prescriptions, which may falsely lower measure rates, specifically in scenarios where the prescriber has made the decision not to prescribe antipsychotic medications for an individual diagnosed with schizophrenia.

Exclusion related to a diagnosis of dementia: Measure 1879 excludes individuals with a diagnosis of dementia during the measurement year which is not considered in Measure

0544. Antipsychotic medications are currently labeled with a Food and Drug Administration (FDA) Black Box warning that states, “Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients.” The Technical Expert Panel, which reviewed the measure, recommended excluding these individuals from the measure denominator, since continued adherence to antipsychotic medications in this subpopulation may increase mortality and not represent quality of care. (Please see Section 2b3.2 that provides descriptive results of testing related to exclusions.)

EFFICIENCY

Measure 1879 requires only one year of administrative claims data, rather than two years of data which is required for TLE 0544. The Technical Expert Panel that reviewed Measure 1879 indicated that the burden of requiring two years of administrative claims data would not meaningfully modify measure rates and would potentially result in the unnecessary exclusion of individuals for which adherence should be assessed but for which only 1 year of claims data were available. Additional rationale for this TEP recommendation was related to an increased length of the continuous enrollment criteria to specify the measure use with two years of data. FMQAI’s (now HSAG) empirical analysis of a related adherence measure (NQF 0542 – Adherence to Chronic Medications) using 2007 and 2008 Medicare Part D data for beneficiaries in Florida and Rhode Island validated this concern and indicated that approximately 10% of the eligible population would be excluded from the measure if the enrollment criteria required two years of administrative claims data as opposed to one year.

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

5.1 Identified measures: 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease

0542 : Adherence to Chronic Medications

0545 : Adherence to Statins for Individuals with Diabetes Mellitus

0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

0580 : Bipolar antimanic agent

0109 : Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors

0110 : Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

0111 : Bipolar Disorder: Appraisal for risk of suicide

0112 : Bipolar Disorder: Level-of-function evaluation

0003 : Bipolar Disorder: Assessment for diabetes

1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia

1927 : Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications

1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879) and the NCQA version of the same measure (Adherence to Antipsychotic Medications for Individuals with Schizophrenia), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in all three measures. The methodology used to identify the denominator population is also calculated the same in all three measures, with the exception of the clinical conditions which is the target of the measure. The data collection burden is identical for the measures. The only differences between Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879), and the related NCQA measure are: (1) the clinical codes used to identify the different populations in each measure (NQF #1880 – individuals with bipolar I disorder; NQF #1879 and NCQA measure– individuals with schizophrenia); (2) the medications includes in each measure (NQF #1880- mood stabilizers; NQF #1879 and the NCQA measure– antipsychotics); and, (3) an exclusion for dementia which is included in NQF #1879 and the NCQA measure but not in NQF #1880. The rationale for these difference is due to the different clinical focus of each measure. There is no impact on interpretability since the measures clearly identify the disparate clinical focus. During development the measure developers worked to harmonize this measure with other measures which were NQF-endorsed at the time of development. The section below is from the original submission of the measure for initial endorsement and refers to measures which are no longer NQF-endorsed. We are including this language to demonstrate the efforts of the measure developers to harmonize this measure with other measures. MEASURES WITH WHICH THE MEASURE IS HARMONIZED. The measure has been harmonized where feasible with NQF #0542, #0543, #0545, #0541, #1879, #1927, and #1932 MEASURES WITH WHICH THE MEASURE IS NOT HARMONIZED. The measure specifications of the measure are not harmonized with the following NQF-endorsed measures that have the same measure focus (use of mood stabilizers among patients with Bipolar Disorder): NQF #0580 Bipolar antimanic agent. DIFFERENCES BETWEEN MEASURE 1880 AND MEASURE 0580. One NQF-endorsed measure (NQF #0580) focuses on a similar concept, but differs from this measure in two important ways. First, the NQF-endorsed measure includes individuals with newly diagnosed bipolar disorder and major depressive disorder. However, this measure includes all individuals with bipolar I disorder, not just those who are newly diagnosed, and does not include individuals with major depressive disorder. Second, the NQF-endorsed measure identifies the percentage of eligible individuals who have received at least 1 prescription for a mood-stabilizing agent during the measurement year, while this measure measures the percentage of eligible individuals with a proportion of days covered (PDC) for mood stabilizer medications greater than 0.8 during the measurement year. RATIONALE. This measure is an improved measure that adds value because it measures adherence to mood stabilizer treatment for individuals with bipolar I disorder. In contrast, the NQF measure (NQF# 0580) is linked to a one-time prescription for mood stabilizer treatment. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN. Differences have not been identified concerning the data collection burden between Measure 1880 and Measure 0580. However, interpretability for Measure 1880 (as compared to NQF #0580) is improved because Measure 1880 focuses on adherence rather than a single prescription,

and Measure 1880 is harmonized with the majority of adherence measures for other chronic diseases in the NQF portfolio and those that are being publicly reported by CMS.

5b.1 If competing, why superior or rationale for additive value: This measure does not address both the same measure focus and population as another NQF-endorsed measure.

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

Comparison of NQF #1880, NQF #0541, NQF #1879 and NQF #1932

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category
1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Steward

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

National Committee for Quality Assurance

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Pharmacy Quality Alliance

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

National Committee for Quality Assurance

Description

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, Statins.

A higher score indicates better quality.

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Type

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Process

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Process

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Process

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Process

Data Source

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Claims For measure calculation in the Medicare product line, the following Medicare files were required:

- Denominator tables
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

For ACO attribution, the following were required:

- Denominator tables for Parts A and B enrollment
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

For physician group attribution, the following were required:

• Non-institutional claims (Part B)—physician carrier/non-DME

• Denominator tables to determine individual enrollment

• Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payor status

• CMS physician and physician specialty tables

• National Plan and Provider Enumeration System (NPPES) database

No data collection instrument provided Attachment NQF_1880_Code_Tables_2018_Final.xlsx

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Claims Health plan prescription claims data and enrollment data (e.g. Medicare Part D)

No data collection instrument provided No data dictionary

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Claims The data source for the measure calculation required the following Medicare files depending on the level of accountability where the measure is being used:

• Denominator tables to determine individual enrollment

• Prescription drug benefit (Part D) coverage tables

• Beneficiary file

• Institutional claims (Part A)

• Non-institutional claims (Part B)—physician carrier/non-DME (durable medical equipment)

• Prescription drug benefit (Part D) claims

• Centers for Medicare and Medicaid Services (CMS) physician and physician specialty tables

• National Plan and Provider Enumeration System (NPPES) database

No data collection instrument provided Attachment NQF_1879_Code_Tables_2018_Final.xlsx

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Claims This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

No data collection instrument provided Attachment 1932_SSD_Value_Sets.xlsx

Level

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : Regional and State

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Clinician : Group/Practice, Health Plan

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Clinician : Group/Practice, Health Plan, Population : Regional and State

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Health Plan, Integrated Delivery System, Population : Regional and State

Setting

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Outpatient Services

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Outpatient Services

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Outpatient Services

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Other, Outpatient Services Any outpatient setting represented with Medicaid claims data

Numerator Statement

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.

Step 1: Determine the patient's treatment period, defined as the index prescription date (date of the first fill of the target medication) to the end of the calendar year, disenrollment, or death.

Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*

Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4: Count the number of patients who had a PDC 80% or greater and then divide by the total number of eligible patients.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of combination product to another combination product where a least one of the drugs from the target therapeutic class is common.

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

Numerator Details

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

PDC NUMERATOR

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all mood stabilizer medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.

Step 1: Determine the patient's treatment period, defined as the index prescription date (date of the first fill of the target medication) to the end of the calendar year, disenrollment, or death.

Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*

Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4: Count the number of patients who had a PDC 80% or greater and then divide by the total number of eligible patients.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of

combination product to another combination product where a least one of the drugs from the target therapeutic class is common.

RENIN ANGIOTENSIN SYSTEM (RAS) ANTAGONISTS: aliskiren, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan,valsartan, azilsartan, benazepril,captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolopril, amlodipine & benazepril, benazepril & HCTZ, captopril & HCTZ, enalapril & HCTZ, fosinopril & HCTZ, lisinopril & HCTZ, moexipril & HCTZ, perindopril & amlodipine, quinapril & HCTZ, trandolopril & verapamil HCL, candesartan & HCTZ, eprosartan & HCTZ, telmisartan & amilodipine, nebivolol & valsartan, irbesartan & HCTZ, losartan & HCTZ, amlodipine & olmesartan, azlisartan & chlorthalidone, olmesartan & HCTZ, telmisartan & HCTZ, olmesartan & amlodipine & HCTZ, valsartan & HCTZ, amlodipine & valsartan, amlodipine & valsartan & HCTZ, aliskiren & amlodipine, aliskiren & amlodipine & HCTZ, aliskiren & HCTZ,

DIABETES MEDICATIONS: (Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV Inhibitors, Incretin Mimetic Agents, Meglitinides, Sodium glucose co-transporter2 (SGLT2) inhibitors and combination products that include these medications)

metformin, glipizide & metformin, glyburide & metformin, chlorpropamide, glimepiride, glipizide, glyburide, tolazamide, tolbutamide, pioglitazone, rosiglitazone, rosiglitazone & metformin, rosiglitazone & glimepiride, pioglitazone & metformin, pioglitazone & glimepiride, alogliptin & pioglitazone, sitagliptin, linagliptin, saxagliptin, alogliptin, sitagliptin & metformin, saxagliptin & metformin SR, sitagliptin & simvastatin, linagliptin & metformin, alogliptin & metformin, exenatide, liraglutide, nateglinide, repaglinide, repaglinide & metformin, canagliflozin, alogliptin & metformin, empagliflozin & linagliptin, dulaglutide, liraglutide, lisxisenatide, albiglutide, empagliflozin, dapagliflozin, dapagliflozin & metformin, empagliflozin & linagliptin, canagliflozin & metformin, empagliflozin & metformin

STATINS: lovastatin, rosuvastatin, fluvastatin, atorvastatin, pravastatin, pitavastatin, simvastatin, niacin & lovastatin, atorvastatin & amlodipine, niacin & simvastatin, sitagliptin & simvastatin, ezetimibe & simvastatin, ezetimibe & atorvastatin

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

PDC NUMERATOR

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all antipsychotic medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

See corresponding Excel document for the Glucose Tests Value Set and the HbA1c Tests Value Set.

Denominator Statement

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year.

For the Diabetes rate only: Exclude any patient with one or more prescriptions for insulin in the treatment period. Exclude any patient with ESRD

For RASA rate only: Exclude any patient with one or more prescription claims for sacubitril/valsartan during the treatment period. Exclude any patient with ESRD

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

Denominator Details

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Target population meets the following conditions:

1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement year;

2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement year; and,

3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement year.

IDENTIFICATION OF BIPOLAR I DISORDER

Individuals with bipolar I disorder are identified by having a diagnosis of bipolar I disorder within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period.

CODES USED TO IDENTIFY BIPOLAR I DISORDER DIAGNOSIS

Codes used to identify bipolar I disorder are included in the attached Excel worksheet of codes (NQF_1880_Code Tables_2018 Final) under the tab NQF_1880_Bipolar_ICD9-10.

TABLE 1. BIPOLAR I DISORDER DIAGNOSIS

ICD-9-CM: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7

ICD-10-CM: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.89, F31.9

CODES USED TO IDENTIFY ENCOUNTER TYPE

Codes used to identify encounters are under tab NQF_1880_Encounter_types.

TABLE 2.1. OUTPATIENT SETTING

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

TABLE 2.2. EMERGENCY DEPARTMENT SETTING

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

TABLE 2.3. NON-ACUTE INPATIENT SETTING

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

TABLE 2.4. ACUTE INPATIENT SETTING

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

POS: 21, 51

IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR MOOD STABILIZER MEDICATION

Individuals with at least two prescription drug claims for any of the following mood stabilizer medications (Table 3: Mood Stabilizer Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1880_Mood_Stabilizers of the attached Excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.

MOOD STABILIZER MEDICATIONS

TABLE 3. MOOD STABILIZER MEDICATIONS

Active ingredients listed below are limited to oral, buccal, sublingual, and translingual formulations only.

Anticonvulsants:

carbamazepine

divalproex sodium

lamotrigine

valproic acid

Atypical Antipsychotics:

aripiprazole

asenapine

cariprazine

lurasidone

olanzapine

quetiapine

quetiapine fumarate (Seroquel)

risperidone

ziprasidone

Phenothiazine/Related Antipsychotics:

chlorpromazine

loxapine succinate

Other Antipsychotics:

olanzapine-fluoxetine

Lithium Salts:

lithium carbonate

lithium citrate

TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS

The following are the long-acting (depot) injectable antipsychotic medications. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Atypical Antipsychotic Medications:

aripiprazole (J0401)

risperidone microspheres (J2794)

Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B:

aripiprazole (J0401) – 28 days' supply

risperidone microspheres (J2794) – 14 days' supply

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year.

(For the Diabetes rate only: Exclude any patient with one or more prescriptions for insulin in the measurement period - See S.10)

RENIN ANGIOTENSIN SYSTEM (RAS) ANTAGONISTS: aliskiren, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan,valsartan, azilsartan, benazepril,captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolopril, amlodipine & benazepril, benazepril & HCTZ, captopril & HCTZ, enalapril & HCTZ, fosinopril & HCTZ, lisinopril & HCTZ, moexipril & HCTZ, perindopril & amlodipine, quinapril & HCTZ, trandolopril & verapamil HCL, candesartan & HCTZ, eprosartan & HCTZ, telmisartan & amilodipine, nebivolol & valsartan, irbesartan & HCTZ, losartan & HCTZ, amlodipine & olmesartan, azlisartan & chlorthalidone, olmesartan & HCTZ, telmisartan & HCTZ, olmesartan & amlodipine & HCTZ, valsartan & HCTZ, amlodipine & valsartan, amlodipine & valsartan & HCTZ, aliskiren & amlodipine, aliskiren & amlodipine & HCTZ, aliskiren & HCTZ,

DIABETES MEDICATIONS: (Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV Inhibitors, Incretin Mimetic Agents, Meglitinides, Sodium glucose co-transporter2 (SGLT2) inhibitors and combination products that include these medications)

metformin, glipizide & metformin, glyburide & metformin, chlorpropamide, glimepiride, glipizide, glyburide, tolazamide, tolbutamide, pioglitazone, rosiglitazone, rosiglitazone & metformin, rosiglitazone & glimepiride, pioglitazone & metformin, pioglitazone & glimepiride, alogliptin & pioglitazone, sitagliptin, linagliptin, saxagliptin, alogliptin, sitagliptin & metformin, saxagliptin & metformin SR, sitagliptin & simvastatin, linagliptin & metformin, alogliptin & metformin, exenatide, liraglutide, nateglinide, repaglinide, repaglinide & metformin, canagliflozin, alogliptin & metformin, empagliflozin & linagliptin, dulaglutide, liraglutide, lisxisenatide, albiglutide, empagliflozin, dapagliflozin, dapagliflozin & metformin, empagliflozin & linagliptin, canagliflozin & metformin, empagliflozin & metformin

STATINS: lovastatin, rosuvastatin, fluvastatin, atorvastatin, pravastatin, pitavastatin, simvastatin, niacin & lovastatin, atorvastatin & amlodipine, niacin & simvastatin, sitagliptin & simvastatin, ezetimibe & simvastatin, ezetimibe & atorvastatin

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Target population meets the following conditions:

1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement period;

2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and,

3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement period.

IDENTIFICATION OF SCHIZOPHRENIA

Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of schizophrenia or schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

CODES USED TO IDENTIFY SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER DIAGNOSIS

Codes used to identify schizophrenia or schizoaffective disorder are included in the attached excel worksheet of codes (NQF_1879_Code Tables_2018_Final.xlsx) under the tab NQF_1879_Schizophrenia.

Table 1: Schizophrenia or Schizoaffective Disorder Diagnosis

ICD-9-CM: 295.xx

ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

CODES USED TO IDENTIFY ENCOUNTER TYPE:

Codes used to identify encounters are under tab NQF_1879_Encounter_types.

Table 2.1: Outpatient Setting

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

Table 2.2: Emergency Department Setting

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

Table 2.3: Non-Acute Inpatient Setting

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

Table 2.4: Acute Inpatient Setting

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

POS: 21, 51

IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR ANTIPSYCHOTIC MEDICATION:

Individuals with at least two prescription drug claims for any of the following oral antipsychotic medications (Table 3: Oral Antipsychotic Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1879_ Antipsychotics of the attached excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.

TABLE 3: ORAL ANTIPSYCHOTIC MEDICATIONS

The following are oral formulations only.

Typical Antipsychotic Medications:

chlorpromazine

fluphenazine

haloperidol

loxapine

molindone

perphenazine

prochlorperazine

thioridazine

thiothixene

trifluoperazine

Atypical Antipsychotic Medications:

aripiprazole

asenapine

brexpiprazole

cariprazine

clozapine

iloperidone

lurasidone

olanzapine

paliperidone

quetiapine

quetiapine fumarate (Seroquel)

risperidone

ziprasidone

Antipsychotic Combinations:

perphenazine-amitriptyline

TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS

The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Typical Antipsychotic Medications:

fluphenazine decanoate (J2680)

haloperidol decanoate (J1631)

Atypical Antipsychotic Medications:

aripiprazole (J0401)

aripiprazole lauroxil (Aristada)

olanzapine pamoate (J2358)

paliperidone palmitate (J2426)

risperidone microspheres (J2794)

Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B:

fluphenazine decanoate (J2680) – 28 days' supply

haloperidol decanoate (J1631) – 28 days' supply

aripiprazole (J0401) – 28 days' supply

aripiprazole lauroxil (Aristada) - 28 days' supply

olanzapine pamoate (J2358) – 28 days' supply

paliperidone palmitate (J2426) – 28 days' supply

risperidone microspheres (J2794) – 14 days' supply

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Follow the steps below to identify the eligible population.

Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.

- At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:
  - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.
  - BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set.
  - BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set.
  - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.
  - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set.
  - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Other Bipolar Disorder Value Set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:

- BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.
- ED Value Set with Schizophrenia Value Set.
- BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria:

- BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set.
- BH Stand Alone Outpatient/PH/IOP Value Set with Other Bipolar Disorder Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Bipolar Disorder Value Set.
- ED Value Set with Bipolar Disorder Value Set.
- ED Value Set with Other Bipolar Disorder Value Set.
- BH ED Value Set with ED POS Value Set with Bipolar Disorder Value Set.
- BH ED Value Set with ED POS Value Set with Other Bipolar Disorder Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Bipolar Disorder Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Other Bipolar Disorder Value Set.

(See corresponding Excel document for the above value sets)

Exclusions

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Not Applicable

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Exclusion criteria for the PDC category of Diabetes medications:

1. Patients who have one or more prescriptions for insulin in the treatment period.

2. Patients with ESRD.

Patients with ESRD can be identified using RxHCC 121 - Dialysis Status (for payment year 2015) or RxHCC 261 - Dialysis Status (for payment year 2016 or 2017) or by using the ICD codes

Exclusion criteria for the PDC category of RASA:

1. Patients with ESRD

Patients with ESRD can be identified using RxHCC 121 - Dialysis Status (for payment year 2015) or RxHCC 261 - Dialysis Status (for payment year 2016 or 2017) or by using the ICD codes

2. Patients with one or more prescription claims for the medication, sacubitril/valsartan, during the treatment period.

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with any diagnosis of dementia during the measurement period.

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients with diabetes during the measurement year or the year prior to the measurement year.

Exclude patients who had no antipsychotic medications dispensed during the measurement year.

Exclusion Details

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Not Applicable

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Exclusion details for PDC category of Diabetes medications (one or more prescriptions for insulin):

INSULINS: insulin aspart, insulin aspart Protamine & Aspart, insulin detemir, insulin glargine, insulin glulisine, insulin isophane & regular human insulin, insulin isophane (human N), insulin lispro, insulin lispro Protamine & Insulin lispro, insulin regular (human R), Insulin regular (human) inhalation powder, Insulin degludec, Insulin degludec & liraglutide, Insulin glargine & lixisenatide

ESRD ICD codes:

ESRD ICD9 codes:

585.6 End stage renal disease

ESRD ICD10 codes:

I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease

I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease

N18.5 Chronic kidney disease, stage 5

N18.6 End stage renal disease

N19 Renal failure, unspecified

Z91.15 Patient's noncompliance with renal dialysis

Z99.2 Dependence on renal dialysis

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below tab NQF_1879_Dementia

Table 5: Codes Used to Identify Dementia

ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 292.82, 294.10, 294.11, 294.20, 294.21, 330.1, 331.0, 331.19, 331.82

ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F10.27, F11.122, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Diabetes Medications List).

Claim/encounter data: Patients who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years).

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-

metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitaglipin

Exclude patients who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.

- Claim/encounter data. An antipsychotic medication (Long-Acting Injections Value Set).
- Pharmacy data. Dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List) on an ambulatory basis.

ANTIPSYCHOTIC MEDICATIONS:

(Antipsychotic Medications List)

Miscellaneous antipsychotic agents:

Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone

Phenothiazine antipsychotics:

Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine

Thioxanthenes:

Thiothixene

Long-acting injections:

Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone

(Antipsychotic Combination Medications List)

Psychotherapeutic combinations:

Fluoxetine-olanzapine, Perphenazine-amitriptyline

See corresponding Excel document for the value sets referenced above.

Risk Adjustment

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

No risk adjustment or risk stratification

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

No risk adjustment or risk stratification

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

No risk adjustment or risk stratification

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

No risk adjustment or risk stratification

Stratification

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Depending on the operational use of the measure, measure results may be stratified by:

- State
- Accountable Care Organization (ACOs)*
- Plan
- Physician Group**
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

*ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers.

**See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

None

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Depending on the operational use of the measure, measure results can be stratified by:

- State
- Physician Group*
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

*See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

None.

Type Score

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Rate/proportion better quality = higher score

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

Rate/proportion better quality = higher score

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Rate/proportion better quality = higher score

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Rate/proportion better quality = higher score

Algorithm

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D.

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).

CREATE DENOMINATOR:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.

2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.

3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).

4. Of those individuals identified in Step 3, keep those who had:

At least two encounters with a diagnosis of bipolar I disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of bipolar I disorder in an acute inpatient setting during the measurement period.

5. Of the individuals identified in Step 4, extract Medicare Part D claims for a mood stabilizer during the measurement period. Attach the drug ID and the generic name to the dataset.

6. For the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any mood stabilizer on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period.

Numerator: Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.

CREATE NUMERATOR:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for a mood stabilizer medication in the measurement period.

2. Within the medication therapy period, count the days the individual was covered by at least one drug in the mood stabilizer medication class based on the prescription drug claim service date and days of supply.

a. Sort and de-duplicate Medicare Part D claims for mood stabilizers by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.

b. Calculate the number of days covered by mood stabilizer therapy per individual.

i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

ii. If claims for the same drug (generic name) overlap, then adjust the latest prescription start date to be the day after the previous fill has ended.

iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the mood stabilizers. This is the numerator.

PHYSICIAN GROUP ATTRIBUTION:

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following

is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPIs. Valid NPIs have 10 numeric characters (no alpha characters).

2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.

3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.

4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).

5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)

a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.

b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.

c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

6. Identify TINs that are not solo practices.

a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.

b. Count unique NPIs per TIN.

c. Keep only those TINs having two or more providers.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).

8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.

9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.

a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.

b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.

a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year.

b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:

• A = working-age individual/spouse with an employer group health plan (EGHP)

• B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP

• G = working disabled for any month of the year

c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.

d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.

a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.

b. Exclude claims with no npi_prfrmg.

12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.

a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.

b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.

14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.

15. Attribute the individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.

16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*

02—General surgery

03—Allergy/immunology

04—Otolaryngology

05—Anesthesiology

06—Cardiology

07—Dermatology

08—Family practice*
09—Interventional pain management
10—Gastroenterology
11—Internal medicine*
12—Osteopathic manipulative therapy
13—Neurology
14—Neurosurgery
16—Obstetrics/gynecology*
18—Ophthalmology
20—Orthopedic surgery
22—Pathology
24—Plastic and reconstructive surgery
25—Physical medicine and rehabilitation
26—Psychiatry*
28—Colorectal surgery
29—Pulmonary disease
30—Diagnostic radiology
33—Thoracic surgery
34—Urology
36—Nuclear medicine
37—Pediatric medicine
38—Geriatric medicine*
39—Nephrology
40—Hand surgery
44—Infectious disease
46—Endocrinology
50—Nurse practitioner*
66—Rheumatology
70—Multi-specialty clinic or group practice*
72—Pain management
76—Peripheral vascular disease
77—Vascular surgery
78—Cardiac surgery
79—Addiction medicine
81—Critical care (intensivists)
82—Hematology
83—Hematology/oncology
84—Preventive medicine*
85—Maxillofacial surgery

86—Neuropsychiatry*

90—Medical oncology

91—Surgical oncology

92—Radiation oncology

93—Emergency medicine

94—Interventional radiology

97—Physician assistant*

98—Gynecologist/oncologist

99—Unknown physician specialty

Other—NA

*Provider specialty codes specific to this measure

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

For EACH PDC rate identify the Denominator:

Step 1: Identify the eligible population that is 18 years and older as of the last day of the measurement year and that are continuously enrolled in the drug plan.

Step 2: Identify those patients in Step 1 that have filled at least two prescriptions for the target class of medication (either RAS Antagonist, Diabetes medication or Statin)

For the Diabetes rate only:Step 3: Exclude any patient with one or more prescriptions for insulin in the measurement period. Exclude any patient with ESRD.

For the RASA rate only: Exclude any patient with one or more prescription claims for the medication sacubitril/valsartan during the treatment period. Exclude any patient with ESRD

For EACH PDC rate calculate the Numerator:

Step 1: Determine the patient's treatment period, defined as the index prescription date (first fill of the target medication) to the end of the calendar year, disenrollment, or death.

Step 2: Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days supply. If prescriptions for the same drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*

Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4: Count the number of patients who had a PDC greater than 80% and then divide by the total number of eligible patients.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the drugs is common.

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D.

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug

claims for antipsychotic medications during the measurement period (12 consecutive months).

CREATE DENOMINATOR:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.

2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.

3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).

4. Of those individuals identified in Step 3, keep individuals who had:

At least two encounters with a diagnosis of schizophrenia of schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

Individuals who had at least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

5. For the individuals identified in Step 4, extract Medicare Part D claims for any antipsychotic medication during the measurement period. Attach the generic name and the drug ID to the dataset.

6. Of the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any antipsychotic medication on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period.

7. Exclude those individuals with a diagnosis of dementia during the measurement period.

Numerator: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

CREATE NUMERATOR:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an antipsychotic medication in the measurement period.

2. Within the medication therapy period, count the days the individual was covered by at least one drug in the antipsychotic medication class based on the prescription drug claim service date and days of supply.

a. Sort and de-duplicate Medicare Part D antipsychotic medication claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug

(generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.

b. Calculate the number of days covered by antipsychotic drug therapy per individual.

i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the antipsychotic medications. This is the numerator.

PHYSICIAN GROUP ATTRIBUTION:

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPIs) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPI. Valid NPIs have 10 numeric characters (no alpha characters).

2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.

3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.

4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).

5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)

a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.

b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.

c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

6. Identify TINs that are not solo practices.

a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.

b. Count unique NPIs per TIN.

c. Keep only those TINs having two or more providers.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).

8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.

9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.

a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.

b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.

a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year.

b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:

• A = working-age individual/spouse with an employer group health plan (EGHP)

• B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP

• G = working disabled for any month of the year

c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.

d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.

a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.

b. Exclude claims with no npi_prfrmg.

12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.

a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.

b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.

14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.

15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.

16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*

02—General surgery

03—Allergy/immunology

04—Otolaryngology

05—Anesthesiology

06—Cardiology

07—Dermatology

08—Family practice*

09—Interventional pain management

10—Gastroenterology

11—Internal medicine*

12—Osteopathic manipulative therapy

13—Neurology

14—Neurosurgery

16—Obstetrics/gynecology*

18—Ophthalmology

20—Orthopedic surgery

22—Pathology

24—Plastic and reconstructive surgery

25—Physical medicine and rehabilitation

26—Psychiatry*

28—Colorectal surgery

29—Pulmonary disease

30—Diagnostic radiology

33—Thoracic surgery

34—Urology

37—Nuclear medicine

38—Geriatric medicine*

39—Nephrology

39—Pediatric medicine

40—Hand surgery

44—Infectious disease

46—Endocrinology

50—Nurse practitioner*

66—Rheumatology

70—Multi-specialty clinic or group practice*

72—Pain management

76—Peripheral vascular disease

77—Vascular surgery

78—Cardiac surgery

79—Addiction medicine

81—Critical care (intensivists)

82—Hematology

83—Hematology/oncology

84—Preventive medicine*

85—Maxillofacial surgery

86—Neuropsychiatry*

90—Medical oncology

91—Surgical oncology

92—Radiation oncology

93—Emergency medicine

94—Interventional radiology

97—Physician assistant*

98—Gynecologist/oncologist

99—Unknown physician specialty

Other—NA

*Provider specialty codes specific to this measure

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Step1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year.

Step 2. Search for an exclusion in the patient's history: Exclude patients from the eligible population if they meet the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

- Patients with diabetes during the measurement year or the year prior to the measurement year.
- Patients who had no antipsychotic medications dispensed during the measurement year.

Step 3. Determine the numerator: the number of patients who had a diabetes screening test during the measurement year.

Step 4. Calculate the rate.

Submission items

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

5.1 Identified measures: 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease

0542 : Adherence to Chronic Medications

0545 : Adherence to Statins for Individuals with Diabetes Mellitus

0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

0580 : Bipolar antimanic agent

0109 : Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors

0110 : Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

0111 : Bipolar Disorder: Appraisal for risk of suicide

0112 : Bipolar Disorder: Level-of-function evaluation

0003 : Bipolar Disorder: Assessment for diabetes

1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia

1927 : Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications

1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879) and the NCQA version of the same measure (Adherence to Antipsychotic Medications for Individuals with Schizophrenia), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in all three measures. The methodology used to identify the denominator population is also calculated the same in all three measures, with the exception of the clinical conditions which is the target of the measure. The data collection burden is identical for the measures. The only differences between Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879), and the related NCQA measure are: (1) the clinical codes used to identify the different populations in each measure (NQF #1880 – individuals with bipolar I disorder; NQF #1879 and NCQA measure– individuals with schizophrenia); (2) the medications includes in each measure (NQF #1880- mood stabilizers; NQF #1879 and the NCQA

measure– antipsychotics); and, (3) an exclusion for dementia which is included in NQF #1879 and the NCQA measure but not in NQF #1880. The rationale for these difference is due to the different clinical focus of each measure. There is no impact on interpretability since the measures clearly identify the disparate clinical focus. During development the measure developers worked to harmonize this measure with other measures which were NQF-endorsed at the time of development. The section below is from the original submission of the measure for initial endorsement and refers to measures which are no longer NQF-endorsed. We are including this language to demonstrate the efforts of the measure developers to harmonize this measure with other measures. MEASURES WITH WHICH THE MEASURE IS HARMONIZED. The measure has been harmonized where feasible with NQF #0542, #0543, #0545, #0541, #1879, #1927, and #1932 MEASURES WITH WHICH THE MEASURE IS NOT HARMONIZED. The measure specifications of the measure are not harmonized with the following NQF-endorsed measures that have the same measure focus (use of mood stabilizers among patients with Bipolar Disorder): NQF #0580 Bipolar antimanic agent. DIFFERENCES BETWEEN MEASURE 1880 AND MEASURE 0580. One NQF-endorsed measure (NQF #0580) focuses on a similar concept, but differs from this measure in two important ways. First, the NQF-endorsed measure includes individuals with newly diagnosed bipolar disorder and major depressive disorder. However, this measure includes all individuals with bipolar I disorder, not just those who are newly diagnosed, and does not include individuals with major depressive disorder. Second, the NQF-endorsed measure identifies the percentage of eligible individuals who have received at least 1 prescription for a mood-stabilizing agent during the measurement year, while this measure measures the percentage of eligible individuals with a proportion of days covered (PDC) for mood stabilizer medications greater than 0.8 during the measurement year. RATIONALE. This measure is an improved measure that adds value because it measures adherence to mood stabilizer treatment for individuals with bipolar I disorder. In contrast, the NQF measure (NQF# 0580) is linked to a one-time prescription for mood stabilizer treatment. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN. Differences have not been identified concerning the data collection burden between Measure 1880 and Measure 0580. However, interpretability for Measure 1880 (as compared to NQF #0580) is improved because Measure 1880 focuses on adherence rather than a single prescription, and Measure 1880 is harmonized with the majority of adherence measures for other chronic diseases in the NQF portfolio and those that are being publicly reported by CMS.

5b.1 If competing, why superior or rationale for additive value: This measure does not address both the same measure focus and population as another NQF-endorsed measure.

0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

5.1 Identified measures: 0544 : Use and Adherence to Antipsychotics among members with Schizophrenia

0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease

0542 : Adherence to Chronic Medications

0545 : Adherence to Statins for Individuals with Diabetes Mellitus

0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

0569 : ADHERENCE TO STATINS

1880 : Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in both measures. The methodology used to identify the denominator population is also calculated the same in both measures with the exception of the clinical conditions which is the target of the measure. The medications included in both measures are specific to the clinical condition targeted in the measure.

5b.1 If competing, why superior or rationale for additive value: The Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NCQA) measure is used for HEDIS reporting and is harmonized with the NQF #1879 in condition, target population, methodology, and medications. The HEDIS measure is only used in Medicaid health plans and therefore is restricted to adults age 18-64.

During development the measure developers identified another competing measure which eventually lost NQF endorsement. The section below is from the original submission of the measures for initial endorsement and compares this measure (#1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia) to a previously NQF-endorsed measure (#0544 Use and Adherence to Antipsychotics among Members with Schizophrenia).

Measure 1879 (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) has both the same measure focus and essentially the same target population as Measure 0544 (Use and Adherence to Antipsychotics among Members with Schizophrenia), which is no longer endorsed after the measure's time-limited endorsement (TLE) status expired. Measure 1879 is superior to the existing Measure 0544 because it represents a more valid and efficient approach to measuring medication adherence to antipsychotic medications. In addition, as discussed above in Section 5a.2, Measure 1879 is harmonized with several other adherence measures in the NQF portfolio. Key differences in measure validity and efficiency are addressed in the sections below.

VALIDITY

The Proportion of Days Covered (PDC), which is the method used to calculate adherence in Measure 1879, has several advantages over the Medication Possession Ratio (MPR), which is used in Measure 0544. First, the PDC was found to be more conservative compared to the Medication Possession Ratio (MPR) and was preferred in clinical scenarios in which there is the potential for more than one drug to be used within a drug class concomitantly (e.g., antipsychotics). This clinical situation applies directly to Measure 1879. Martin et al. (2009) demonstrated this in a study published in the Annals of Pharmacotherapy by comparing the methodology for drugs that are commonly switched, where the MPR was 0.690, truncated MPR was 0.624, and PDC was 0.562 and found significant differences between the values for adherence ($p < 0.001$). Martin et al (2009) also compared drugs with therapeutic duplication where the PDC was 0.669, truncated MPR was 0.774, and MPR was 1.238, and again obtained significant differences ($p < 0.001$). These findings were

partially replicated by testing results from FMQAI (now HSAG) of Measure 1879 where MPR produced a higher measure rate (as compared to PDC) as shown below.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Method Measure Rate

Comparison of MPR and PDC

Method Measure Rate

MPR 74.4%

PDC 70.0%

Based on initial draft measure specifications and data from a 100% sample of Medicare fee-for-service beneficiaries

with Part D coverage in Florida and Rhode Island, using 2008 Medicare Parts A, B, and D data.

Additional differences between Measure 1879 and TLE 0544 related to validity include the following concerns:

Denominator: The measure denominator requires at least two antipsychotic medication prescriptions; whereas, the NQF TLE measure (NQF# 0544) does not require any antipsychotic medication prescriptions in the measure denominator. In 0544, an MPR of "0" is assigned to those without any antipsychotic medication prescriptions, which may falsely lower measure rates, specifically in scenarios where the prescriber has made the decision not to prescribe antipsychotic medications for an individual diagnosed with schizophrenia.

Exclusion related to a diagnosis of dementia: Measure 1879 excludes individuals with a diagnosis of dementia during the measurement year which is not considered in Measure 0544. Antipsychotic medications are currently labeled with a Food and Drug Administration (FDA) Black Box warning that states, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients." The Technical Expert Panel, which reviewed the measure, recommended excluding these individuals from the measure denominator, since continued adherence to antipsychotic medications in this subpopulation may increase mortality and not represent quality of care. (Please see Section 2b3.2 that provides descriptive results of testing related to exclusions.)

EFFICIENCY

Measure 1879 requires only one year of administrative claims data, rather than two years of data which is required for TLE 0544. The Technical Expert Panel that reviewed Measure 1879 indicated that the burden of requiring two years of administrative claims data would not meaningfully modify measure rates and would potentially result in the unnecessary exclusion of individuals for which adherence should be assessed but for which only 1 year of claims data were available. Additional rationale for this TEP recommendation was related to an increased length of the continuous enrollment criteria to specify the measure use with two years of data. FMQAI's (now HSAG) empirical analysis of a related adherence measure (NQF 0542 – Adherence to Chronic Medications) using 2007 and 2008 Medicare Part D data for beneficiaries in Florida and Rhode Island validated this concern and

indicated that approximately 10% of the eligible population would be excluded from the measure if the enrollment criteria required two years of administrative claims data as opposed to one year.

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

5.1 Identified measures: 1933 : Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

1934 : Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: N/A

Comparison of NQF #1932, NQF #1933 and NQF #1934

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Steward

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

National Committee for Quality Assurance

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

National Committee for Quality Assurance

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

National Committee for Quality Assurance

Description

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

The percentage of patients 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

The percentage of patients 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

Type

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Process

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Process

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Process

Data Source

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Claims This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

No data collection instrument provided Attachment 1932_SSD_Value_Sets.xlsx

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Claims This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

No data collection instrument provided Attachment 1933_SMC_Value_Sets.xlsx

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

No data collection instrument provided Attachment 1934_SMD_Value_Sets.xlsx

Level

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Health Plan, Integrated Delivery System, Population : Regional and State

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Health Plan, Integrated Delivery System, Population : Regional and State

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Health Plan, Integrated Delivery System, Population : Regional and State

Setting

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Other, Outpatient Services Any outpatient setting represented with Medicaid claims data

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Outpatient Services

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Outpatient Services

Numerator Statement

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

An LDL-C test performed during the measurement year.

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

One or more HbA1c tests and one or more LDL-C tests performed during the measurement year.

Numerator Details

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

See corresponding Excel document for the Glucose Tests Value Set and the HbA1c Tests Value Set.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

An LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

- See corresponding Excel document for the LDL-C Tests Value Set

The organization may use a calculated or direct LDL.

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

An HbA1c test (HbA1c Tests Value Set) and an LDL-C test (LDL-C Tests Value Set) performed during the measurement year (on the same or different dates of service), as identified by claim/encounter or automated laboratory data. The patient must have both tests to be included in the numerator. The organization may use a calculated or direct LDL.

See corresponding Excel document for the LDL-C Tests Value Set and the HbA1c Tests Value Set

Denominator Statement

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Patients 18-64 years of age as of the end of the measurement year (e.g., December 31) with a diagnosis of schizophrenia and cardiovascular disease.

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Patients age 18-64 years of age as of the end of the measurement year (e.g. December 31) with a schizophrenia and diabetes diagnosis.

Denominator Details

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Follow the steps below to identify the eligible population.

Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.

• At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:

- BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.
- BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set.
- BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set.
- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.
- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set.
- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Other Bipolar Disorder Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:

- BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.
- ED Value Set with Schizophrenia Value Set.
- BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.

- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria:

- BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set.
- BH Stand Alone Outpatient/PH/IOP Value Set with Other Bipolar Disorder Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Bipolar Disorder Value Set.
- ED Value Set with Bipolar Disorder Value Set.
- ED Value Set with Other Bipolar Disorder Value Set.
- BH ED Value Set with ED POS Value Set with Bipolar Disorder Value Set.
- BH ED Value Set with ED POS Value Set with Other Bipolar Disorder Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Bipolar Disorder Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Other Bipolar Disorder Value Set.

(See corresponding Excel document for the above value sets)

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Follow the steps below to identify the eligible population.

Step 1: Identify patients with schizophrenia as those who met at least one of the following criteria during the measurement year:

• At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:

– BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.

– BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:

– BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.

– BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.

– ED Value Set with Schizophrenia Value Set.

– BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.

– BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.

– BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set

Step 2: Identify patients from step 1 who also have cardiovascular disease. Members are identified as having cardiovascular disease in two ways: by event or by diagnosis. The organization must use both methods to identify the eligible population, but a patient need only be identified by one to be included in the measure.

Event. Any of the following during the year prior to the measurement year meet criteria:

• AMI. Discharged from an inpatient setting with an AMI (AMI Value Set). To identify discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Identify the discharge date for the stay.

• CABG. Members who had CABG (CABG Value Set) in any setting.

• PCI. Members who had PCI (PCI Value Set) in any setting (e.g., inpatient, outpatient, ED).

Diagnosis. Identify members with IVD as those who met at least either 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 outpatient visit (Outpatient Value Set) with a diagnosis of IVD (IVD Value Set).

• At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of IVD (IVD Value Set).

(See corresponding Excel document for the above value sets)

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Follow the steps below to identify the eligible population.

Step 1: Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year:

• At least one acute inpatient encounter, with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:

- BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.

- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:

- BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.

- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.

- ED Value Set with Schizophrenia Value Set.

- BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.

- BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.

- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set.

Step 2 Identify members from step 1 who also have diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member need only be identified by one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.
- At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set).

Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

(See corresponding Excel document for the above value sets)

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitaglipin

Exclusions

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients with diabetes during the measurement year or the year prior to the measurement year.

Exclude patients who had no antipsychotic medications dispensed during the measurement year.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Exclusion Details

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Diabetes Medications List).

Claim/encounter data: Patients who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years).

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlinitide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitaglipin

Exclude patients who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.

- Claim/encounter data. An antipsychotic medication (Long-Acting Injections Value Set).
- Pharmacy data. Dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List) on an ambulatory basis.

ANTIPSYCHOTIC MEDICATIONS:

(Antipsychotic Medications List)

Miscellaneous antipsychotic agents:

Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone

Phenothiazine antipsychotics:

Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine

Thioxanthenes:

Thiothixene

Long-acting injections:

Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone

(Antipsychotic Combination Medications List)

Psychotherapeutic combinations:

Fluoxetine-olanzapine, Perphenazine-amitriptyline

See corresponding Excel document for the value sets referenced above.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Optional exclusion: Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

If a member was identified as a diabetic based on claim or encounter data, as described in step 2 of S.7, the optional exclusions do not apply because the member had a diagnosis of diabetes.

See corresponding Excel document for the value sets referenced above.

Risk Adjustment

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

No risk adjustment or risk stratification

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

No risk adjustment or risk stratification

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

No risk adjustment or risk stratification

Stratification

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

None.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

N/A

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

None.

Type Score

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Rate/proportion better quality = higher score

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Rate/proportion better quality = higher score

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Rate/proportion better quality = higher score

Algorithm

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Step1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year.

Step 2. Search for an exclusion in the patient's history: Exclude patients from the eligible population if they meet the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
- Patients with diabetes during the measurement year or the year prior to the measurement year.

- Patients who had no antipsychotic medications dispensed during the measurement year.

Step 3. Determine the numerator: the number of patients who had a diabetes screening test during the measurement year.

Step 4. Calculate the rate.

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Step 1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year with a diagnosis of schizophrenia and cardiovascular disease

Step 2. Determine the numerator: the number of patients who had an LDL-C test during the measurement year

Step 3. Calculate the rate.

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Step 1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year

Step 2. Search for an optional exclusion in the patient's history: Exclude patients from the eligible population if the eligible population if they meet the following criteria:

- Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

- Exclude patients who do not have a diagnosis of diabetes during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes during the measurement year or the year prior to the measurement year.

Step 3. Determine the numerator: the number of patients who have one or more HbA1c tests and one or more LDL-C tests performed during the measurement year.

Step 4. Calculate the rate.

Submission items

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

5.1 Identified measures: 1933 : Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

1934 : Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: N/A

1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

5.1 Identified measures: 1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

1934 : Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: N/A

1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

5.1 Identified measures: 1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

1933 : Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: N/A

Comparison of NQF #3389 and NQF#2940, NQF #2950, and NQF #2951

3389 Concurrent Use of Opioids and Benzodiazepines (COB)
2940 Use of Opioids at High Dosage in Persons Without Cancer
2950 Use of Opioids from Multiple Providers in Persons Without Cancer
2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Steward

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

PQA, Inc.

2940 Use of Opioids at High Dosage in Persons Without Cancer

Pharmacy Quality Alliance

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Pharmacy Quality Alliance

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Pharmacy Quality Alliance

Description

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year.

A lower rate indicates better performance.

2940 Use of Opioids at High Dosage in Persons Without Cancer

The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.

Type

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Process

2940 Use of Opioids at High Dosage in Persons Without Cancer

Process

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Process

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Process

Data Source

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Claims Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs)

No data collection instrument provided Attachment PQA_ICD_Code_Cancer_Value_Set_Feb_2018.xlsx

2940 Use of Opioids at High Dosage in Persons Without Cancer

Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.

No data collection instrument provided Attachment Cancer_Exclusion_RxHCC-_ICD-9_and_10_Codes.xlsx

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.

No data collection instrument provided Attachment Cancer_Exclusion_RxHCC-_ICD-9_and_10_Codes-635969250747751020.xlsx

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.

No data collection instrument provided Attachment Cancer_Exclusion_RxHCC-_ICD-9_and_10_Codes-635969265833553126.xlsx

Level

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Health Plan

2940 Use of Opioids at High Dosage in Persons Without Cancer

Health Plan, Other, Population : Regional and State

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Health Plan, Other, Population : Regional and State

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Health Plan, Other, Population : Regional and State

Setting

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Other The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.

2940 Use of Opioids at High Dosage in Persons Without Cancer

Other, Outpatient Services The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Other, Outpatient Services The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Other, Outpatient Services The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.

Numerator Statement

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

The number of individuals from the denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year.

2940 Use of Opioids at High Dosage in Persons Without Cancer

Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer*

*MED calculation is included in S.6 Numerator Details

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Any member in the denominator who received opioid prescription claims from 4 or more prescribers AND 4 or more pharmacies.

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer* AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies.

*MED calculation is included in S.6 Numerator Details

Numerator Details

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

The number of individuals from the denominator with:

- 2 or more prescription claims for any benzodiazepine with unique dates of service, AND
- Concurrent use of opioids and benzodiazepines for 30 or more cumulative days.

Complete the steps below to identify individuals with concurrent use of opioids and benzodiazepines:

Step 1: From the denominator population, identify individuals with 2 or more prescriptions claims on unique dates of service for any benzodiazepine (Table COB-B, below) during the measurement year.

Step 2: Of the population identified in Step 1, determine the total days of overlap (concurrent use) between the opioid and benzodiazepine prescriptions during the measurement year.

- Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of overlap that occur after the end of the measurement year.

Step 3: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator.

Note: When identifying days' supply for opioids (or benzodiazepines):

- Exclude any days' supply that occur after the end of the measurement year.
- Multiple prescription claims with the same date of service: If multiple prescription claims for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

Table COB-B: Benzodiazepines:

Alprazolam, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, estazolam, flurazepam, lorazepam, midazolam, oxazepam, quazepam, temazepam, triazolam

(note: excludes injectable formulations)

2940 Use of Opioids at High Dosage in Persons Without Cancer

Any member in the denominator with opioid prescription claims greater than 120mg MED for 90 consecutive days or longer* (See Table Opioids-A: Opioid Medications)

*Identifying members with prescription opioids that exceeded the MED threshold:

To identify members with prescription opioids that exceeded the MED threshold, each claim is to be converted into the MED using the appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MED for each day's claims then are summed to determine the total MED for that day.

For each member in the denominator:

1. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations:

• # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply)

• MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED

conversion factor)

2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member.

3. Identify the days where the MED threshold is exceeded.

4. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator.

Table Opioid-A: Opioid Medications (MED conversion factor)

buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dihydrocodeine (0.25) fentanyl buccal or SL tablets, or lozenze/troche (0.13) fentanyl film or oral spray (0.18) fentanyl nasal spray (0.16) fentanyl patch (7.2) hydrocodone (1) hydromorphone (4) levorphanol (11) meperidine (0.1) methadone (3) morphine (1) opium (1) oxycodone (1.5) oxymorphone (3) pentazocine (0.37) tapentadol (0.4) tramadol (0.1)

*Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., BunavailTM, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys® (fentanyl transdermal patch) is also excluded as it is only for inpatient use; It is also only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

For each member in the denominator:

1. Calculate the number of unique pharmacy providers associated with an opioid prescription claim.

2. Calculate the number of unique prescribers associated with an opioid prescription claim.

3. Any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Any member in the denominator with opioid prescription claims greater than 120mg MED for 90 consecutive days or longer* AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies(See Table Opioids-A: Opioid Medications)

*Identifying members with prescription opioids that exceeded the MED threshold:

To identify members with prescription opioids that exceeded the MED threshold, each claim is to be converted into the MED using the appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MED for each day's claims then are summed to determine the total MED for that day.

For each member in the denominator:

1. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations:

• # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply)

• MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED

conversion factor)

2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member.

3. Identify the days where the MED threshold is exceeded.

4. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator.

5. From the members meeting the criteria for the MED component of the numerator (4), calculate the number of unique pharmacy providers associated with an opioid prescription claim.

6. From the members meeting the criteria for the MED component of the numerator (4), calculate the number of unique prescribers associated with an opioid prescription claim.

7. From the members meeting the criteria for the MED component of the numerator (4), any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.

Table Opioid-A: Opioid Medications (MED conversion factor)

buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dihydrocodeine (0.25) fentanyl buccal or SL tablets, or lozenze/troche (0.13) fentanyl film or oral spray (0.18) fentanyl nasal spray (0.16) fentanyl patch (7.2) hydrocodone (1) hydromorphone (4) levorphanol (11) meperidine (0.1) methadone (3) morphine (1) opium (1) oxycodone (1.5) oxymorphone (3) pentazocine (0.37) tapentadol (0.4) tramadol (0.1)

*Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., BunavailTM, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys® (fentanyl transdermal patch) is also excluded as it is only for inpatient use; It is also only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)

Denominator Statement

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

The denominator includes individuals 18 years and older with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days' supply is 15 or more days. Individuals with cancer or in hospice are excluded.

2940 Use of Opioids at High Dosage in Persons Without Cancer

Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Denominator Details

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

The denominator includes individuals 18 years and older by the first day of the measurement year with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days' supply is 15 or more days. Use Table COB-A: Opioids, below, to identify the opioid medications for the measure.

Complete the steps below to determine the denominator:

Step 1: Identify individuals aged 18 years and older as of the first day of the measurement year

Step 2: Of those identified in step 1, identify individuals meeting the continuous enrollment criteria.

- To be continuously enrolled, an individual may have no more than one gap in enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Step 3: Of those identified in step 2, identify individuals with 2 or more prescription claims for opioids on unique dates of service, for which the sum of the days' supply is 15 or more days' supply during the measurement year.

Step 4: Of those identified in step 3, identify individuals where the earliest prescription for an opioid (i.e. Index Prescription Start Date [IPSD]) is 30 or more days from the last day of the measurement year (January 1 through December 2)

Note: When identifying days' supply for opioids:

- Exclude any days' supply that occur after the end of the measurement year.
- Multiple prescription claims with the same date of service: If multiple prescription claims for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

Table COB-A: Opioids:

buprenorphine, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol

(note: excludes injectable formulations; includes prescription opioid cough medications; excludes single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

2940 Use of Opioids at High Dosage in Persons Without Cancer

Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Table Opioid-A: Opioid Medications

buprenorphine

butorphanol

codeine

dihydrocodeine

fentanyl

hydrocodone

hydromorphone

levorphanol

meperidine

methadone

morphine

opium

oxycodone

oxymorphone

pentazocine

tapentadol

tramadol

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Table Opioid-A: Opioid Medications

buprenorphine butorphanol

codeine dihydrocodeine

fentanyl

hydrocodone

hydromorphone levorphanol meperidine

methadone morphine

opium

oxycodone oxymorphone pentazocine

tapentadol

tramadol

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Table Opioid-A: Opioid Medications

buprenorphine butorphanol

codeine dihydrocodeine fentanyl

hydrocodone

hydromorphone levorphanol meperidine methadone morphine

opium

oxycodone oxymorphone pentazocine tapentadol tramadol

Exclusions

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Individuals with cancer or in hospice at any point during the measurement year are excluded from the denominator.

2940 Use of Opioids at High Dosage in Persons Without Cancer

Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016; (see list in S.11 and S.2b); or a hospice indicator from the enrollment database.

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.

Exclusion Details

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Hospice exclusion: Exclude any individual in hospice during the measurement year. To identify individuals in hospice:

- Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or
- Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid)

Cancer exclusion: Exclude any individuals with cancer during the measurement year. To identify individuals with cancer:

- Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
- For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

2940 Use of Opioids at High Dosage in Persons Without Cancer

Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice.

Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19

ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Hospice Exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice.

Cancer Exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19

ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice.

Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19

ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b

Risk Adjustment

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

No risk adjustment or risk stratification

2940 Use of Opioids at High Dosage in Persons Without Cancer

No risk adjustment or risk stratification

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

No risk adjustment or risk stratification

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

No risk adjustment or risk stratification

Stratification

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

The measure is stratified by the following lines of business for the health plan:

- Commercial
- Medicare
- Medicaid

Medicare Plans are further stratified by Low-Income Subsidy (LIS) status.

LIS is a subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency.

The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify LIS status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-

subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.

2940 Use of Opioids at High Dosage in Persons Without Cancer

The measure is stratified by the following lines of business for the health plan:

Commercial

Medicare

Medicaid

Medicare Plans are further stratified by Low Income Subsidy status

Definition: Medicare Low Income Subsidy (LIS) - A subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency.

The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name correspond with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

The measure is stratified by the following lines of business for the health plan:

Commercial

Medicare

Medicaid

Medicare Plans are further stratified by Low Income Subsidy status

Definition: Medicare Low Income Subsidy (LIS)

A subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency.

The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name correspond with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

The measure is stratified by the following lines of business for the health plan:

Commercial

Medicare

Medicaid

Medicare Plans are further stratified by Low Income Subsidy status

Definition: Medicare Low Income Subsidy (LIS)

A subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency.

The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name correspond with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.

Type Score

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Rate/proportion better quality = lower score

2940 Use of Opioids at High Dosage in Persons Without Cancer

Rate/proportion better quality = lower score

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Rate/proportion better quality = lower score

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Rate/proportion better quality = lower score

Algorithm

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

A. Target population (denominator):

Step 1: Identify individuals aged 18 years and older as of the first day of the measurement year

Step 2: Of those identified in step 1, identify individuals meeting the continuous enrollment criteria.

- To be continuously enrolled, an individual may have no more than one gap in enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Step 3: Of those identified in step 2, identify individuals with 2 or more prescription claims for opioids on unique dates of service, for which the sum of the days' supply is 15 or more days' supply during the measurement year.

Step 4: Of those identified in step 3, identify individuals where the earliest prescription for an opioid (i.e. Index Prescription Start Date [IPSD]) is 30 or more days from the last day of the measurement year (January 1 through December 2)

Note: When identifying days' supply for opioids:

- Exclude any days' supply that occur after the end of the measurement year.
- Multiple prescription claims with the same date of service: If multiple prescription claims for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

Step 5: Identify individuals with cancer or in hospice during the measurement year.

To identify individuals in hospice:

- Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or
- Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid)

To identify individuals with cancer:

- Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
- For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

Step 6: Exclude individuals with cancer or in hospice (Step 5) from those identified in Step 4. This is the denominator.

B. Numerator Population:

Step 7: From the denominator population (from Step 6), identify individuals with 2 or more prescriptions claims on unique dates of service for any benzodiazepine during the measurement year.

Step 8: Of the population identified in Step 7, determine the total days of overlap (concurrent use) between the opioid and benzodiazepine prescriptions during the measurement year.

- Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of overlap that occur after the end of the measurement year.

Step 9: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator.

Note: When identifying days' supply for opioids (or benzodiazepines):

- Exclude any days' supply that occur after the end of the measurement year.

• Multiple prescription opioid (or benzodiazepine) claims with overlap: For multiple prescription claims for opioids (or benzodiazepines) with overlapping days' supply, count each day in the measurement year only once toward the denominator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines).

C. Measure Rate:

Step 10: Divide the number of individuals in the numerator (Step 9) by the denominator (Step 6) and multiply by 100. This is the measure rate reported as a percentage.

• Report the rates separately by line of business (e.g. Medicare, Medicaid, Commercial). For Medicare, report rates for low-income subsidy (LIS) and non-LIS populations separately.

2940 Use of Opioids at High Dosage in Persons Without Cancer

Step One:

Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Step Two:

Calculate the numerator by:

For each member in the denominator:

a. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations:

• # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply)

• MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor)

b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member.

c. Identify the days where the MED threshold is exceeded.

d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator.

Step Three:

Divide the number of members that met the criteria in numerator (Step Two d.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Step One:

Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Step Two:

Calculate the numerator by:

a. Calculate the number of unique pharmacy providers associated with an opioid prescription claim.

b. Calculate the number of unique prescribers associated with an opioid prescription claim.

c. Any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.

Step Three:

Divide the number of members that met the criteria in numerator (Step Two c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Step One:

Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Step Two:

Calculate the numerator by:

For each member in the denominator:

a. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations:

• # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply)

• MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor)

b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member.

c. Identify the days where the MED threshold is exceeded.

d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator.

Step Three: From those members meeting the MED component in (Step 2d.) identify those members who received opioids from 4 or more prescribers AND 4 or more pharmacies.

a. Calculate the number of unique pharmacy providers associated with an opioid prescription claim.

b. Calculate the number of unique prescribers associated with an opioid prescription claim.

c. Any member from Step 2d with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.

Step Four:

Divide the number of members that met the criteria in numerator (Step Three c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.

Submission items

3389 Concurrent Use of Opioids and Benzodiazepines (COB)

5.1 Identified measures: 2940 : Use of Opioids at High Dosage in Persons Without Cancer

2950 : Use of Opioids from Multiple Providers in Persons Without Cancer

2951 : Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The PQA opioid measures (NQF # 2940, 2950, and 2951) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The NCQA opioid measures were developed as an adaptation to existing PQA measures; the NCQA opioid measure denominators are similar to the PQA opioid measures, but have a different area of focus than the concurrent use of opioids and benzodiazepines measure.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that addresses both the same measure focus and the same target population).

2940 Use of Opioids at High Dosage in Persons Without Cancer

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: N/A

2950 Use of Opioids from Multiple Providers in Persons Without Cancer

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: N/A

2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: N/A

Comparison of NQF #3400 and NQF# 3175

3400 Use of pharmacotherapy for opioid use disorder (OUD)
3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Steward

3400 Use of pharmacotherapy for opioid use disorder (OUD)

PCPI

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

University of Southern California

Description

3400 Use of pharmacotherapy for opioid use disorder (OUD)

The percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the

disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment

Type

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Process

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Process

Data Source

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Claims Medicaid Alpha-MAX 2014 data: eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided.

No data collection instrument provided Attachment NQF_Value_Sets_SUD-4_FINAL_SUD_team.01.24.18.xlsx

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Claims, Electronic Health Data For measure calculation, the following files from the Truven MarketScan® Commercial Database were used:

- Enrollment data
- Drug claims
- Medical claims

We used data from these files (including data from Standard Quarterly Updates) for calendar years 2010-2015. This database has long been a commonly used data source to study patterns of commercially insured patients. The database contains fully adjudicated, patient-level claims. All records in these files were used as input to identify individuals that met the measure's eligibility criteria. We present detailed results in the MIF for 2013-2014, as we have the most data for this time period, but we include measure scores for each of the two-year periods within 2010-2015. The final analytic file for 2013-2014 contained a total of 43,812 episodes.

No data collection instrument provided Attachment NQF_3175_OUD_Code_Lists_1-12-17_To_NQF.xlsx

Level

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Population : Regional and State

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Health Plan, Population : Regional and State

Setting

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Outpatient Services

Numerator Statement

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

Numerator Details

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Beneficiaries identified as filling a prescription for or were administered or ordered an FDA-approved medication for OUD, during the 12-month measure year, through pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. Only formulations with an OUD indication (not pain management) are included in measure calculation.

The measure will be calculated both overall and stratified by four medications/mode of administration: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. NDC codes listed are codes that were used in testing and are current as of June 2017.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

The measure numerator is calculated based on commercial claims data for rolling two-year periods from 2010 to 2015: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. The measure numerator is defined as individuals in the denominator with at least 180 days of “continuous pharmacotherapy” with an OUD medication.

Continuous pharmacotherapy for OUD is identified on the basis of the days covered by the days’ supply of all prescription claims for any OUD medication (see list below) or number of days for which the drug was dispensed in a physician office or treatment center with the exceptions noted in this paragraph. The period of continuous pharmacotherapy starts on the day the first claim for an OUD medication is filled/supplied (index date) and lasts through the days’ supply of the last claim for an OUD medication. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period. For claims with a days’ supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement

period. If two or more prescription claims occur on the same day or overlap, the surplus based on the days' supplies accumulates over all prescriptions. However, if another claim is submitted after a claim for an injectable OUD medication or an oral OUD medication that is dispensed in an office or treatment center, the surplus from the day's supply for the injectable or office-dispensed medication is not retained.

An individual is considered to have continuous pharmacotherapy with OUD medication if there is no treatment gap of more than seven days. A gap is defined as a period during which the individual does not have oral OUD medication available based on the days' supply, or is more than 7 days overdue for having an injection of an extended-release OUD medication.

OUD medications were identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-dispensed oral medications (methadone and buprenorphine/naloxone) are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office and is therefore identified based on either NDC or HCPCS codes.

Justification of Measure Definition: We define treatment continuity as (1) receiving at least 180 days of treatment and (2) no gaps in medication use of more than 7 days.

Our definition of minimum duration is based on the fact that the FDA registration trials for OUD drugs studied the effect of treatment over three to six months (US FDAa, undated; US FDAb, undated), and we have no evidence for effectiveness of shorter durations. In addition, several recommendations support a minimum six-month treatment period as the risk of relapse is the highest in the first 6-12 months after start of opioid abstinence (US FDAa, undated; US FDAb, undated; US DHHS, 2015). Longer treatment duration is associated with better outcomes compared to shorter treatments and the best outcomes have been observed among patients in long-term methadone maintenance programs ("Effective medical treatment of opiate addiction", 1998; Gruber et al., 2008; Moos et al., 1999; NIDA, 1999; Ouimette et al., 1998; Peles et al., 2013). Studies with long-term follow-up suggest that ongoing pharmacotherapy is associated with improved odds of opioid abstinence (Hser et al., 2015; Weiss et al., 2015). We did not specify a maximum duration of treatment, as no upper limit for duration of treatment has been empirically established (US DHHS, 2015).

We opted for using a treatment gap of more than seven days in our definition, given that the measure includes three active ingredients with different pharmacological profiles. There is substantial evidence for an elevated mortality risk immediately after treatment

cessation (Cornish et al., 2010; Cousins et al., 2016; Davoli et al, 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016). Research suggests that methadone tolerance is lost after three days and this three-day threshold has been used in other observational methadone studies and in developing a United Kingdom treatment guideline which recommends revaluating patients for intoxication and withdrawal after a three-day methadone treatment gap (Cousins et al., 2016; Cousins et al., 2011; "Drug Misuse and Dependence—Guidelines on Clinical Management", 1999). Across all the medications, the mortality risk is highest in the first four weeks out of treatment, with many studies showing an increase in mortality in days 1-14 after treatment cessation.

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Denominator Statement

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Number of Medicaid beneficiaries with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

Denominator Details

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Medicaid beneficiaries age 18 through 64, enrolled for full 12 months of measurement year, and had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-9 and ICD-10 codes for OUD are provided in the attached Excel file in required format at S.2b.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

The measure denominator is calculated for rolling two-year periods from 2010 to 2015: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. The denominator includes individuals 18-64 years of age during their treatment period who had a diagnosis code of OUD during an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department encounter at any time during the measurement period. To meet the 180-day requirement and be eligible for the measure, the date on the

first claim for an OUD medication must fall at least 180 days before the end of the measurement period.

The diagnosis codes used to identify individuals with OUD included:

- ICD-9: 304.0x, 305.5x
- ICD-10: F11.xxx

These codes and descriptions are contained in the sheets called “ICD-9 Diagnosis Codes” and “ICD-10 Diagnosis Codes” in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b.

OUD medications were identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-or treatment-center dispensed oral medications (methadone and buprenorphine) are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office/treatment center and is therefore identified based on either NDC or HCPCS codes.

Exclusions

3400 Use of pharmacotherapy for opioid use disorder (OUD)

None.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

There are no denominator exclusions.

Exclusion Details

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Not applicable.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

There are no denominator exclusions.

Risk Adjustment

3400 Use of pharmacotherapy for opioid use disorder (OUD)

No risk adjustment or risk stratification

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

No risk adjustment or risk stratification

Stratification

3400 Use of pharmacotherapy for opioid use disorder (OUD)

The measure will be calculated both overall and stratified by four medications/mode of administration: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

The NDC pharmacy codes used to identify the FDA-approved medications for OUD are listed in an Excel file attached in S.2b.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Measure results may be stratified by:

- Age – Divided into four categories: 18-34, 35-44, 45-54, 55-64 years
- Gender: Male, Female
- State
- Health plan

Type Score

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Rate/proportion better quality = higher score

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Rate/proportion better quality = higher score

Algorithm

3400 Use of pharmacotherapy for opioid use disorder (OUD)

Step 1: Identify denominator

Identify Medicaid beneficiaries age 18 through 64 years with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (primary or other diagnosis) during the measurement year and continuously enrolled during the measurement year. Age is calculated as of January 1 of the measurement year.

Step 2: Identify the numerator as beneficiaries with evidence of at least one prescription filled, or were administered or ordered an FDA-approved medication for the disorder during the measurement year.

The measure will report any medications used in MAT of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

Step 2A: Identify beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year.

Step 2B: Identify beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year.

Step 2C: Identify beneficiaries with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year.

Step 2D: Identify beneficiaries with evidence of at least one prescription for methadone at any point during the measurement year.

Note: Pharmacotherapy for opioid abuse, dependence, or remission prescriptions and procedures, might occur in several files. Similarly, a diagnosis of opioid abuse, dependence, or remission might occur in several files. For example, one claims file may contain injectables while another claims file may contain oral medications. Consequently, pharmacotherapy and opioid abuse, dependence, or remission variables are created separately in each source and then merged by beneficiary ID.

Step 3: Calculate the overall rate by dividing the number of beneficiaries with evidence of at least one prescription (Step 2) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1). Then, calculate rates separately for each of the four medications.

Step 3A: Calculate the buprenorphine prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for buprenorphine during the measurement year (Step 2A) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).

Step 3B: Calculate the oral naltrexone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for oral naltrexone during the measurement year (Step 2B) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).

Step 3C: Calculate the long-acting, injectable naltrexone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for injectable naltrexone during the measurement year (Step 2C) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).

Step 3D: Calculate the methadone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for methadone during the measurement year (Step 2D) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

The measure score is calculated for rolling two-year periods from 2010 to 2015. The steps described below are repeated for five rolling two-year periods: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. We present detailed results in the MIF for 2013-2014, as we have the most data for this time period, but we include measure scores for each of the two-year periods within 2010-2015.

DENOMINATOR: Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

CREATE DENOMINATOR:

1. For each two-year period, identify individuals who are 18-64 years of age for the duration of the first year during which they appear in the period.

2. Of individuals identified in Step 1, keep those who had at least one encounter with any diagnosis (primary or secondary) of OUD in an outpatient setting, acute inpatient setting, or emergency department setting at any time during the two-year measurement period. The OUD diagnosis codes with descriptions are contained in the sheets called “ICD-9 Diagnosis Codes” and “ICD-10 Diagnosis Codes” in the Excel file called “NQF 3175 OUD Code Lists”, which is attached to this form under Item S.2b.

3. Of individuals identified in Step 2, keep those who have at least one claim with a National Drug Code (NDC) for any of the following oral OUD medications during the two-

year period with a date at least 180 days before the end of the final calendar year of the measurement period:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

Or a HCPCS code for any of the following OUD medications:

- Buprenorphine or Buprenorphine/naloxone, oral
- Methadone administration
- Naltrexone (extended-release injectable)

Claims for oral medications with negative, missing, or zero days' supply were not included. The NDCs for the oral medications and the HCPCS codes for the injectable and office- or treatment center-dispensed medications are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists," which is attached to this form under Item S.2b.

4. Of individuals identified in Step 3, keep individuals who were continuously enrolled in a commercial health plan captured by our data for at least 6 months after the month with the first OUD medication claim in the measurement period, with no gap in enrollment. Individuals who are not enrolled for 6 months, including those who die during the period, are not eligible and are not included in the analysis. This is the denominator.

NUMERATOR: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

CREATE NUMERATOR:

For the individuals in the denominator, identify those who have at least 180 days of continuous pharmacotherapy with an OUD medication without a gap of more than seven days using the following method:

1. Determine the number of days for the PDC denominator. The start date is the service date (fill date) of the first prescription or injection/dispensing claim for an OUD medication in the two-year measurement period. The end date is defined as the earliest of:

- The date on which the individual exhausts their days' supply, including any pre-existing surplus, following their final claim (assuming daily use).
- The individual's death date.
- December 31st of the second year in the two-year period.

2. For each individual: Count the days during the observation period for which the individual was covered by at least one OUD medication based on the prescription drug or injection/dispensing claim service dates and days' supply.

2a. Sort OUD medication claims by individual's ID and service date. Scan the claims in order, calculating a rolling surplus which accumulates any remaining days' supply from other prior or same-day fills.

2b. Naltrexone injections contribute 30 days' supply unless another claim is found sooner, in which case the Naltrexone injection covers only the days up to the next claim.

2c. Methadone and buprenorphine/naloxone supply is determined by the start and end dates on the outpatient claims with the codes for in-office/treatment center dispensation of methadone (H0020) and buprenorphine/naloxone (J0571-J0575).

2d. Claims for Naltrexone injections and for licensed treatment center-dispensed methadone and office-dispensed buprenorphine/naloxone are not added to the surplus supply and only one such claim per day is counted.

2e. For claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

3. Determine treatment gaps as periods, in which the individual has exhausted his/her available supply, defined as the days' supply from the most recent previous fill/dispensing and any pre-existing surplus available before that fill/dispensing.

4. Of the individuals in Step 2, count the number of individuals who have a period of 180 days or greater from the start date of the first claim for OUD medication to the end date of the last claim for OUD medication within the two-year period and who do not have a gap of more than seven days without OUD medication available. This is the numerator.

CALCULATE MEASURE SCORE:

1. Calculate the measure score by dividing the numerator by the denominator.

2. Calculate the measure score for each state. The state code on the claim record is used to identify individuals in each state. The measure score is then reported for each state that has at least 20 individuals in the denominator.

3. Calculate the measure score for each health plan. Health plan membership is approximated based on a combination of two variables found on the claim record, industry type and Metropolitan Statistical Area (MSA). A health plan identifier is assigned based on each unique combination of industry and MSA. The health plan identifier is used to group individuals into health plans. The measure score is then reported for each health plan that has at least 20 individuals in the denominator.

Submission items

3400 Use of pharmacotherapy for opioid use disorder (OUD)

5.1 Identified measures: 3175 : Continuity of Pharmacotherapy for Opioid Use Disorder

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Not Applicable.

5b.1 If competing, why superior or rationale for additive value: Not Applicable.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

1664 : SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The target population of the proposed measure is related to the two measures listed above (NQF 0004 and NQF 1664). Differences among the three measures, along with the rationale and

impact, are discussed below in the text box for Item 5b.1. The text box for this item (5a.2) would not accommodate the length of our response.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures that address both the same measure focus and the same target population as the proposed measure.

RESPONSE TO ITEM 5A.2

The information below is the response to Item 5a.2, describing the differences, rationale, and impact on interpretability and data collection burden for the two NQF-endorsed RELATED measures which were identified. (We have inserted it here because the text box under Item 5a.2 would not accept this volume of formatted text.)

The target population of the proposed measure is related to the two NQF-endorsed measures listed above (NQF 0004 and NQF 1664). The proposed measure focuses on continuity of pharmacotherapy for patients with OUD. NQF 0004 focuses on treatment initiation and engagement of patients with a new episode of OUD or other substance use disorders, including alcohol use disorder (AUD). NQF 1664 focuses on 0UD and other drug use disorders among hospital discharges. Differences among the three measures, along with the rationale and impact are discussed below.

Diagnoses Included in Denominator Definition

- Proposed measure: Diagnosis of OUD
- NQF 0004: Diagnosis of alcohol or other drug dependence
- NQF 1664: Diagnosis of AUD or another substance use disorder
- Rationale and impact of focusing on only OUD: There are different medications for treatment of OUD and AUD, and there are no FDA-approved medications for treatment of other substance use disorders. In addition, the conceptual issues related to continuity of pharmacotherapy differ between OUD and AUD, so developing separate measures for the two disorders is required. The impact of this is a more narrowly focused measure that provides information specific to individuals with OUD.

Age Range

- Proposed measure: Patients 18-64 years of age
- NQF 0004: Patients aged 13 years of age and older
- NQF 1664: Patients 18 years of age and older
- Rationale and impact of limiting to individuals 18-64 years of age: Medications for treatment of OUD have not been approved by the FDA for adolescent patients 13-17 years of age; therefore, the proposed measure is restricted to adults 18-64 years of age.

Data Source

- Proposed measure: Electronic claims data
- NQF 0004: Administrative claims, electronic clinical data
- NQF 1664: Electronic clinical data, paper medical records
- Rationale and impact of using electronic claims data: Electronic claims data are timely, accessible, and relatively inexpensive to use for analyses of a large number of patients. Using a single source of data expedites the calculation of the measure, and will provide feedback to providers sooner.

Inpatient vs. Outpatient

- Proposed measure: Inpatient and outpatient
- NQF 0004: Inpatient and outpatient
- NQF 1664: Inpatient discharges
- Rationale and impact of using inpatient and outpatient records to identify patients: A large majority of patients with OUD are not admitted to a hospital, so using inpatient and outpatient data leads to more complete identification of the population eligible for treatment.

Process of Care Included in Numerator Definition

- Proposed measure: Continuity of pharmacotherapy for OUD
- NQF 0004: Inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization for adults with a new episode of AUD, OUD, or other substance use disorders
- NQF 1664: Medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment
- Rationale and impact of the process of care included in the numerator definition: Successful pharmacotherapy of OUD requires continuity over at least a 180-day period. Therefore, providing feedback to providers about continuity of OUD pharmacotherapy has the potential to improve continuity rates by increasing provider awareness, and motivating health plans and insurers to develop educational material and programs about pharmacotherapy for OUD for both providers and patients.

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