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Primary Care and Chronic Illness, Spring 2019 Review Cycle: CDP Report

TECHNICAL REPORT
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Executive Summary

Primary care providers serve as the most common contact point for many people within the U.S. healthcare system. As such, primary care has a central role in improving the health of people and populations. Primary care practitioners work with each patient to manage the health of that individual. In the primary care setting, the diagnosis and treatment of the patient focuses on the health of the entire patient and not a single disease.

Chronic illnesses are long-lasting or persistent health conditions or diseases that patients and providers must manage on an ongoing basis. The incidence, impact, and cost of chronic disease is increasing in the United States. For example, more than 30 million Americans (9.4 percent) are living with diabetes, and in 2017, the U.S. spent $237 billion on diabetes care, making it one of the most expensive health conditions.[1,2] In addition, studies have estimated the yearly costs for glaucoma, rheumatoid arthritis and hepatitis C at $5.8 billion, $19.3 billion, and $6.5 billion, respectively.[3–5] The net economic burden for medication nonadherence—a common issue with primary care patients—has been estimated at nearly $300 billion per year.[6]

For this project, the Primary Care and Chronic Illness (PCCI) Standing Committee evaluated five newly submitted measures and five measures undergoing maintenance review against NQF's standard evaluation criteria. The Committee endorsed seven measures and did not endorse three measures. The endorsed measures are:

- 0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation (PCPI Foundation)
- 0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation (PCPI Foundation)
- 0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category (Pharmacy Quality Alliance)
- 2522 Rheumatoid Arthritis: Tuberculosis Screening (American College of Rheumatology)
- 2523 Rheumatoid Arthritis: Assessment of Disease Activity (American College of Rheumatology)
- 2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy (American College of Rheumatology)
- 3059e One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (PCPI Foundation)

The Committee did not endorse the following measures:

- 0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (PCPI Foundation)
- 0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (PCPI Foundation)
- 3060e Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (PCPI Foundation)

Brief summaries of the reviewed 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

Over the last 15 years, NQF has endorsed more than 50 measures addressing improvements in primary care and care for chronic illnesses. These measures are used in many national and state-level public reporting and accountability programs, as well as for quality improvement. With the formation of the Primary Care and Chronic Illness Standing Committee in 2017, NQF was able to consolidate and streamline the measure maintenance and endorsement process for a broad set of measures related to primary care and chronic illness.

High-quality performance measurement that captures the complexity of primary care and chronic illnesses is essential to improve diagnosis, treatment, and management of conditions. NQF will review measures in these important healthcare areas under a consolidated measure portfolio that reflects the importance of caring for chronic illness in primary care settings. Measures may focus on nonsurgical eyes or ears, nose, and throat conditions; diabetes care, osteoporosis; Human Immunodeficiency Virus (HIV); rheumatoid arthritis; gout; back pain; asthma; chronic obstructive pulmonary disease (COPD); and acute bronchitis.

NQF Portfolio of Performance Measures for Primary Care and Chronic Illness

The Primary Care and Chronic Illness Standing Committee (Appendix C) oversees NQF's portfolio of Primary Care and Chronic Illness measures (Appendix B). This portfolio contains 47 total measures: 40 process measures, five outcome measures, one intermediate outcome measure, and one composite measure (see table below).

Table 1. NQF Primary Care and Chronic Illness Portfolio of Measures

	Process	Outcome	Intermediate Outcome	Composite
Ears, Nose, Throat (ENT), Eye Care	14	–	–	–
Endocrine	6	3	–	1
Infectious Disease	8	2	1	–
Musculoskeletal	6	–	–	–
Pulmonary	5	–	–	–
Other	1	–	–	–
Total	40	5	1	1

Other measures related to primary care and chronic illness have been assigned to other portfolios. These include functional status measures (Patient Experience and Function), opioid use measures (Patient Safety and Behavioral Health), diabetes-related admission rate measures (Prevention and Population Health), and a variety of condition- or population-specific measures (Cardiovascular, Pediatric, Geriatric and Palliative Care, etc.).

Primary Care and Chronic Illness Measure Evaluation

At the Primary Care and Chronic Illness Standing Committee's in-person meeting on June 26, 2019 at the NQF offices in Washington, DC and two additional web meetings on July 1 and July 8, 2019, the Standing Committee evaluated five new measures and five measures undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 2. Primary Care and Chronic Illness Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	5	5	10
Measures endorsed	3	4	7
Measures not endorsed	2	1	3
Reasons for not endorsing	Importance – 2 Scientific Acceptability – 0 Use – 0 Overall Suitability – 0 Competing Measure – 0	Importance – 0 Scientific Acceptability – 1 Overall Suitability – 0 Competing Measure – 0	

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 May 1, 2019 and will close on August 23, 2019. As of June 12, one comment was submitted and shared with the Committee prior to the June 26 in-person meeting (Appendix F). One comment from the public was received on measure 2525 related to the value set of the measure.

Comments Received After Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on August 30, 2019. Following the Committee's evaluation of the measures under review, NQF received 16 comments from six organizations (all member organizations) and individuals pertaining to the draft report and to the measures under consideration. All comments for each measure under consideration have been summarized in Appendix A.

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. NQF did not receive any member expressions of support/nonsupport.

Overarching Issues

During the Standing Committee's discussion of the measures, a clear overarching issue emerged that was factored into the Committee's ratings and recommendations for multiple measures and is not repeated in detail with each individual measure.

Testing Measures to Specifications

Many of the measures that the Committee reviewed during this cycle did not meet NQF's requirements for testing to specifications. This occurs when a measure developer does not use appropriate methodologies or data sources that align with how the developer has specified the measure in conducting analyses such as reliability and validity testing. For example, if a measure developer stipulates in the testing that a certain number of events must have occurred over the measurement period for a given provider to be included in the analysis, this is considered an exclusion criterion for the analysis. If that exclusion is not included in the specifications of the measure, then the measure is said to not be tested to specifications. This is problematic because excluding providers with low numbers of events in reliability and validity analyses removes sources of instability from the sample and may artificially bolster the performance of the measure over the data set.

Another way measures were not tested to specification during this review cycle was by not including analyses by provider type for all providers listed in the specification. For example, if a measure is specified by level of analysis for individual clinicians and for clinician groups, then for the measure to be tested to specifications, at least two analyses must be performed by each level of analysis separately, and not pooled together into one analysis. One reason that this is important is that score level reliability is partially dependent on the number of measurement events over the measurement period, and individual providers as a whole tend to have fewer measurable events than provider groups. By pooling the analysis, individual providers may appear to have higher reliability performance within the data set than they actually do.

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.

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation (PCPI Foundation): Endorsed

Description: Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Other, Outpatient Services, Post-Acute Care; **Data Source**: Claims, Registry Data

The Committee agreed that this process measure is important to assess the percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation. This measure is reported through claims and registry, whereas 0086e is reported through the electronic health records (EHR). The Committee agreed that the evidence remains strong and a performance gap continues to exist and did not have further discussion.

The Committee had some discussion on the reliability and validity testing of the measure. Since testing on the measure was not at the clinician: individual level of analysis, this measure would be evaluated by the Committee at the clinician: group/practice level of analysis only. The developer noted that they were unable to parse out their data at the clinician: individual level of analysis for this measure. One Committee member noted that ICD-10 coding of this measure included normal-tension and low-tension glaucoma in the definition of primary open-angle glaucoma. The developer noted that they will share that coding feedback with their technical expert panel during their annual update. The Committee noted that the empirical validity results using Pearson's correlation coefficients to compare performance of 0086 with PQRS #117 *Diabetes: Eye Exam* were moderate at the registry level (0.57), but weak at the claims level (0.22).

The Committee had no further discussion or concerns on the feasibility and use. Regarding the usability criterion, a few Committee members expressed support that this measure will encourage performing optic nerve evaluations and, hopefully in the future, encourage measures that address optic nerve evaluation. The Committee noted that there is one related measure, 0563 *Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure* by *15 percent or Documentation of a Plan of Care*; however, 0563 has a different measure focus than 0086. One Committee member noted that 0563 and 0086 differ with respect to including patients who have normal or low-tension glaucoma and would like to see harmonization in the target populations of the two measures. A few Committee members suggested that the developer consider whether the appropriate measure title and target population is primary open-angle glaucoma or the general glaucoma population. The developer will share that feedback with their technical expert panel during their annual update. The Standing Committee recommended the measure for continued endorsement.

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation (PCPI Foundation): Endorsed

Description: Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Other, Outpatient Services, Post-Acute Care; **Data Source**: Electronic Health Records

This process measure is the eMeasure version of 0086 which assesses the percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation. The Committee agreed to pull the votes on evidence from 0086 as it is identical information. The Committee agreed that a performance gap continues to exist and did not have further discussion on the criterion.

The Committee initially did not reach consensus on the validity of the measure. In regard to validity of the specifications, the Committee members again asked the developer to consider the appropriate coding of this measure which includes normal-tension and low-tension glaucoma, and questioned if the appropriate measure title and target population is primary open-angle glaucoma or the general glaucoma population. The developer reiterated their plan to share that feedback with their technical expert panel during their annual update process. One Committee member questioned if the appropriate sample of specialists is reporting on the measure. The developer noted that specialists can choose which

measure they report on and therefore would generally report on measures for which they have expertise. The Committee noted the empirical validity result using Pearson's correlation coefficients to compare performance of 0086e with PQRS #117 *Diabetes: Eye Exam* was weak at the EHR level (0.36); however, one Committee member believed the correlation coefficients would be stronger except that the providers reporting the two measures may be taking care of different types of patients. One Committee member raised concern that the measure is not risk adjusted for potential social determinants of health and/or age. However, other Committee members did not believe this measure needs risk adjustment. The Committee had no further discussion or concerns on the feasibility, use, and usability of the measure.

The Standing Committee did not vote on the recommendation for endorsement at the July 1, 2019 meeting because the Committee did not reach consensus on validity—a must-pass criterion. The Committee was reconvened for the PCCI Post-Comment Meeting on September 24, 2019 to address public comments and continue adjudicating measures where consensus was not reached. Committee Co-chair Dr. Bratzler and NQF senior director Dr. Stolpe summarized the Committee's previous concerns on validity, including: (1) consideration of the appropriate coding of this measure which includes normal-tension and low-tension glaucoma; (2) if the appropriate measure title and target population is primary open-angle glaucoma or the general glaucoma population; and (3) that the empirical validity result using Pearson's correlation coefficients to compare performance of 0086e with PQRS 117 *Diabetes: Eye Exam* was weak at the EHR level (0.36).

The developer noted again their plan to share the Committee's feedback on coding and the measure title with their technical expert panel during their annual update process. After the review of public comments and the developer response on 0086e, the Committee re-voted on the validity criterion and the overall recommendation for endorsement. The Committee passed the measure on the validity criterion and overall recommendation for NQF endorsement.

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (PCPI Foundation): Not Endorsed

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Other, Outpatient Services, Post-Acute Care; **Data Source**: Claims, Registry Data

The Standing Committee did not vote on the recommendation for endorsement because the measure did not pass the validity criterion—a must-pass criterion. In addition, the measure did not reach consensus on the evidence and reliability criteria. This process measure assesses the percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam. This measure is reported through claims and registry, whereas 0089e is reported through the electronic health records.

More than 60 percent of Committee members voted insufficient on Evidence. Committee members noted that there is no evidence indicating communication between physicians performing the dilated macular or fundus exam and those treating the diabetes will lead to improved health outcomes for patients. The Committee was able to vote on evidence with exception; however, the Committee did not reach consensus on evidence with exception. Some Committee members did not see value in a performance measure addressing this measure focus, in addition to their concern about the evidence. One Committee member also expressed that quality of care is mandatory; however, if a quality measure does not meet applicable standards, then the benefit of measurement may not justify the reporting burden. However, some Committee members had a different opinion: They did see value in the measure as a potential driver of improved outcomes. The developer noted that care coordination measures are an important gap in the measurement field.

The Committee agreed that a performance gap continues to exist and did not have further discussion on the criterion.

The Committee did not reach consensus on the reliability of the measure. Since testing on the measure was not at the clinician: individual level of analysis, this measure was evaluated at the clinician: group/practice level of analysis only. In addition, the developer specified the measure for outpatient, post-acute care, and domiciliary settings, but these analyses were not conducted separately. A few Committee members with an ophthalmology background noted that a very small percentage of ophthalmologists reporting on this measure would be from the domiciliary setting and would be predominantly reporting at the outpatient setting.

The Committee did not pass the measure on validity. The Committee noted that the empirical validity results using Pearson's correlation coefficients to compare performance of 0089 with PQRS #117 *Diabetes: Eye Exam* were weak at the claims and registry levels (0.11 and 0.16). However, one Committee member believed the correlation coefficients would be stronger except that the providers reporting the two measures may be taking care of different types of patients. Discussion and voting stopped at the validity criterion, as it is a must-pass criterion.

During the PCCI Post-Comment Meeting, the Committee was asked by the developer and other stakeholders to reconsider this measure and its e-Measure companion. The developer's rationale for reconsideration was as follows: (1) Committee members with ophthalmology and endocrinology backgrounds supported the measure; (2) the measure could pass under the exception to evidence criterion, where gap in care can substitute for empirical evidence; (3) while there was limited data available for the empirical validity correlation analysis, and despite weak correlation results of 0089, it was still positive and the measure also had strong face validity; (4) the Committee had expressed a preference for a general measure on care coordination, but no general measure currently exists; (5) and there was a lack of Committee quorum on the call for the discussion of 0089e.

During the post-comment call, the developer emphasized that the measures address a CMS priority area of effective communication and coordination. One Committee member was supportive of the measures, as care coordination between the primary care practitioner and/or endocrinologist with the ophthalmologist is important. The Committee member noted that all providers caring for the patient

need to know the level of diabetic retinopathy and dates of evaluation by the ophthalmologist. He also indicated that obtaining evidence on these measures would be extremely challenging. Another Committee member noted that it would be more beneficial for the primary care practitioner to receive a note from the ophthalmologist or a copy of the ophthalmologist office visit note. Some Committee members reiterated the discussion from the measure evaluation web meetings in July 2019: There is no evidence indicating that communication will lead to improved health outcomes for the patient. In addition, the level of retinopathy or knowing the outcome of the diabetic retinopathy evaluation will not change the endocrinologist's or primary care practitioner's treatment of the diabetic patient. One Committee member noted unintended consequences as the lack of interoperability of the current systems allows clinicians other than the treating practitioner to receive the ophthalmologist reports. Finally, one Committee member stressed that the measures did not pass multiple NQF criteria and should not be recommended for endorsement.

NQF noted that five organizations submitted supportive comments to re-endorse the two measures during the commenting period. The Committee voted on whether they would like to re-consider measures 0089 and 0089e, and by a vote of 3-Yes, 11-No, they elected not to reconsider measures 0089 and 0089e. Both measures were not recommended for NQF re-endorsement.

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (PCPI Foundation): Not Endorsed

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Other, Outpatient Services, Post-Acute Care; **Data Source**: Electronic Health Records

The Committee did not have quorum for voting on the measure at the July 8 post-meeting call and submitted their votes via SurveyMonkey afterwards. The measure did not pass the evidence and validity criteria—both of which are must-pass. In addition, the Committee did not reach consensus on the reliability criterion. This process measure assesses the percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam. This measure is reported through electronic health records, whereas 0089 is reported through claims and registry.

The Committee did not discuss evidence or performance gap further for measure 0089e. The evidence was thoroughly discussed previously on measure 0089, which has identical evidence information.

The Committee noted that the empirical validity result using Pearson's correlation coefficients to compare performance of 0089 with PQRS #117 *Diabetes: Eye Exam* was weak at the EHR level (0.08). There was a moderate correlation (0.59) with the measure, *Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy*. One Committee member asked the developer about the usability and feasibility of this eMeasure. The developer noted no issues

thus far in the usability of the measure. The developer clarified for the Committee the type of communications qualifying for the measure. The Committee recapped previous Committee discussion on measure 0089 about the usability of the measure and whether the measure adds value and improves outcomes, which also applies to 0089e.

As noted in the previous measure description, during the PCCI Post-Comment Meeting, the Committee was asked by the developer and other stakeholders to reconsider this measure and its e-Measure companion. Committee discussion is described in detail above. The Committee voted on whether they would like to re-consider measures 0089 and 0089e, and by a vote of 3-Yes, 11-No, they elected not to reconsider measures 0089 and 0089e.

The Standing Committee did not recommend this measure for continued endorsement.

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category (Pharmacy Quality Alliance): Endorsed

Description: The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement year.
Report a rate for each of the following:

- Diabetes All Class (PDC-DR)
- Renin Angiotensin System Antagonists (PDC-RASA)
- Statins (PDC-STA)

A higher rate indicates better performance. **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Enrollment Data

The Committee noted that these are known measures with broad national adoption. Committee discussion was prefaced with the note that the data source for this measure is electronic pharmacy claims, a source with significantly higher precision than conventional medical claims. Nonetheless, pharmacy data do not contain the breadth of information that is found either in the EHR, or what may be present in traditional medical claims. Committee members questioned the measure developer on the logic model that connects pharmacy claims with positive patient outcomes, specifically voicing concern about pharmacy claims that might not be adequate proxies for patient medication adherence. The lead discussant pointed to evidence provided by the developer that adherence measures using the proportion of days covered (PDC) methodology have been repeatedly demonstrated to serve as a strong proxy for medication adherence, with clear connections to positive patient medical outcomes and decreased cost of care at the population level.

The Committee asked the developer what occurs when patients experience side effects or significant adverse drug events (ADE) associated with medication use. The developer responded that the measures demonstrate a robust resilience to these effects for two reasons. First, the measure specifications stipulate that a patient must have two fills of a medication in order to appear in the denominator, with most patients discontinuing therapy because of side effects or ADEs on the first fill of a given medication. Second, assuming an equal distribution of these types of events across populations, health plans would theoretically be affected by such discontinuations at the same rate, and hence still have accurate comparability using these three PDC rates. The Committee was satisfied with the evidence and

performance gap for the measure. This measure was deemed complex due to risk adjustment and was evaluated by the NQF Scientific Methods Panel. The measure developer submitted a first-of-its-kind risk-adjustment model for a process measure.

The Committee had limited discussion on the reliability of the measure and elected to uphold the Methods Panel reliability ranking. The validity discussion centered on risk adjustment, stratification, and correlation with other measures. The developer noted that the thresholds for performance indicate that validity correlations were moderate by conventional evaluation standards for Pearson correlation coefficients between quality measures. The Committee upheld the Methods Panel's validity ranking.

During the discussion of feasibility, the Committee introduced concerns that prescriptions that are not captured through claims will not be captured in the data. This could result in consequences for health plans as well as downstream consequences for providers and pharmacists accountable for patients who appear to be nonadherent to their medications, but simply have not been captured by claims data. The developer noted that they are currently in the process of specifying measures that draw exclusively on pharmacy dispensing data, which would alleviate this concern. In the discussion on use and usability, it was noted that these measures are currently in use. The Committee noted hospice and end stage renal disease (ESRD) exclusions, but after some discussion determined these exclusions to be appropriate. When the Committee asked how plans can improve performance, the developer noted how research has demonstrated that interventions such as medication therapy management, performance reports, dashboards, outreach to patients, among other approaches, return positive improvements in population-level adherence rates. The Committee also noted that rates in Medicare PDC performance have continually improved year-over-year, and that Medicare has acknowledged significant financial benefits associated with increased medication adherence across Medicare beneficiaries. The Standing Committee recommended the measure for continued endorsement.

2522 Rheumatoid Arthritis: Tuberculosis Screening (American College of Rheumatology): Endorsed

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who have documentation of a tuberculosis (TB) screening performed within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Outpatient Services; **Data Source**: Electronic Health Records, Registry Data

Committee members discussed the role of registries and registry-based data in quality measurement. The Committee noted there is evidence that screening prevents disease and results in treatment of tuberculosis, and after some clarifying discussion on the NQF evidence algorithm, the measure passed the evidence criteria. Committee members noted that while performance is improving, there remains a gap of about 15 percent. This led Committee members to question whether there was an actual gap in care or just problems with extracting the data from EHRs. The developer explained that they have done rigorous validation of the data elements, and after confirming there are actual gaps in screening, the Committee passed the measure on performance gap. The Committee discussed the types of testing included in the measure specifications. It noted challenges with reading skin tests and requested that the developer provide more guidance to ensure consistency, flagging these challenges as potential

causes of both over- and under-treatment. The developer noted that they anticipate tuberculosis skin testing rates will continue to decline in favor of blood tests.

The Committee noted that a particular medication should not be included in the measure (Rituximab) because it does not cause the same problems, and the developer agreed to remove it. The developer provided additional data on testing for the individual provider level after the original submission deadline. The Committee requested, and the developer agreed, that the measure requires a minimum threshold of 10 cases for accountability purposes to ensure the measure is fully reliable. The Committee did not consider the measure to have strong reliability below 10 patients, but there will be no minimum threshold for quality improvement purposes. With the two changes specified, and in light of the additional information submitted, the Committee agreed that the measure met NQF's reliability and validity criteria. Committee members noted that the measure's data elements are pulled from structured fields. This fact and the trend toward assay testing (and away from skin testing) further increases the feasibility. Since the measure is currently in use, the Committee had no major concerns related to use or usability. In response to questions, the developer explained that patients had been included on the measure development team. The Standing Committee recommended the measure for continued NQF endorsement.

2523 Rheumatoid Arthritis: Assessment of Disease Activity (American College of Rheumatology): Endorsed

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis and >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure. **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Outpatient Services; **Data Source**: Electronic Health Records, Registry Data

Committee members requested clarification on how visits are counted, noting that patients could see their general practitioner and discuss their rheumatoid arthritis (therefore coding it as discussed) but that a provider would not be screening for disease activity. The developer explained that only providers in the registry are participating in the measure, participation is voluntary, and they have set a lower bar for capturing disease activity (at 50 percent of visits) because there are encounters when a provider would appropriately not be capturing disease activity. Committee members noted, and the developer agreed, that there are potential scalability issues to implementing the measure outside the registry, but that not all patients with rheumatoid arthritis are being treated by rheumatologists. Committee members suggested minor adjustments to the coding to assist with this. The developer agreed to consider these comments as the measure is expanded. The measure is based on the guidelines, which are themselves based on systematic reviews, so the Committee agreed that the measure met the evidence criteria. The Committee agreed there is a gap in care, and the measure passed performance gap.

Similar to the previous measure (2522), the developer provided additional testing information for the individual provider level of analysis, and the Committee noted that this measure achieved better reliability scores than 2522. The measure passed reliability. After some discussion of the process of calculating the measure and what counts as a disease activity measure, the Committee agreed the

measure is valid. Committee members noted feasibility challenges, stating that in practice, providers are doing this with paper and check boxes and waiting for the test results to come back, and later inputting the data, and that EHRs have not yet caught up with practice. Committee members also noted that having six different tools is meant to make the measure more feasible, but since only some of the tools require lab work and some do not, there may be differing results. The developer noted there is no best-in-class disease activity assessment tool and that different providers prefer different tools. They further noted it is burdensome for providers to collect needed data but that it is very important to treat the disease properly, and that the American College of Rheumatology (ACR) is continuing to work to improve the feasibility across more EHRs.

Committee members noted that implementation of a measure can help drive the field as well, and if a measure is in use, EHR vendors may be more likely to include the appropriate structured data fields needed to calculate the measure. Committee members noted that the assessment of disease activity itself is incredibly important and is feasible, but there are challenges with getting the data into the EHR properly which may cause negative consequences, such as providers refusing to take patients. The developer noted they have just started working with Epic, which greatly increased the number of providers who can easily use the measure. The Committee agreed that the measure was feasible for providers using the Rheumatology Informatics System for Effectiveness (RISE) database, which only includes about 30 percent of practicing rheumatologists, but that 95 percent of rheumatologists are ACR members and are eligible to use the RISE registry. Ultimately, the Committee did not reach consensus on whether the measure is feasible (50 percent rated moderate, and 50 percent rated low); however, feasibility is not a must-pass criterion, so consideration of the measure continued. The measure is currently in use in the RISE registry and will be reported on in MIPS in 2020, and feedback is given to participating providers; therefore, the Committee agreed that the measure met both the use and usability criteria. Ultimately the Standing Committee recommended the measure for NQF endorsement.

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy (American College of Rheumatology): Endorsed

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months. **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Outpatient Services; **Data Source**: Electronic Health Records, Registry Data

The measure is based on guidelines, which were developed based on evidence from systematic reviews; the Committee had no concerns and agreed that the measure met the evidence criterion. There is a limited performance gap, with over 90 percent adherence; the Committee questioned whether the measure might be topped out or nearly topped out. The developer noted that new practices are using the measure, and that it is useful to help them understand their performance. They see rapid improvement when the measure is implemented. The developer also noted the need to understand the role of disparities in the measure performance. The Committee noted that the measure looks at providers' prescribing practices, but that does not necessarily follow through to whether a prescription was filled and used, so the gap in care received is likely larger. The Committee discussed various exclusion criteria; the developer clarified that patient refusal is not included due to concerns about

gaming and the role of shared decision making which should ensure patients are selecting drugs that work for them. Ultimately, the Committee agreed there was likely a larger gap in care than current performance data suggest; the measure passed performance gap.

As with measure 2523, the Committee discussed the scalability. The Committee agreed that the measure performed well on reliability testing and met the reliability criteria. During the validity discussion, the developer clarified that the list of drugs is updated annually, and the Committee agreed that the measure is valid. The Committee noted that data for this measure are available in discrete data fields and had no concerns about feasibility. The measure is currently only in use in the RISE registry, and it is similar to the previous two measures (2522 and 2523). The Committee voted to pass the measure on both use and usability. The Committee then voted to recommend the measure for NQF endorsement.

3059e One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (PCPI): Endorsed

Description: Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965 who received one-time screening for hepatitis C virus (HCV) infection; **Measure Type**: Process; **Level of Analysis**: Clinician: Individual; **Setting of Care**: Home Care, Inpatient/Hospital, Other, Outpatient Services; **Data Source**: Electronic Health Records

This is a new eMeasure submitted for endorsement consideration; the measure was previously approved for Trial Use. The Committee reviewed the evidence and performance gap and commented that there are very few measures in the portfolio of NQF-endorsed measures that address hepatitis C screening and treatment, an important area of clinical concern. The Committee was satisfied with the developer's demonstration of evidence and performance gap. In the reliability discussion, the Committee expressed some concern around the lack of clarity for the care settings contained in the developer's testing sample. The specifications for the measure outlined care settings where the measure could be deployed, with no indication in the testing if those settings were indeed present in the data. The developer explained that they received their data from CMS, with limited ability to identify provider types. The Committee requested that the developer secure data that allow them to test the measure's to specifications for future submissions. In the discussion related to validity, the Standing Committee noted that because this is a new measure, the developer was only required to submit face validity testing. However, the Committee had fairly extensive discussion surrounding the exceptions, specifically concern that the measure does not address the stigma associated with intravenous drug use and the potential penalization of providers for things that are outside of the provider's control, such as refusal by patients to receive a blood test screening for hepatitis C as recommended by the provider.

The feasibility discussion also aligned with some themes in the exclusion criteria, namely that patients potentially may have a strong disinclination to having intravenous drug use documented within a structured data field, and many providers do not include coding to that effect due to the stigma associated with intravenous drug use. It was noted during the discussion of use that the developer plans to submit this eMeasure on the Measures Under Consideration List for potential inclusion in the Merit-based Incentive Payment System. As this is a new measure, use is not a must-pass criterion. The

conversation about usability revealed a concern by the Committee for potential over-screening if the documentation is not available and noted the difficulty in obtaining certain data elements, such as blood transfusion (before 1992) and history of injection drug use. Potential harms of stigma or anxiety waiting for results were considered not to outweigh the benefits of the measure. The Standing Committee recommended the measure for NQF endorsement.

3060e Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (PCPI): Not Endorsed

Description: Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12-month reporting period; **Measure Type**: Process; **Level of Analysis**: Clinician: Individual; **Setting of Care**: Home Care, Inpatient/Hospital, Other, Outpatient Services; **Data Source**: Electronic Health Records

This is a new eMeasure submitted for endorsement consideration; the measure was previously approved for Trial Use. The Committee noted that the evidence for this measure was similar to that for the previous measure 3059e in that it is supported by guidelines, but they noted concern about the grade of the evidence. The Committee was also concerned that there is a proliferation of measures, and not a clear need for a metric on every desirable outcome. While the developer did not present a formalized performance gap analysis using primary data, they did summarize articles that noted an independent disparity gap, with Caucasians and women being less likely to be tested. The Committee noted a gap based on the number of people that probably should be tested, according to the data presented by the developer.

The Committee cited a number of concerns related to reliability. First, the occurrence rate is very small, with only 30 events in the first data set, and 22,000 events from 4.8 million visits in the second. This implies that there may be an issue with who is self-reporting as an active intravenous drug user, compounded by the potential for self-reporters to be the same population that would be willing to get tested. The Committee also noted that injection drug users do not typically schedule care, so the exclusion of emergency departments as a care setting is also a potential confounder. The developer noted that the larger data set excluded all providers who had fewer than 10 events due to potential reidentification issues in the deidentified data. This indicates that the measure was not tested to specifications due to misalignment of exclusion criteria in the testing and specifications. Due to these concerns, the Committee was not able to achieve consensus on reliability.

Similar to measure 3059e, the developer used face validity testing to fulfill the validity requirement. It was noted that this measure has several exclusions, which was viewed as a threat to validity. During the feasibility discussion, Committee members noted that the measure should be a byproduct of routine patient care. There was some concern that the distinction between active and inactive drug use may not lend itself to good measurement. The developer noted the importance of this distinction, and also added that this is a yearly evaluation for patients who remain at continued risk, which is different from the one-time screening in measure 3059e. The measure did not pass feasibility, but it is not a must-pass criterion. The Committee noted that because this is a new measure with potential for inclusion in accountability programs, it would still be appropriate to pass for the use criterion. In the discussion of

usability, the Committee appreciated that there were no harms identified in the measure, but added that the identification of the population that needs screening remains a challenge.

During the in-person meeting, the Standing Committee did not vote on the recommendation for endorsement because the Committee did not reach consensus on reliability—a must-pass criterion. The Committee reconvened the discussion of the measure on the post-comment web meeting on September 24, 2019. NQF staff summarized previous Committee concerns on reliability which included: (1) the occurrence rate is very small, with only 30 events in the first data set, and 22,000 events from 4.8 million visits in the second. The Committee felt that this implies that there may be an issue with who is self-reporting as an active injection drug user, compounded by the potential for self-reporters to be the same population that would be willing to get tested. (2) The Committee also previously noted that injection drug users do not typically schedule care, so the exclusion of emergency departments as a care setting is also a potential confounder. (3) The developer noted that the larger data set excluded all providers who had fewer than 10 events due to potential reidentification issues in the deidentified data. This indicates that the measure was not tested to specifications due to misalignment of exclusion criteria in the testing and specifications.

The developer shared with the Committee on the post-comment call that the second data set has a structured field which does capture a good portion of active injection drug users at the site, but not for the entire data set. There were no public comments received on this measure during the commenting period. The Standing Committee had no further discussion. The Committee re-voted on reliability criterion and did not pass the measure on the reliability criterion—a must-pass criterion. Therefore, the measure is not recommended for endorsement.

Measures Withdrawn from Consideration

One measure previously recommended for eMeasure trial approval by NQF was not submitted for endorsement. The eMeasure trial approval for this measure has been removed.

Table 3. Measures Withdrawn from Consideration

Measure	Reason for withdrawal
2550e Gout: ULT Therapy (Recommended for eMeasure Trial Approval)	The developer chose not to submit this eMeasure which was approved for trial use

References

1 Centers for Disease Control and Prevention. *National Diabetes Statistics Report, 2017*. Atlanta, GA: Centers for Disease Control and Prevention; 2017. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Last accessed July 2019.

2 American Diabetes Association. Economic costs of diabetes in the U.S. in 2017. *Diabetes Care*. 2018;41(5):917-928.

3 Birnbaum H, Pike C, Kaufman R, et al. Societal cost of rheumatoid arthritis patients in the US. *Curr Med Res Opin*. 2010;26(1):77-90.

4 Prevent Blindness. Glaucoma Costs Reach $5.8 Billion Annually. https://www.preventblindness.org/glaucoma-costs-reach-5-point-8-billion-annually. Last accessed July 2019.

5 Razavi H, ElKhoury AC, Elbasha E, et al. Chronic hepatitis C virus (HCV) disease burden and cost in the United States. *Hepatology*. 2013;57(6):2164-2170.

6 Network for Excellence in Health Innovation (NEHI). *Improving Patient Medication Adherence: A $290 Billion Opportunity*. Boston, MA: NEHI; 2011. https://www.nehi.net/bendthecurve/sup/documents/Medication_Adherence_Brief.pdf. Last accessed July 2019.

Appendix A: Details of Measure Evaluation

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

Measures Endorsed

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Submission | Specifications

Description: Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

Numerator Statement: Patients who have an optic nerve head evaluation during one or more office visits within 12 months

Denominator Statement: All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Exclusions: Denominator Exceptions:

Documentation of medical reason(s) for not performing an optic nerve head evaluation

Adjustment/Stratification: No risk adjustment or risk stratification. Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) 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.

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

Setting of Care: Other, Outpatient Services, Post-Acute Care

Type of Measure: Process

Data Source: Claims, Registry Data

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING [06/26/2019]

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

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

1a. Evidence: **H-9**; **M-8**; **L-0**; **I-0** 1b. Performance Gap: **H-4**; **M-14**; **L-0**; **I-0**;

Rationale:

- The developer noted that there have been no changes in evidence; however, they have updated their submission to capture the current language in the most recent AAO 2015 Preferred Practice Pattern Guidelines. Optic nerve head assessment remains one of two exams used in evaluating the status of glaucoma.
- The developer provided performance data from CMS' Quality Payment Program (QPP) and former Physician Quality Reporting Program from 2013 through 2017. The Committee agree a performance gap continues to exist.

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-2**; **M-15**; **L-1**; **I-0**; 2b. Validity: **H-0**; **M-11**; **L-7**; **I-0**

<u>Rationale</u>:

- Reliability testing was done at the performance score level, using a beta-binomial model (i.e. signal to noise) at the claims and registry levels of analysis. Reliability results for both claims and registry were very high.
- Since testing on the measure was not at the clinician: individual level of analysis, this measure was evaluated by the Committee at the clinician: group/practice level of analysis only.
- The developer performed convergent validity testing with Pearson's correlation coefficients and compared performance of 0086 with PQRS #117 *Diabetes: Eye Exam*. The results were moderate for the registry level (0.57), but weak at the claims level (0.22).
- The Committee shared concern that ICD 10 coding of this measure included normal-tension and low-tension glaucoma in the definition of primary open-angle glaucoma. A few Committee members suggested that the developer consider whether the appropriate measure title and target population is primary open-angle glaucoma or the general glaucoma population. The developer noted they will share that coding feedback with their technical expert panel during their annual update.
- The Committee voted to pass the measure on the reliability and validity criteria.

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3. Feasibility: H-0; M-17; 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 measure is generated from claims and registry data.
- The Committee had no concerns on the feasibility of the measure.

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4. Usability and Use: <u>The maintenance measure meets the Use subcriterion</u>

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-18; No Pass-0**; 4b. Usability: **H-2; M-15; L-0; I-0**

<u>Rationale</u>:

- The measure is currently used in accountability programs.
- A few Committee members expressed support that this measure will encourage optic nerve evaluations being performed and hopefully in the future encourage measures that address optic nerve evaluation.

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5. Related and Competing Measures

- This measure 0086 is related with NQF 0563 *Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15 percent or Documentation of a Plan of Care*.

- One Committee member noted that 0563 and 0086 differ with respect to including patients who have normal or low-tension glaucoma and would like to see harmonization in the target populations of the two measures.
- The developer will share that feedback with their technical expert panel during their annual update.

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6. Standing Committee Recommendation for Endorsement: **Yes-17**; **No-1**

Rationale

- The Standing Committee recommended the measure for continued endorsement.

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7. Public and Member Comment

- One supportive post-evaluation public comment was submitted on #0086. The commenter noted measure #0086 contributes to advanced improvement in routine evaluation of open-angle glaucoma and also the use of this measure in the Merit Based Incentive Payment System (MIPS).

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8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-14; No-0 (10/21/2019)

Decision: Approved for continued endorsement

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9. Appeals

No appeals were received.

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Submission | Specifications

Description: Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

Numerator Statement: Patients who have an optic nerve head evaluation during one or more office visits within 12 months

Denominator Statement: All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Exclusions: Documentation of medical reason(s) for not performing an optic nerve head evaluation

Adjustment/Stratification: No risk adjustment or risk stratification

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) 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.

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

Setting of Care: Other, Outpatient Services, Post-Acute Care

Type of Measure: Process

Data Source: Electronic Health Records

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING [07/01/2019]

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

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

1a. Evidence: **H-9; M-8; L-0; I-0** 1b. Performance Gap: **H-0**; **M-15**; **L-1**; **I-0**

Rationale:

- The developer noted that there have been no changes in evidence; however, they have updated their submission to capture the current language in the most recent AAO 2015 Preferred Practice Pattern Guidelines. Optic nerve head assessment remains one of two exams used in evaluating the status of glaucoma.
- The Committee agreed to pull the votes on evidence from 0086 as it is identical information and not re-vote on evidence for 0086e.
- The developer provided performance data from American Optometric Association (AOA) Measures and Outcomes Registry for Eyecare (MORE) Registry/QCDR for 2017 and 2018. The Committee agree a performance gap continues to exist.

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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-0**; **M-12**; **L-4**; **I-0**; 2b. Validity: **H-0**; **M-7**; **L-8**; **I-1 |** Validity: (Revote on post-comment call 9/24/19): **H-2; M-7; L-5 ; I- 0**

Rationale:

- Reliability testing was done at the performance score level, using a beta-binomial model (i.e. signal to noise) using EHR data. Reliability results were very high.
- Since testing on the measure was not at the clinician: individual level of analysis, this measure would be evaluated by the Committee at the clinician: group/practice level of analysis only.
- The developer performed convergent validity testing with Pearson's correlation coefficients and compared performance of 0086e with PQRS #117 *Diabetes: Eye Exam*. The results were weak at the EHR level (0.36). However, one Committee member believed the correlation coefficients would be stronger except that the providers reporting the two measures may be taking care of different types of patients.
- One Committee member was concerned that the measure is not risk adjusted for potential social determinants of health and/or age. However, other Committee members did not believe this measure needs risk adjustment.
- In regard to validity of the specification, the Committee members reiterated concern with the coding of this measure which includes normal-tension and low-tension glaucoma; and also, if the appropriate measure title and target population is primary open-angle glaucoma or the general glaucoma population. The developer noted again their plan to share that feedback with their technical expert panel during their annual update process.
- The Committee voted to pass the measure on the reliability criterion, but consensus was not reached on the validity criterion, due to the concerns noted in the above bullets.

- Consensus was achieved on validity and an overall endorsement recommendation was given during the post-comment call.

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3. Feasibility: H-1; M-15; 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 measure is generated from EHR data.
- The Committee had no concerns on the feasibility of the measure.

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4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-1; M-15; L-0; I-0**

Rationale:

- The measure is currently used in an accountability program.
- The Committee had no concerns on the use and usability of the measure.

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5. Related and Competing Measures

- This measure 0086e is related with NQF 0563 *Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15 percent or Documentation of a Plan of Care*.
- One Committee member noted that 0563 and 0086e differ with respect to including patients who have normal or low-tension glaucoma and would like to see harmonization in the target populations of the two measures.

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6. Standing Committee Recommendation for Endorsement: **Yes-11**; **No-3**

Rationale

- The Committee voted to recommend the measure for endorsement during the post-comment meeting.

7. Public and Member Comment

- Two comments requested that the Committee recommend measure 0086e for endorsement; the Committee did not reach consensus on validity at the measure evaluation meeting. One commenter noted that measure 0086e contributes to advancing improvement in routine evaluation of open-angle glaucoma and also noted that the measure is widely reported by ophthalmologists participating in the Merit-Based Payment System (MIPS) program. The developer of measure 0086e (PCPI Foundation) submitted a comment noting the importance of routine optic nerve evaluations. The developer also addressed the validity testing of the measure on which the Committee did not reach consensus, noting that although the correlation analysis results were weak, the developer was restricted by limited data as the only available eMeasure was PQRS 117 *Diabetes: Eye Exam*. Finally, the developer commented that 0086e

does have a score of 93.8 percent agreement through comparison of automated versus manual EHR review, as well as 87.5 percent face validity score by their expert panel.

Committee Response:

Thank you for your comments. On its September 24, 2019 post-comment call, the Committee reviewed submitted comments and heard once more from the developer. After the Committee discussion, the Committee re-voted on the validity criterion. The Committee passed the measure on the validity criterion and overall recommendation for NQF endorsement.

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8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-14; No-0 (10/21/2019)

Decision: Approved for continued endorsement

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9. Appeals

No appeals were received.

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Submission | Specifications

Description: The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement year.

Report a rate for each of the following:

- Diabetes All Class (PDC-DR)
- Renin Angiotensin System Antagonists (PDC-RASA)
- Statins (PDC-STA)

A higher rate indicates better performance.

Numerator Statement: The number of individuals who met the PDC threshold of 80 percent during the measurement year.

Denominator Statement: Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (Diabetes; RASA; Statins) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period.

Note: The IPSD is the earliest date of service for a target medication during the measurement year

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)

- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

Exclusions: Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)

- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

Adjustment/Stratification: Statistical risk model /Commercial, Medicaid, Medicare (report each product line separately)

For Medicare, rates should be stratified by the following to allow health plans to identify disparities and understand how their patient population mix is affecting their risk-adjusted measure rates:

-Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+)

-Gender (Male; Female)

-LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual)

-Disability status (Disability as reason for Medicare entitlement; Other)

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Enrollment Data

Measure Steward: Pharmacy Quality Alliance

STANDING COMMITTEE MEETING [06/26/2019]

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

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

1a. Evidence: **H-0**; **M-14**; **L-6**; **I-0** 1b. Performance Gap: **H-3**; **M-16**; **L-0**; **I-0**

Rationale:

- The Committee noted that these are known measures with broad national adoption.
- Committee discussion was prefaced with the note that the data source for this measure is electronic pharmacy claims, a source with significantly higher precision than conventional medical claims.

Nonetheless, pharmacy data do not contain the breadth of information that is found either in the EHR, or what may be present in traditional medical claims.

- Committee members questioned the measure developer on the logic model that connects pharmacy claims with positive patient outcomes, specifically voicing the concern that pharmacy claims might not be an adequate proxy for medication adherence.
- The lead discussant pointed to evidence provided by the developer that adherence measures using the proportion of days covered (PDC) methodology have been repeatedly demonstrated to serve as a strong proxy for medication adherence, with clear connections to positive patient medical outcomes and decreased cost of care at the population level.
- The Committee asked the developer what occurs when patients experience side effects or significant adverse drug events (ADE) associated with medication use. The developer responded that the measure demonstrates a robust resilience to these effects, for two reasons. First, the measure specifications stipulate that a patient must have two fills of a medication in order to appear in the denominator, with most patients discontinuing therapy because of side effects or ADEs on the first fill of a given medication. Second, assuming an equal distribution of these types of events across populations, health plans would theoretically be affected by such discontinuations at the same rate, and hence still have accurate comparability using these three PDC rates.
- The Committee was satisfied with the evidence and performance gap for the measure.

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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)

Do you accept the Scientific Method Panel's Moderate rating for Reliability? **Yes-19; No-0**

Do you accept the Scientific Method Panel's Moderate rating for Validity? **Yes-18; No-2**

2a. NQF Scientific Methods Panel Ratings for Reliability: **H-1**; **M-3**; **L-1**; **I-0**;

2b. NQF Scientific Methods Panel Ratings for Validity: **H-1**; **M-3**; **L-1**; **I-0**

The Committee accepted the NQF Scientific Methods Panel's rating for reliability and validity.

<u>Rationale</u>:

- *This measure is deemed as complex and was evaluated by the NQF Scientific Methods Panel.*
- The measure developer submitted a first-of-its-kind risk-adjustment model for a process measure for evaluation by the Scientific Methods Panel.
- The Committee had limited discussion on the reliability of the measure and elected to uphold the Methods Panel reliability rating.
- The validity discussion centered on risk adjustment, stratification, and correlation with other measures.
- The developer noted that the thresholds for performance indicate that validity correlations were moderate by conventional evaluation standards for Pearson correlation coefficients between quality measures.
- The Committee upheld Methods Panel reliability and validity rating.

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3. Feasibility: H-2; M-16; L-2; 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:

- During the discussion of feasibility, the Committee introduced concerns that prescriptions that are not captured by claims will not be captured in the data.
- This could result in consequences for health plans as well as downstream consequences for providers and pharmacists accountable for patients who appear to be nonadherent to their medications, but simply have not been captured by claims data.
- The developer noted that they are currently in the process of specifying measures that draw exclusively on pharmacy dispensing data, which would alleviate this concern.

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4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-14; No Pass-6**; 4b. Usability: **H-3; M-9; L-7; I-0**

Rationale:

- In the discussion on use and usability, it was noted that these measures are currently in use in several federal and state-based programs.
- The Committee noted hospice and ESRD exclusions, but after some discussion determined these exclusions to be appropriate.
- When the Committee asked how plans can improve performance, the developer highlighted research that demonstrated interventions such as medication therapy management, performance reports, dashboards, outreach to patients, among other approaches, return positive improvements in population level adherence rates.
- The Committee also noted that rates in Medicare PDC performance have continually improved year-over-year, and that Medicare has acknowledged significant financial benefits associated with increased medication adherence across Medicare beneficiaries.

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5. Related and Competing Measures

- This measure 0541 is related to NQF 1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia and NQF 1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder. The Committee did not discuss these other measures in detail.

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6. Standing Committee Recommendation for Endorsement: **Yes-16**; **No-4**

Rationale

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7. Public and Member Comment

- Three comments supported the Committee's recommendation for re-endorsement of measure 0541 *Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category*. The commenters applauded quality measure 0541 for adjusting for beneficiary-level sociodemographic status characteristics.

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8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-14; No-0 (10/21/2019)

Decision: Approved for continued endorsement

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9. Appeals

No appeals were received.

2522 Rheumatoid Arthritis: Tuberculosis Screening

Submission | Specifications

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who have documentation of a tuberculosis (TB) screening performed within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).

Numerator Statement: Any record of TB testing documented or performed (PPD, IFN-gamma release assays, or other appropriate method) in the medical record in the 12 months preceding the biologic DMARD prescription.

Denominator Statement: Patients 18 years and older with a diagnosis of rheumatoid arthritis who are seen for at least one face-to-face encounter for RA who are newly started on biologic therapy during the measurement period.

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification

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

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Electronic Health Records, Registry Data

Measure Steward: American College of Rheumatology

STANDING COMMITTEE MEETING [06/26/2019]

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

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

1a. Evidence: **M-16**; **L-0**; **I-0** 1b. Performance Gap: **H-7**; **M-12**; **L-0**; **I-0**;

Rationale:

- Committee members discussed the role of registries and registry-based data in quality measurement. The Committee noted there is evidence that screening prevents and results in treatment of tuberculosis, and after some clarifying discussion on the NQF evidence algorithm, the measure passed the evidence criteria.
- In response to questions, the developer explained that the mean number of patients per practice qualifying for the measure is 208 but that range goes from 1-1,500. The developer also noted that practices are diverse geographically and demographically, and that MACRA has led to a large number of practices participating in RISE.
- Committee members noted that while performance is improving, there remains a gap of about 15 percent. This led Committee members to question whether there was an actual gap in care

or just problems with capturing the data out of EHRs. The developer explained that they have done rigorous validation of the data elements, and after confirming there are actual gaps in screening, the Committee passed the measure on gap.

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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-15**; **L-2**; **I-0**; 2b. Validity: **H-1**; **M-18**; **L-0**; **I-0**

<u>Rationale</u>:

- The Committee discussed the types of testing included in the measure specifications, and noted challenges with reading skin tests. The Committee requested the developer provide more guidance to ensure consistency, flagging these challenges as potential causes of both over- and under-treatment. The developer noted they anticipate skin testing rates will continue to decline in favor of blood tests.
- The Committee noted that a particular medication should not be included in the measure (Rituximab) because it does not cause the same problems, and the developer agreed to remove it.
- The developer provided additional data on testing for the individual provider level after the original submission deadline. Committee members asked and the developer clarified that performance ranges were similar for both high and low volume providers, so they did not think that seeing fewer patients necessarily impacted performance.
- The Committee requested, and the developer agreed, that the measure require a minimum threshold of 10 cases for accountability purposes to ensure the measure is fully reliable. It was noted the MIPS reporting threshold is 20 cases. The Committee did not consider the measure to have strong reliability below 10 patients, but there will be no minimum threshold for quality improvement purposes.
- With the two changes specified (threshold of 10 patients and removal of Rituzimab), and in light of the additional information submitted, the Committee agreed the measure met NQF's reliability and validity criteria.

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3. Feasibility: H-8; M-11; 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>:

- Committee members noted that the measure's data elements are pulled from structured fields. This fact and the trend toward assay testing (and away from skin testing) further increase the feasibility.

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4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-20; No Pass-0**; 4b. Usability: **H-6; M-14; L-0; I-0**

<u>Rationale</u>:

- Since the measure is currently in use, the Committee had no major concerns on the use or usability. Committee members did note they would like to see more public reporting and the developer said they hope to have the measure incorporated into MIPS in the future.
- In response to questions, the developer explained that patients had been included in the development team for the measure.

5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: **Yes-19**; **No-1**

Rationale

7 Public and Member Comment

- NQF did not receive comments following the Committee's evaluation of the measure.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-14; No-0 (10/21/2019)

Decision: Approved for endorsement

9. Appeals

No appeals were received.

2523 Rheumatoid Arthritis: Assessment of Disease Activity

Submission | Specifications

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis and >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

Numerator Statement: # of patients with >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

Denominator Statement: Patients 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period.

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification

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

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Electronic Health Records, Registry Data

Measure Steward: American College of Rheumatology

STANDING COMMITTEE MEETING [06/26/2019]

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

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

1a. Evidence: **H-5**; **M-15**; **L-0**; **I-0** 1b. Performance Gap: **H-5**; **M-14**; **L-1**; **I-0**

Rationale:

- Committee members requested clarification on how visits are counted, noting that a patient could see their general practitioner and discuss their rheumatoid arthritis (therefore coding it as discussed) but that provider would not be screening for disease activity. The developer explained that only providers in the registry are participating in the measure, participation is voluntary, and that they have set a lower bar for capturing disease activity (at 50 percent of visits) because there are encounters when a provider would appropriately not be capturing disease activity.
- Committee members noted, and the developer agreed, there are potential scalability issues to implementing the measure outside the registry, but that not all patients with rheumatoid arthritis are being treated by rheumatologists; Committee members suggested minor adjustments to the coding to assist with this. The developer agreed to consider these comments as the measure is expanded.
- The measure is based on the guidelines, which are themselves based on systematic reviews, so the Committee agreed the measure met the evidence criteria.
- The Committee agreed there is a gap in care, noting a decreased performance when the measure went to wider use in 2017.

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-8**; **M-11**; **L-1**; **I-0**; 2b. Validity: **H-2**; **M-15**; **L-2**; **I-1**

Rationale:

- Similar to the previous measure (2522), the developer provided additional testing information for the individual provider level of analysis, and the Committee noted this measure achieved better reliability scores than 2522. The measure passed reliability.
- The Committee requested more details from the developer on the process of calculating the measure and what counts as a disease activity measure. The developer explained that the measure accepts a number of different disease activity measures; some require labs and some do not. The Committee agreed the measure is valid.

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

- Committee members noted feasibility challenges, stating that in practice, providers are doing this with paper and check boxes and waiting for the test results to come back, and later inputting the data, and that EHRs have not yet caught up with practice.

- Committee members also noted that having six different tools is meant to make the measure more feasible, but since only some of the tools require lab work and some do not, there may be differing results. The developer noted there is no best-in-class disease activity assessment tool and that different providers prefer different tools; a systematic process relying on both experts and literature was used to select the instruments included. The developer further noted it is burdensome for providers to collect but the results of the activity tests are very important to treat the disease properly, since they are used to determine appropriate treatments. The developer added that ACR is continuing to work to improve the feasibility across more EHRs.
- Committee members noted that implementation of a measure can help drive the field as well, and if a measure is in use, EHR vendors may be more likely to include the appropriate structured data fields needed to calculate the measure. Committee members noted that the assessment of disease activity itself is incredibly important and is feasible, but that the challenges are with getting the data into the EHR properly, and that could lead to potential negative impacts for providers whose EHRs can't manage, therefore potentially leading to these providers refusing to take patients. There were strong concerns about potential harms for patients and providers due to limitations in EHRs. A Committee member stated that pressure from providers can push EHR vendors to make updates to allow measures to be collected more easily.
- The developer noted they have just started working with Epic, which greatly increases the number of providers who can easily use the measure, and that the measure does use natural language processing.
- The Committee agreed the measure was feasible for providers using the RISE database, which only includes about 30 percent of practicing rheumatologists, but that a large percentage of rheumatologists are ACR members and eligible to use the RISE registry; the measure is free to use. Participation may be limited by organizations' agreements to transfer data to the registry and not by providers' willingness to use the registry or the measure. Having the measure in Epic should assist with this and will greatly increase the number of academic medical centers participating.
- Ultimately, the Committee did not reach consensus on whether the measure is feasible (50 percent rated moderate and 50 percent rated low), but feasibility is not a must-pass criterion, so consideration of the measure continued. The Committee noted that they will re-assess the feasibility during the next maintenance review to discern how EHR vendors are doing to make the measure more feasible.

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4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-15; No Pass-5**; 4b. Usability: **H-1; M-14; L-5; I-0**

Rationale:

- The measure is currently in use in the RISE registry and will be reported on in MIPS in 2020, and feedback is given to participating providers. The Committee agreed the measure met both the use and usability criteria.

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5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: **Yes-15**; **No-5**

7. Public and Member Comment

- NQF did not receive comments following the Committee's evaluation of the measure.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-14; No-0 (10/21/2019)

Decision: Approved for endorsement

9. Appeals

No appeals were received.

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Submission | Specifications

Description: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months.

Numerator Statement: Patient received a DMARD

Denominator Statement: Patient age 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period

Exclusions: Patients with a diagnosis of HIV; patients who are pregnant; or patients with inactive Rheumatoid Arthritis.

Adjustment/Stratification: No risk adjustment or risk stratification

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

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Electronic Health Records, Registry Data

Measure Steward: American College of Rheumatology

STANDING COMMITTEE MEETING [06/26/2019]

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

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

1a. Evidence: **H-0**; **M-20**; **L-0**; **I-0** 1b. Performance Gap: **H-0**; **M-20**; **L-0**; **I-0;**

Rationale:

- The measure is based on guidelines, which were developed based on evidence from systematic reviews; the Committee had no concerns and agreed it met the evidence criterion.

- There is a limited gap, with over 90 percent adherence and a limited inter quartile range of 6.42; the Committee questioned whether the measure might be topped out or nearly topped out. The developer noted that new practices are increasingly using the measure, and that it is useful to help them understand their performance; they see rapid improvement when the measure is implemented.
- They also noted the need to understand the role of disparities in the measure performance. The Committee noted some data suggest that there may be disparities by race, income, age, and region, especially for Medicare Advantage plans. The Committee noted the measure looks at providers' of prescribing practices, but that does not necessarily follow through to whether a prescription was filled and used, so the gap in care received is likely larger.
- Committee members asked about infusion medication delivered by a home infusion company, which may not be included in an EHR; it may be included in the medication reconciliation table or may be included elsewhere in the medical record. The developer stated it should be included somewhere even if it's not a standardized field, and that is something they work on with measure implementors.
- There was some discussion about how some insurance companies may deny medication coverage; there were concerns about holding providers accountable for decisions the insurance company made. It was noted medication reconciliation should assist with this issue as well. It was also noted that performance should not reach 100 percent on this measure.
- The Committee discussed various exclusion criteria; the developer clarified patient refusal is not included due to concerns about gaming and the role of shared decision making which should ensure patients are selecting drugs that work for them. Ultimately the Committee agreed there was likely a larger gap in care than current performance suggest and the measure passed gap.

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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-7**; **M-12**; **L-1**; **I-0**; 2b. Validity: **H-3**; **M-16**; **L-1**; **I-0**

<u>Rationale</u>:

- The Committee discussed the scalability again, similar to measure 2523. They noted the exceptions were low, and that in the RISE registry there is no missing data, but that could be an issue outside of the registry. The Committee agreed the measure performed well on reliability testing and met the reliability criteria.
- During the validity discussion, the developer clarified the list of drugs is updated annually, with feedback from practicing rheumatologists. The Committee agreed the measure is valid.

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3. Feasibility: H-2; M-18; 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 Committee noted data for this measure is available in discrete data fields and had no concerns about feasibility.

4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-20; No Pass-0**; 4b. Usability: **H-2; M-17; L-1; I-0**

Rationale:

- The measure is currently only in use in the RISE registry, and is similar to the previous two measures (2522 and 2523); the Committee voted to pass both use and usability. The Committee briefly discussed a public comment received on the measure during the pre-meeting commenting period, regarding brand name drugs. The developer said they would take the comment under review.

5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: **Yes-20; No-0**

7. Public and Member Comment

- NQF received one pre-evaluation comment on #2525. The commenter highlighted the value set of the measure and recommended removing brand name TTYs and using Semantic Clinical Drugs (SCDs). NQF did not receive comments following the Committee's evaluation of the measure.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-14; No-0 (10/21/2019)

Decision: Approved for endorsement

9. Appeals

No appeals were received.

3059e One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk

Submission | Specifications

Description: Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965 who received one-time screening for hepatitis C virus (HCV) infection

Numerator Statement: Patients who received one-time screening for HCV infection

Denominator Statement: All patients aged 18 years and older who were seen twice for any visit or who had at least one preventive visit within the 12 month reporting period with one or more of the

following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965

Exclusions: Denominator Exclusions

Patients with a diagnosis of chronic hepatitis C

Denominator Exceptions

Documentation of medical reason(s) for not receiving one-time screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not receiving one-time screening for HCV infection (eg, patient declined, other patient reasons)

Adjustment/Stratification: No risk adjustment or risk 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.

Level of Analysis: Clinician : Individual

Setting of Care: Home Care, Inpatient/Hospital, Other, Outpatient Services

Type of Measure: Process

Data Source: Electronic Health Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [06/26/2019]

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

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

1a. Evidence: **H-10**; **M-9**; **L-0**; **I-0** 1b. Performance Gap: **H-11**; **M-8**; **L-0**; **I-0**

Rationale:

- The Committee initiated the discussion by noting that this is a new eMeasure submitted for endorsement consideration; the measure was previously approved for Trial Use.
- The Committee reviewed the evidence and performance gap and commented that there are very few measures in the portfolio of NQF endorsed measures that address hepatitis C screening and treatment, an important area of clinical concern.
- The Committee noted that the developer provided an updated evidence submission based on the Hepatitis C Guidance 2018 Update: AASLD-IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection.
- The Committee discussed the strength of the overall recommendation from the guidelines, which was characterized as follows:
    - "One-time HCV testing is recommended for persons born between 1945 and 1965* without prior ascertainment of risk." (Rating: Class I, Level B)
    - "Other persons should be screened for risk factors for HCV infection, and one-time testing should be performed for all persons with behaviors, exposures, and conditions associated with an increased risk of HCV infection." (Rating: Class I, Level B)

  - Class I recommendations refer to, "Conditions for which there is evidence and/or general agreement that a given diagnostic evaluation, procedure, or treatment is beneficial, useful, and effective."
  - Level B recommendation indicates that data are derived from a single randomized trial, nonrandomized studies, or equivalent
- The Committee also reviewed the developer's submission on the performance gap, which was characterized by the Committee as adequate, although it was clear that the care settings where the analysis was performed was not clearly delineated in the submission.

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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-1**; **M-13**; **L-1**; **I-5**; 2b. Validity: **H-0**; **M-15**; **L-5**; **I-0**

<u>Rationale</u>:

- In the reliability discussion, the Committee once again expressed some concern around the lack of clarity for the care settings contained in the developer's testing sample.
- The specifications for the measure outlined care settings where the measure could be deployed, with no indication in the testing if those settings were indeed present in the data.
- The developer explained that they received their data from CMS but with limited ability to identify provider types.
- The Committee requested that the developer secure data that allow them to test measures to specifications for future submissions.
- In the discussion related to validity, the Standing Committee noted that as this is a new measure, the developer was only required to submit face validity testing.
- However, the Committee had fairly extensive discussion surrounding the exceptions, including the concern that the measure does not address the stigma associated with intravenous drug use and the potential penalization of providers for things that are outside of the provider's control, such as patients refusal to receive a blood test screening for hepatitis C as recommended by the provider.

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3. Feasibility: H-3; M-14; L-3; 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 feasibility discussion also connected with some themes in the exclusion criteria carried over from the validity discussion, namely that patients potentially may have a strong disinclination to having intravenous drug use documented within a structured data field, and many providers do not include coding to that effect due to the stigma associated with intravenous drug use.
- Committee members noted that the Prevention and Population Health Committee (formerly Health and Well Being Committee) who previously reviewed this Approved for Trial use measure had discussed the one-time test and high risk behavior continuing and questioned the one-time only testing for hepatitis C.
- The Standing Committee noted that increase cost and lack of access to treatment (in particular to the Medicaid populations) remains a disincentive to test for hepatitis C.

4. Usability and Use: <u>The maintenance measure meets the Use subcriterion</u>

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-17; No Pass-2**; 4b. Usability: **H-1; M-16; L-1; I-1**

<u>Rationale</u>:

- The Committee noted during the discussion of use that the developer plans to submit this eMeasure on the Measures Under Consideration List for potential inclusion in the Merit-based Incentive Payment System.
- As this is a new measure, use is not a must-pass criterion.
- The conversation about usability revealed a concern by the Committee for potential over-screening if the documentation is not available and noted the difficulty in obtaining certain data elements, such as blood transfusion before 1992 and history of injection drug use.
- Potential harms of stigma or anxiety waiting for results were considered to not outweigh the benefits of the measure.

5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: **Yes-16**; **No-3**

7. Public and Member Comment

- NQF did not receive comments following the Committee's evaluation of the measure.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-14; No-0 (10/21/2019)

Decision: Approved for endorsement

9. Appeals

No appeals were received.

Measures Not Endorsed

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Submission | Specifications

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

Numerator Statement: Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Denominator Statement: All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

Exclusions: Denominator Exceptions:

Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes.

Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes.

Adjustment/Stratification: No risk adjustment or risk 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.

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

Setting of Care: Other, Outpatient Services, Post-Acute Care

Type of Measure: Process

Data Source: Claims, Registry Data

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING 07/01/2019

1. Importance to Measure and Report: The measure did not reach consensus on the Importance criteria (1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0**; **M-1**; **L-2**; **I-13** 1b. Performance Gap: **H-0**; **M-15**; **L-0**; **I-0;** Evidence Exception: **Yes-7; No-8**

Rationale:

- Committee members noted that there is no evidence indicating communication between physicians performing the dilated macular or fundus exam and those treating the diabetes will lead to improved health outcomes for the patient.

- Some Committee members did not see value in a performance measure addressing this measure focus, in addition to their concern about the evidence. However, some Committee members had a different opinion, and saw value in the measure as a potential driver of improved outcomes. The developer noted that care coordination measures are an important gap in the measurement field.
- More than 60 percent of the Committee members voted Insufficient on evidence. The Committee was able to vote on evidence with exception; however, the Committee did not reach consensus on evidence with exception.
- The developer provided performance data from CMS' Quality Payment Program (QPP) and former Physician Quality Reporting Program from 2014 through 2017. The Committee agreed a performance gap continues to exist.

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2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-1**; **M-7**; **L-6**; **I-1**; 2b. Validity: **H-0**; **M-5**; **L-11**; **I-0**

<u>Rationale</u>:

- Reliability testing was done at the performance score level, using a beta-binomial model (i.e. signal to noise) at the claims and registry levels of analysis.
- Since testing on the measure was not at the clinician: individual level of analysis, this measure would be evaluated by the Committee at the clinician: group/practice level of analysis only.
- In addition, the developer specified the measure for outpatient, post-acute care and domiciliary settings, but these analyses were not conducted separately. However, a few Committee members with an ophthalmology background noted a very small percentage of ophthalmologists reporting on this measure would be from the domiciliary setting and would be predominantly reporting at the outpatient setting.
- The Committee did not reach consensus on the reliability of the measure.
- The developer performed convergent validity testing with Pearson's correlation coefficients and compared performance of 0089 with PQRS #117 *Diabetes: Eye Exam*. The results were weak at the claims and registry levels (0.11 and 0.16).
- The Committee did not pass the measure on the validity criterion.

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3. Feasibility: N/A

(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 Committee did not discuss or vote on this criterion, since the measure did not pass the validity criterion.

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4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: N/A**; 4b. Usability: **N/A**

<u>Rationale</u>:

- The Committee did not discuss or vote on this criterion, since the measure did not pass the validity criterion.

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5. Related and Competing Measures

- The Committee did not discuss related and competing measures, since the measure did not pass the validity criterion.

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6. Standing Committee Recommendation for Endorsement: **Yes-N/A**; **No-N/A**

Reconsideration Vote (Vote on post-comment call 9/24/19): Yes-3; No-11

Rationale

- The Committee did not vote on this measure because it did not pass the validity criterion, which is a must-pass criterion. In addition, the Committee did not reach consensus on evidence with exception and the reliability criteria. During the post-comment call, the Committee was asked to readjudicate their decision to not recommend the measure for endorsement. After careful consideration and discussion, the Committee elected not to reconsider the measure.

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7 Public and Member Comment

- NQF received five post-evaluation comments on this measure. Four commenters (including one from the developer) stressed the importance of care coordination measures. Commenters noted that both 0089 and 0089e are widely reported by ophthalmologists participating in the Merit-Based Payment System (MIPS) program and continues to measure a gap in care. One commenter also referenced the American Academy of Ophthalmology's Preferred Practice Pattern guideline which recommends that ophthalmologists should communicate findings and level of retinopathy to the primary care physician.

  One commenter noted high reliability results for both 0089 and 0089e. In regard to the validity testing, two commenters (including the developer) noted that the correlation analysis results for 0089 were weak; however, the developer was restricted by data with limited options for available measures for comparison.

  Finally, the American Society of Retina Specialists (ASRS) submitted a comment noting several concerns with the evaluation process of measures 0089 and 0089e during the Committee's evaluation web meetings.

  ASRS referenced evidence in their comment which they believe supports measures 0089 and 0089e meeting the evidence requirement. In addition, ASRS expressed concern that the Committee did not reach consensus on reliability of both measures when the measure score reliability results were high. In regard to the validity testing, ASRS commented that although the correlation analysis results were weak, the results still demonstrated positive correlation. ASRS feels NQF has passed other measures for validity with similar correlation results.

  Committee Response:

Thank you for your comments. On its September 24, 2019 post-comment call, the Committee reviewed submitted comments and heard once more from the developer. Overall, the Committee reiterated that there is not adequate evidence supporting this measure, that the Committee properly reserved their discretionary ability to grant an exception to evidence, and the measures does not sufficiently meet other NQF criteria. After Committee discussion, the Committee voted on if they would like to re-consider their previous recommendation to not re-endorse this measure. The Committee elected to not re-consider their previous recommendation.

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8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-0; No-14 (10/21/2019)

Decision: Not approved for continued endorsement

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9. Appeals

N/A-This measure did not move forward to appeals period.

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Submission | Specifications

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

Numerator Statement: Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Denominator Statement: All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

Exclusions: Denominator Exceptions:

Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes.

Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

Adjustment/Stratification: No risk adjustment or risk 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.

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

Setting of Care: Other, Outpatient Services, Post-Acute Care

Type of Measure: Process

Data Source: Electronic Health Records

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING 07/08/2019

1. Importance to Measure and Report: The measure does not meet the Importance criteria

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

1a. Evidence: **H-0**; **M-3**; **L-3**; **I-8**; 1b. Performance Gap: **H-3**; **M-10**; **L-1**; **I-0;** Evidence Exception: **Yes-8; No-6**

Rationale:

- The Committee did not have quorum for voting on the measure at the July 8 post-meeting call and submitted their votes via SurveyMonkey afterwards.
- Committee members did not re-discuss evidence criterion as it is identical to the evidence for measure 0089, which was previously noted that there is no evidence indicating communication between physicians performing the dilated macular or fundus exam and those treating the diabetes will lead to improved health outcomes for the patient.
- Also recapped from the evidence discussion from measure 0089, some Committee members did not see value in a performance measure addressing this measure focus, in addition to their concern about the evidence. However, some Committee members had a different opinion, and saw value in the measure as a potential driver of improved outcomes. The developer previously noted that care coordination measures are an important gap in the measurement field.
- The developer provided performance data from CMS' Quality Payment Program (QPP) and former Physician Quality Reporting Program. The Committee did not further discuss and agreed a performance gap continues to exist.
- The voting results from the SurveyMonkey, which were submitted after the Committee meeting, indicated the measure did not pass the evidence criterion.

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2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

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

2a. Reliability: **H-1**; **M-7**; **L-4**; **I-2**; 2b. Validity: **H-0**; **M-4**; **L-9**; **I-1**

Rationale:

- Reliability testing was conducted at the performance score level, using a beta-binomial model (i.e. signal to noise) using EHR data. Results were high.
- Since testing on the measure was not at the clinician: individual level of analysis, this measure was evaluated by the Committee at the clinician: group/practice level of analysis only.
- The developer performed convergent validity testing with Pearson's correlation coefficients and compared performance of 0089 with PQRS #117 *Diabetes: Eye Exam*. The results were weak at the EHR level (0.08). There was a moderate correlation (0.59) with the measure, *Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy*.

- The Committee recapped previous Committee discussion on measure 0089 about whether the measure adds value and improves outcomes, which also applies to 0089e.
- The voting results from the SurveyMonkey, which were submitted after the Committee meeting, indicated the Committee did not reach consensus on the reliability criterion. In addition, the Committee did not pass the measure on the validity criterion.

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3. Feasibility: H-1; 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)

Rationale:

- The measure is generated from EHR data.
- The voting results for feasibility were submitted via SurveyMonkey after the Committee meeting, however the Committee did not pass the measure on the evidence and validity criteria.

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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-1** 4b. Usability*:* **H-1; M-8; L-4; I-1**

Rationale:

- The measure is currently used in an accountability program.
- The voting results for use and usability were submitted via SurveyMonkey after the Committee meeting, however the Committee did not pass the measure on the evidence and validity criteria.

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5. Related and Competing Measures

- The Committee did not discuss related and competing measures, since the Committee did not pass the measure on the evidence and validity criteria.

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6. Standing Committee Recommendation for Endorsement: **Yes-5**; **No-9**

Reconsideration Vote (Vote on post-comment call 9/24/19): Yes-3; No-11

Rationale

- The Committee did not have quorum for voting on the measure at the July 8 post-meeting call and submitted their votes via SurveyMonkey afterwards. Although the recommendation for endorsement votes were captured in the SurveyMonkey, the measure did not pass the evidence and validity criteria—both of which are must-pass criteria. In addition, the Committee did not reach consensus on the reliability criterion. During the post-comment call, the Committee was asked to re-adjudicate their decision to not recommend the measure for endorsement. After careful consideration and discussion, the Committee elected not to reconsider the measure. The measure is not recommended for continued endorsement.

7. Public and Member Comment

- NQF received five post-evaluation comments on this measure. Four commenters (including the developer) stressed the importance of care coordination measures. Commenters noted that both 0089 and 0089e are widely reported by ophthalmologists participating in the Merit-Based Payment System (MIPS) program and continues to measure a gap in care. One commenter also referenced the American Academy of Ophthalmology's Preferred Practice Pattern guideline which recommends that ophthalmologists should communicate findings and level of retinopathy to the primary care physician. One commenter noted high reliability results for both 0089 and 0089e. For 0089e, the developer commented that the correlation analysis results for validity were moderate and significant.

  Finally, the American Society of Retina Specialists (ASRS) submitted a comment noting several concerns with the evaluation process of measures 0089 and 0089e during the Committee's evaluation web meetings.

  ASRS referenced evidence in their comment which they believe supports measures 0089 and 0089e meeting the evidence requirement. In addition, ASRS expressed concern that the Committee did not reach consensus on reliability of both measures when the measure score reliability results were high. In regard to the validity testing, ASRS commented that although the correlation analysis results were weak, the results still demonstrated positive correlation. ASRS feels NQF has passed other measures for validity with similar correlation results.

- Finally, ASRS expressed concern that there was a lack of quorum for the July 8 Committee web meeting, when measure 0089e was reviewed, raising a concern that there was not meaningful discussion on measure 0089e. ASRS also noted the July 8 Committee meeting was scheduled under an extremely short turnaround time, and that some Committee members and ASRS' technical expert lead were unavailable to attend and participate in support of the measure.

  NQF Response:

  Thank you for your comments regarding the quorum and short turnaround time for scheduling the July 8 call. NQF makes every effort for all Committee meetings to achieve quorum and for all Committee calls/meetings to be posted to our website one week prior to the call. In this case, due to the number of measures under review in this cycle, the Committee was unable to complete their evaluations in the scheduled dates of June 26 and July 1. The July 8 call was added after the July 1 call was completed, and the date was selected based on when the majority of the Committee could attend. We do understand your concerns and will do the best we can to schedule Committee calls with more notice in the future.

  Committee Response:

  Thank you for your comments. On its September 24, 2019 post-comment call, the Committee reviewed submitted comments and heard once more from the developer. Overall, the Committee reiterated that there is not adequate evidence supporting this measure, that the Committee properly reserved their discretionary ability to grant an exception to evidence, and

the measure does not sufficiently meet other NQF criteria. After Committee discussion, the Committee voted on whether or not to re-consider their previous recommendation to not re-endorse this measure. The Committee elected to not re-consider their previous recommendation.

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8. Consensus Standards Approval Committee (CSAC) Vote: Yes-0; No-14 (10/21/2019)

Decision: Not approved for continued endorsement

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9. Appeals

N/A-This measure did not move forward to appeals period.

3060e Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users

Submission | Specifications

Description: Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12-month reporting period

Numerator Statement: Patients who received screening for HCV infection within the 12-month reporting period

Denominator Statement: All patients, regardless of age, who are seen twice for any visit or who had at least one preventive care visit within the 12-month reporting period who are active injection drug users

Exclusions: Denominator Exclusions:

Patients with a diagnosis of chronic hepatitis C

Denominator Exceptions:

Documentation of medical reason(s) for not receiving annual screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not receiving annual screening for HCV infection (eg, patient declined, other patient reasons)

Adjustment/Stratification: No risk adjustment or risk 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.

Level of Analysis: Clinician : Individual

Setting of Care: Home Care, Inpatient/Hospital, Other, Outpatient Services

Type of Measure: Process

Data Source: Electronic Health Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [06/26/2019]

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

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

1a. Evidence: **H-4**; **M-14**; **L-0**; **I-1** 1b. Performance Gap: **H-11**; **M-7**; **L-0**; **I-1**

Rationale:

- This is a new eMeasure submitted for endorsement consideration; the measure was previously approved for Trial Use.
- The Committee noted that the evidence for this measure was similar to that for measure 3059e in that it is supported by guidelines, but they noted concern about the grade of the evidence.
- The Committee was also concerned that there is a proliferation of measures, and not a clear need for a metric on every desirable outcome.
- While the developer did not present formalized performance gap analysis using primary data, they did summarize articles that noted an independent disparity gap, with Caucasians and women being less likely to be tested.
- The Committee noted a gap based on the number of people that probably should be tested, according to the data presented by the developer.

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2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

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

2a. Reliability: **H-0**; **M-8**; **L-9**; **I-2** Reliability (Revote on post-comment call 9/24/19): **H-0; M-5; L-7; I-2.**
2b. Validity: **H-X**; **M-12**; **L-7**; **I-0**

Rationale:

- The Committee cited a number of concerns related to reliability.
- First, the occurrence rate is very small, with only 30 events in the first data set, and 22,000 events from 4.8 million visits in the second.
- This implies that there may be an issue with who is self-reporting as an active intravenous drug user, compounded by the potential for self-reporters to be the same population that would be willing to get tested.
- The Committee also noted that injection drug users do not typically schedule care, so the exclusion of emergency departments as a care setting is also a potential confounder.
- The developer noted that the larger data set excluded all providers who had fewer than 10 events due to potential reidentification issues in the deidentified data.
- This indicates that the measure was not tested to specifications due to misalignment of exclusion criteria in the testing and specifications.
- Due to these concerns, the Committee was not able to achieve consensus on the vote for reliability.
- Similar to the previous measure 3059e, the developer used face validity testing to fulfill the validity requirement.
- It was noted that there were a high number of exclusions in this measure, which was viewed as a threat to validity.

- During the post-comment, all Committee reliability concerns above revisited, and the Committee voted not to pass the measure on reliability.

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3. Feasibility: H-0; M-4; L-15; 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:

- In the discussion of the feasibility of the measure, Committee members noted that the measure should be a byproduct of routine patient care.
- There was some concern that the distinction between active and inactive drug use may not lend itself to good measurement.
- The developer noted the importance of this distinction, and also added that this is a yearly evaluation for patients who remain at continued risk, which is different from the one-time screening in the previous measure 3059e.
- The measure did not pass feasibility, but it is not a must-pass criterion.

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4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-12; No Pass-6**; 4b. Usability: **H-0; M-8; L-10; I-0**

Rationale:

- The Committee noted that because this is a new measure with potential for inclusion in accountability programs, it would still be appropriate to pass for use even though it is yet to be adopted.
- In the discussion of usability, the Committee appreciated that there was no harm identified in the measure but added that the identification of the population that needs screening remains a challenge.

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5. Related and Competing Measures

- The Committee did not discuss related and competing measures, since the measure did not pass the reliability criterion.

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6. Standing Committee Recommendation for Endorsement: **Yes-N/A**; **No-N/A**

Rationale

- The Standing Committee did not vote on the recommendation for endorsement because the Committee did not pass the measure on reliability—a must-pass criterion. The measure is not recommended for endorsement.

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7. Public and Member Comment

- NQF did not receive comments following the Committee's evaluation of the measure.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-0; No-14 (10/21/2019)

Decision: Not approved for endorsement

9. Appeals

N/A-This measure did not move forward to appeals period.

Appendix B: Primary Care and Chronic Illness Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Programs: Implemented or Finalized as of February 22, 2019
0046	Screening for Osteoporosis for Women 65-85 Years of Age	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0047	Asthma: Pharmacologic Therapy for Persistent Asthma	None
0053	Osteoporosis Management in Women Who Had a Fracture	Merit-Based Incentive Payment System (MIPS) Program (Finalized), Medicare Part C Star Rating (Implemented)
0054	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	None
0055	Comprehensive Diabetes Care: Eye Exam (retinal) performed	Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)
0056	Comprehensive Diabetes Care: Foot Exam	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0057	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Medicaid (Implemented), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)
0058	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid (Implemented), Medicare Shared Savings Program (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0061	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	None
0062	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)
0086	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0087	Age-Related Macular Degeneration: Dilated Macular Examination	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	None

[a]Per CMS Measures Inventory Tool as of 2/22/2019

NQF #	Title	Federal Programs: Implemented or Finalized as of February 22, 2019
0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0091	COPD: Spirometry Evaluation	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0409	HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0416	Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0417	Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0541	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)
0563	Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0566	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	None
0575	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)
0577	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	None
0653	Acute Otitis Externa: Topical Therapy	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0654	Acute Otitis Externa: Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0655	Otitis Media with Effusion: Antihistamines or decongestants – Avoidance of inappropriate use	None
0657	Otitis Media with Effusion: Systemic antimicrobials – Avoidance of inappropriate use	Merit-Based Incentive Payment System (MIPS) Program (Implemented)
0729	Optimal Diabetes Care	None
1800	Asthma Medication Ratio	Medicaid (Implemented)

NQF #	Title	Federal Programs: Implemented or Finalized as of February 22, 2019
2079	HIV medical visit frequency	Merit-Based Incentive Payment System (MIPS) Program (Finalized)
2080	Gap in HIV medical visits	None
2082	HIV viral load suppression	Medicaid (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized)
2083	Prescription of HIV Antiretroviral Therapy	None
2522e	Rheumatoid Arthritis: Tuberculosis Screening	None
2523e	Rheumatoid Arthritis: Assessment of Disease Activity	None
2524e	Rheumatoid Arthritis: Functional Status Assessment	None
2525e	Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	None
2549e	Gout: Serum Urate Target	None
2550e	Gout: ULT Therapy (Recommended for eMeasure Trial Approval)	None
2811e	Acute Otitis Media - Appropriate First-Line Antibiotics	None
2856	Pharmacotherapy Management of COPD Exacerbation	None
3086	Population Level HIV Viral Load Suppression	None
3209e	HIV medical visit frequency	None
3210e	HIV viral load suppression	None
3211e	Prescription of HIV Antiretroviral Therapy	None

Appendix C: Primary Care and Chronic Illness Standing Committee and NQF Staff

STANDING COMMITTEE

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Appendix D: Measure Specifications

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

TYPE

Process

DATA SOURCE

Claims, Registry Data Not applicable.

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Other, Outpatient Services, Post-Acute Care Domiciliary

NUMERATOR STATEMENT

Patients who have an optic nerve head evaluation during one or more office visits within 12 months

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the measurement period

Report CPT Category II Code, 2027F: Optic nerve head evaluation performed

DENOMINATOR STATEMENT

All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

Patients aged >= 18 years on date of encounter

AND

Diagnosis for primary open-angle glaucoma (ICD-10-CM): H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.1110, H40.1111, H40.1112, H40.1113, H40.1114, H40.1120, H40.1121, H40.1122, H40.1123, H40.1124, H40.1130, H40.1131, H40.1132, H40.1133, H40.1134, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.151, H40.152, H40.153

AND

Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

EXCLUSIONS

Denominator Exceptions:

Documentation of medical reason(s) for not performing an optic nerve head evaluation

EXCLUSION DETAILS

Time Period for Data Collection: During the encounter within the 12-month period

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation, exceptions may include medical reason(s) for not performing an optic nerve head evaluation. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Append a modifier to CPT Category II Code, 2027F-1P: Documentation of medical reason(s) for not performing an optic nerve head evaluation

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) 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.

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.
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not performing an optic nerve head evaluation]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 140560| 135810| 139260

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

TYPE

Process

DATA SOURCE

Electronic Health Records Not applicable

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Other, Outpatient Services, Post-Acute Care Domiciliary

NUMERATOR STATEMENT

Patients who have an optic nerve head evaluation during one or more office visits within 12 months

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the measurement period

GUIDANCE:

Optic nerve head evaluation includes examination of the cup to disc ratio and identification of optic disc or retinal nerve abnormalities. Both of these components of the optic nerve head evaluation are examined using ophthalmoscopy.

The measure, as written, does not specifically require documentation of laterality. Coding limitations in particular clinical terminologies do not currently allow for that level of specificity (ICD-10-CM includes laterality, but ICD-9-CM and SNOMED-CT do not uniformly include this distinction). Therefore, at this time, it is not a requirement of this measure to indicate laterality of the diagnoses, findings or procedures. Available coding to capture the data elements specified in this measure has been provided. It is assumed that the eligible professional or eligible clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality.

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 primary open-angle glaucoma

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

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

EXCLUSIONS

Denominator Exceptions:

Documentation of medical reason(s) for not performing an optic nerve head evaluation

EXCLUSION DETAILS

Time Period for Data Collection: During the encounter within the 12-month period

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation, exceptions may include medical reason(s) for not performing an optic nerve head evaluation. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

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

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) 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.

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.
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not performing an optic nerve head evaluation]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 139260| 140560| 141015| 149320

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0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

TYPE

Process

DATA SOURCE

Claims, Registry Data Not applicable.

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Other, Outpatient Services, Post-Acute Care Domiciliary

NUMERATOR STATEMENT

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the measurement period

DEFINITIONS:

Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Findings – Includes level of severity of retinopathy (e.g., mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema.

Report CPT Category II Code, 5010F: Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care

AND

Report Quality Data Code, G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

DENOMINATOR STATEMENT

All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

Patients aged >= 18 years on date of encounter

AND

Diagnosis of diabetic retinopathy (ICD-10-CM): E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593

AND

Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

EXCLUSIONS

Denominator Exceptions:

Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes.

Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes.

EXCLUSION DETAILS

Time Period for Data Collection: During the encounter within the 12-month period

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, exceptions may include medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Append a modifier to CPT Category II Code:

5010F-1P: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes

OR

5010F-2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes

AND

Report Quality Data Code, G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) and NQF, the PCPI encourages collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

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.
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 136432| 140560| 135810| 109218| 141015| 149320

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0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

TYPE

Process

DATA SOURCE

Electronic Health Records Not applicable.

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Other, Outpatient Services, Post-Acute Care Domiciliary

NUMERATOR STATEMENT

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the measurement period

DEFINITIONS:

Communication - May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (eg, verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Findings - Includes level of severity of retinopathy (eg, mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema.

GUIDANCE:

The measure, as written, does not specifically require documentation of laterality. Coding limitations in particular clinical terminologies do not currently allow for that level of specificity (ICD-10-CM includes laterality, but ICD-9-CM and SNOMED-CT do not uniformly include this distinction). Therefore, at this time, it is not a requirement of this measure to indicate laterality of the diagnoses, findings or procedures. Available coding to capture the data elements specified in this measure has been provided. It is assumed that the eligible professional or

eligible clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality.

The communication of results to the primary care physician providing ongoing care of a patient's diabetes should be completed soon after the dilated exam is performed. Eligible professionals or eligible clinicians reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, eligible professionals or eligible clinicians who see patients towards the end of the reporting period (ie, December in particular), should communicate the results of the dilated macular exam as soon as possible in order for those patients to be counted in the measure numerator. Communicating the results as soon as possible after the date of the exam will ensure the data are included in the submission to CMS.

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 diabetic retinopathy who had a dilated macular or fundus exam performed

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

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

EXCLUSIONS

Denominator Exceptions:

Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes.

Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

EXCLUSION DETAILS

Time Period for Data Collection: During the encounter within the 12-month period

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, exceptions may include medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for

exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

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

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) and NQF, the PCPI encourages collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

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.
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 136432| 140560| 135810| 109218| 149320

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0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

STEWARD

Pharmacy Quality Alliance

DESCRIPTION

The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement year.

Report a rate for each of the following:

- Diabetes All Class (PDC-DR)
- Renin Angiotensin System Antagonists (PDC-RASA)
- Statins (PDC-STA)

A higher rate indicates better performance.

TYPE

Process

DATA SOURCE

Claims, Enrollment Data Administrative claims (i.e., prescription claims), ICD codes, prescription drug hierarchical condition categories (RxHCC), enrollment data

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

The number of individuals who met the PDC threshold of 80 percent during the measurement year.

NUMERATOR DETAILS

The number of individuals who met the PDC threshold of 80 percent for medications within the specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table PCD-STA-A: Statins for the PDC-STA rate) during the measurement year. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.

Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment, or death.

Step 2: Within the treatment period, count the days the individual 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 target 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 individual.

Step 4: Count the number of individuals who had a PDC of 80% or greater. This is the numerator.

*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 target drugs is common.

Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications

metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

chlorpropamide

glimepiride (+/- pioglitazone)

glipizide (+/- metformin)

glyburide (+/- metformin)

tolazamide

tolbutamide

pioglitazone (+/- alogliptin, glimepiride, metformin)

rosiglitazone (+/- metformin)

alogliptin (+/- metformin, pioglitazone)

linagliptin (+/- empagliflozin, metformin)

saxagliptin (+/- metformin, dapagliflozin))

sitagliptin (+/- metformin, ertugliflozin)

albiglutide

dulaglutide

exenatide

liraglutide

lixisenatide

semaglutide

nateglinide

repaglinide (+/- metformin)

canagliflozin (+/- metformin)

dapagliflozin (+/- metformin, saxagliptin)

empagliflozin (+/- metformin, linagliptin)

ertugliflozin (+/- sitagliptin, metformin)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists

aliskiren (+/- hydrochlorothiazide)

azilsartan (+/- chlorthalidone)

candesartan (+/- hydrochlorothiazide)

eprosartan (+/- hydrochlorothiazide)

irbesartan (+/- hydrochlorothiazide)

losartan (+/- hydrochlorothiazide)

olmesartan (+/- amlodipine, hydrochlorothiazide)

telmisartan (+/- amlodipine, hydrochlorothiazide)

valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol)

benazepril (+/- amlodipine, hydrochlorothiazide)

captopril (+/- hydrochlorothiazide)

enalapril (+/- hydrochlorothiazide)

fosinopril (+/- hydrochlorothiazide)

lisinopril (+/- hydrochlorothiazide)

moexipril (+/- hydrochlorothiazide)

perindopril (+/- amlodipine)

quinapril (+/- hydrochlorothiazide)

ramipril

trandolapril (+/- verapamil)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

Table PCD-STA-A: Statins

atorvastatin (+/- amlodipine, ezetimibe)

fluvastatin

lovastatin (+/- niacin)

pitavastatin

pravastatin

rosuvastatin

simvastatin (+/-ezetimibe, niacin)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

DENOMINATOR STATEMENT

Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (Diabetes; RASA; Statins) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period.

Note: The IPSD is the earliest date of service for a target medication during the measurement year

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)

- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

DENOMINATOR DETAILS

Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table PCD-STA-A: Statins for the PDC-STA rate) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period.

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)

- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications

metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

chlorpropamide

glimepiride (+/- pioglitazone)

glipizide (+/- metformin)

glyburide (+/- metformin)

tolazamide

tolbutamide

pioglitazone (+/- alogliptin, glimepiride, metformin)

rosiglitazone (+/- metformin)

alogliptin (+/- metformin, pioglitazone)

linagliptin (+/- empagliflozin, metformin)

saxagliptin (+/- metformin, dapagliflozin))

sitagliptin (+/- metformin, ertugliflozin)

albiglutide

dulaglutide
exenatide
liraglutide
lixisenatide
semaglutide
nateglinide
repaglinide (+/- metformin)
canagliflozin (+/- metformin)
dapagliflozin (+/- metformin, saxagliptin)
empagliflozin (+/- metformin, linagliptin)
ertugliflozin (+/- sitagliptin, metformin)
NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.
Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists
aliskiren (+/- hydrochlorothiazide)
azilsartan (+/- chlorthalidone)
candesartan (+/- hydrochlorothiazide)
eprosartan (+/- hydrochlorothiazide)
irbesartan (+/- hydrochlorothiazide)
losartan (+/- hydrochlorothiazide)
olmesartan (+/- amlodipine, hydrochlorothiazide)
telmisartan (+/- amlodipine, hydrochlorothiazide)
valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol)
benazepril (+/- amlodipine, hydrochlorothiazide)
captopril (+/- hydrochlorothiazide)
enalapril (+/- hydrochlorothiazide)
fosinopril (+/- hydrochlorothiazide)
lisinopril (+/- hydrochlorothiazide)
moexipril (+/- hydrochlorothiazide)
perindopril (+/- amlodipine)
quinapril (+/- hydrochlorothiazide)
ramipril
trandolapril (+/- verapamil)
NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.
Table PCD-STA-A: Statins
atorvastatin (+/- amlodipine)
fluvastatin
lovastatin (+/- niacin)

pitavastatin

pravastatin

rosuvastatin

simvastatin (+/-ezetimibe, niacin)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

EXCLUSIONS

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)

- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

EXCLUSION DETAILS

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)

- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the Statins rate:

- Individuals in hospice or with end-stage renal disease during the measurement year

Hospice exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA

Individuals in hospice care at any time during the measurement year, identified with a hospice indicator from the enrollment database, where available (e.g., Medicare) or place of service code 34 where a hospice indicator is not available (e.g., Commercial, Medicaid).

End-Stage Renal Disease (ESRD) exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA

Individuals with an ESRD diagnosis at any time during the measurement year.

- See PQA ICD Value Set, ESRD Exclusion (file name, 2019_PQA_ESRD_ICD_Codes_20190221.xlsx attached in S.2b.)

- An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.

- Medicare Data (if ICD codes not available): RxHCC 261 - Dialysis Status for Payment Years 2017 or 2018.

Insulin exclusion: Applies to PDC-DR

Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

Table PDC-H: Insulin Exclusion

insulin aspart (+/-insulin aspart protamine)

insulin degludec (+/- liraglutide)

insulin detemir

insulin glargine (+/- lixisenatide)

insulin glulisine

insulin isophane (+/- regular insulin)

insulin lispro (+/- insulin lispro protamine)

insulin regular (including inhalation powder)

Note: Active ingredients are limited to inhaled and injectable formulations only.

Sacubitril/valsartan exclusion: Applies to PDC-RASA

Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion).

Table PDC-RASA-B: Sacubitril/Valsartan Exclusion

sacubitril/valsartan

RISK ADJUSTMENT

Statistical risk model

STRATIFICATION

Commercial, Medicaid, Medicare (report each product line separately).

For Medicare, rates should be stratified by the following to allow health plans to identify disparities and understand how their patient population mix is affecting their risk-adjusted measure rates:

-Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+)

-Gender (Male; Female)

-LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual)

-Disability status (Disability as reason for Medicare entitlement; Other)

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

For EACH PDC rate, identify the Denominator:

Step 1: Identify the eligible population, which includes individuals 18 years and older as of the first day of the measurement year who are continuously enrolled during the treatment period. Exclude patients who dis-enroll and re-enroll in the same plan more than one day later (i.e., >1 day gap in enrollment) after a valid treatment period, but prior to the end of the measurement year.

Step 2: Identify those individuals in Step 1 that have two or more prescription claims for the target class of medication (either Diabetes medication; or RAS Antagonist; or Statin)

Step 3: Exclude any individual in hospice or with end-stage renal disease.

Step 3a: For the PDC-DR rate: Also exclude any individual with one or more prescription claims for insulin during the treatment period.

Step 3b: For the PDC-RASA rate: Also exclude any individual with one or more prescription claims for the medication sacubitril/valsartan during the treatment period.

For EACH PDC rate, calculate the Numerator:

Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment or death.

Step 2: Within the treatment period, count the days the individual was covered by at least one drug in the class (Diabetes; RASA; Statins) based on the prescription fill date and days of supply. If prescriptions for the same target 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 individual.

Step 4: Count the number of individuals who had a PDC of 80% or greater for medications within the specific therapeutic category.

*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 target drugs is common.

Measure Rate:

Report a rate for each of the following:

- Diabetes All Class (PDC-DR)
- Renin Angiotensin System Antagonists (PDC-RASA)
- Statins (PDC-STA)

Divide each numerator by the corresponding denominator and multiply by 100 to calculate each rate as a percentage.

Risk Adjustment (for Medicare- calculated separately for each therapeutic category)

-identify and categorize the variables for risk adjustment:

- Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+)
- Gender (Male; Female)
- LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual)
- Disability status (Disability as reason for Medicare entitlement; Other)

-Using a random-effects multivariable logistic regression model controlling for the plan-contract (generalized linear mixed model), the patient predicted probability of adherence is calculated after adjusting for the covariates identified above

-for each plan-contract, the expected measure rate is calculated as the average of the patient predicted probability of adherence based on the multivariable logistic regression model

-The risk-adjusted measure rate for each plan-contract is calculated as the ratio of the unadjusted measure scores to the expected score, multiplied by the aggregate unadjusted score for all Part D contracts. 114349| 135329| 135614

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2522 Rheumatoid Arthritis: Tuberculosis Screening

STEWARD

American College of Rheumtology

DESCRIPTION

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who have documentation of a tuberculosis (TB) screening performed within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).

TYPE

Process

DATA SOURCE

Electronic Health Records, Registry Data Data source 1: electronic health records

Instrument: RA Measure Testing Data Collection Form

Data source 2: Rheumatology Informatics System for Effectiveness (RISE) Registry

Data collection: passive abstraction from EHR

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Outpatient Services

NUMERATOR STATEMENT

Any record of TB testing documented or performed (PPD, IFN-gamma release assays, or other appropriate method) in the medical record in the 12 months preceding the biologic DMARD prescription.

NUMERATOR DETAILS

Acceptable TB tests include tuberculin skin test or laboratory tests for TB-specific peptide antigens, during the 12 month measurement period. A list of biologic DMARDs is provided below. Available procedure and drug codes that can be used identify both TB tests and biologic DMARDs are included in S.2b.

Biologic DMARDs:

- Adalimumab (Humira)
- Etanercept (Enbrel)
- Infliximab (Remicade)
- Abatacept (Orencia)
- Anakinra (Kineret)
- Rituximab (Rituxan)
- Certolizumab pegol (Cimzia)
- Tocilizumab (Actemra)

- Golimumab (Simponi)
- Tofacitinib (Xeljanz)
- Sarilumab (Kevzara)
- Infliximab-dyyb (Inflectra)
- Infliximab-abda (Renflexis)
- Infliximab-qbtx (Ixifi)
- Etanercept-szzs (Erelzi)
- Adalimumab-atto (Amjevita)
- Adalimumab-adbm (Cyltezo)

DENOMINATOR STATEMENT

Patients 18 years and older with a diagnosis of rheumatoid arthritis who are seen for at least one face-to-face encounter for RA who are newly started on biologic therapy during the measurement period.

DENOMINATOR DETAILS

For the purposes of this measure, patients who are 'newly started on biologic therapy' are those who have been prescribed DMARD biologic therapy during the measurement period and who were not prescribed DMARD biologic therapy in the 12 months preceding the encounter where DMARD biologic therapy was newly started.

EXCLUSIONS

N/A

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Cases meeting target process/Target population 136880| 146682| 146683| 144243

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2523 Rheumatoid Arthritis: Assessment of Disease Activity

STEWARD

American College of Rheumatology

DESCRIPTION

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis and >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

TYPE

Process

DATA SOURCE

Electronic Health Records, Registry Data Data source 1: electronic health records

Instrument: RA Measure Testing Data Collection Form

Data source 2: Rheumatology Informatics System for Effectiveness (RISE) Registry

Data collection: passive abstraction from EHR

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Outpatient Services

NUMERATOR STATEMENT

of patients with >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

NUMERATOR DETAILS

For purposes of this measure, “Rheumatoid Arthritis Disease Activity Measurement Tools” include the following instruments:

-Clinical Disease Activity Index (CDAI)

-Disease Activity Score with 28-joint counts (erythrocyte sedimentation rate or C-reactive protein) (DAS-28)

-Patient Activity Scale (PAS)

-Patient Activity Score-II (PAS-II)

-Routine Assessment of Patient Index Data with 3 measures (RAPID 3)

-Simplified Disease Activity Index (SDAI)

A result of any kind qualifies for meeting numerator performance.

DENOMINATOR STATEMENT

Patients 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period.

DENOMINATOR DETAILS

One of the requirements for a patient to be included in the Initial Patient Population is that the patient has a minimum of 2 RA encounters with the same provider, all occurring during the measurement period.

If the patient qualifies for the Initial Patient Population, then every encounter for RA should be evaluated to determine whether disease activity using a standardized measurement tool was assessed. The logic represented in this measure will determine if the patient had a disease activity assessment performed at each visit during the measurement period (ie, Occurrence A of Encounter, Performed). The measure requires all of the eligible encounters to be analyzed in order to determine if the patient's disease activity was assessed at >=50% of encounters for RA. Once it has been determined if the patient meets >=50% threshold, all patient data across a single physician should be aggregated to determine the performance rate.

EXCLUSIONS

N/A

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Cases Meeting the Target Process / Target Population 136880| 146682| 146683

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2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

STEWARD

AMERICAN COLLEGE OF RHEUMATOLOGY

DESCRIPTION

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months.

TYPE

Process

DATA SOURCE

Electronic Health Records, Registry Data Data source 1: electronic health records

Instrument: RA Measure Testing Data Collection Form

Data source 2: Rheumatology Informatics System for Effectiveness (RISE) Registry

Data collection: passive abstraction from EHR

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Outpatient Services

NUMERATOR STATEMENT

Patient received a DMARD

NUMERATOR DETAILS

DMARD therapy includes:

abatacept
adalimumab
Adalimumab-adbm
Adalimumab-atto
anakinra
certolizumab
etanercept
Etanercept-szzs
golimumab
infliximab
Infliximab-abda
Infliximab-dyyb
Infliximab-qbtx
Sarilumab

rituximab
tocilizumab
Tofacitinib
Non-Biologic Agents-
auranofin
azathioprine
gold
hydroxychloroquine
leflunomide
methotrexate
minocycline
penicillamine
sulfasalazine
Anti-inflammatory medications, including glucocorticoids do not meet the measure.

DENOMINATOR STATEMENT

Patient age 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period

DENOMINATOR DETAILS

Patients 18 years and older with a diagnosis of Rheumatoid Arthritis seen for two or more encounters for Rheumatoid Arthritis during the measurement period.

EXCLUSIONS

Patients with a diagnosis of HIV; patients who are pregnant; or patients with inactive Rheumatoid Arthritis.

EXCLUSION DETAILS

Patients who have a diagnosis of HIV, who are pregnant, or have inactive rheumatoid arthritis can be identified using the ICD-9, ICD-10, and/or SNOMED diagnosis codes included in S2b.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

CASES MEETING TARGET PROCESS/TARGET POPULATION 136880| 146682| 146683

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3059e One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk

STEWARD

PCPI

DESCRIPTION

Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965 who received one-time screening for hepatitis C virus (HCV) infection

TYPE

Process

DATA SOURCE

Electronic Health Records Not applicable.

LEVEL

Clinician : Individual

SETTING

Home Care, Inpatient/Hospital, Other, Outpatient Services Domiciliary

NUMERATOR STATEMENT

Patients who received one-time screening for HCV infection

NUMERATOR DETAILS

NUMERATOR DEFINITION:

Screening for HCV Infection includes current or prior receipt of:

1) HCV antibody test
2) HCV RNA test
3) Recombinant immunoblot assay (RIBA) test (if performed at any time in the past)

NUMERATOR GUIDANCE:

This measure evaluates the proportion of at-risk patients who have received a one-time screening for Hepatitis C Virus (HCV). In order to meet the measure, the reporting provider must have the laboratory test result present in the patient´s medical record. On occasion, providers will view HCV screening results that were performed elsewhere and therefore the results are not present in the EHR in a structured format. To allow such tests to be applied to this measure, they should be entered into the EHR as a laboratory test in a manner consistent with the EHR in use. If the specific LOINC code of the test is not known, the entry should use the more generic LOINC Panel code which is included in the HCV test value sets as outlined below:

If the provider does not know the exact HCV RNA test performed elsewhere, report the generic LOINC HCV RNA Panel code 75888-8, found in the value set titled, "HCV RNA Test".

If the provider does not know the exact HCV Antibody test performed elsewhere, report the generic LOINC HCV Ab Panel code, 75886-2, found in the value set titled, "HCV Antibody Test".

If the provider does not know the exact HCV RIBA test performed elsewhere, report the generic LOINC HCV RIBA Panel code, 75887-0, found in the value set, "HCV RIBA Test".

The following screening tests are included as allowable screening tests for HCV: HCV antibody test, HCV RNA test or RIBA test. The RIBA test qualifies as "one-time screening" if it was performed at some time in the past. Because RIBA is not a screening method currently used in clinical practice, it is not included as an option in the numerator logic for a screening that occurred during the measurement period.

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 who were seen twice for any visit or who had at least one preventive visit within the 12 month reporting period with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

DENOMINATOR GUIDANCE

The start datetime stamp associated with the data element "Diagnosis: History of Blood Transfusion" should be the datetime of the transfusion event, and not a datetime stamp associated with the documentation action in order to satisfy the logic clause.

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

EXCLUSIONS

Denominator Exclusions

Patients with a diagnosis of chronic hepatitis C

Denominator Exceptions

Documentation of medical reason(s) for not receiving one-time screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not receiving one-time screening for HCV infection (eg, patient declined, other patient reasons)

EXCLUSION DETAILS

Time Period for Data Collection: During the measurement period

The PCPI distinguishes between measure exceptions and measure exclusions. Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk, exclusions include Patients with a diagnosis of chronic hepatitis C. Exclusions, including applicable value sets, are included in the measure specifications.

Measure Exceptions

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk, exceptions may include documentation of medical reason(s) for not receiving one-time screening for HCV infection, (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons), or patient reason(s) (eg, patient declined, other patient reasons). Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eCQM. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

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

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. Find the patients who qualify for denominator exclusions and subtract from the denominator.

4. From the patients within the denominator (after denominator exclusions have been subtracted from 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.
5. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons) or patient reason(s) (eg, patient declined, other patient reasons) for the patient not receiving one-time screening for HCV infection)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage of patients with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 140560| 135810

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3060e Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users

STEWARD

PCPI

DESCRIPTION

Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12-month reporting period

TYPE

Process

DATA SOURCE

Electronic Health Records Not applicable.

LEVEL

Clinician : Individual

SETTING

Home Care, Inpatient/Hospital, Other, Outpatient Services Domiciliary

NUMERATOR STATEMENT

Patients who received screening for HCV infection within the 12-month reporting period

NUMERATOR DETAILS

NUMERATOR DEFINITIONS

Screening for HCV infection - includes HCV antibody test or HCV RNA test

NUMERATOR GUIDANCE

This measure evaluates the proportion of patients who are active injection drug users, who receive screening for Hepatitis C Virus (HCV). In order to meet the measure, the reporting provider must have the laboratory test result present in the patient's medical record. On occasion, providers will view HCV screening results that were performed elsewhere and therefore the results are not present in the EHR in a structured format. To allow such tests to be applied to this measure, they should be entered into the EHR as a laboratory test in a manner consistent with the EHR in use. If the specific LOINC code of the test is not known, the entry should use the more generic LOINC code which is present in the HCV test value sets as outlined below:

If the provider does not know the exact HCV RNA test performed elsewhere, report the generic LOINC HCV RNA Panel Code, 75888-8, found in the value set titled, "HCV RNA Test".

If the provider does not know the exact HCV Antibody test performed elsewhere, report the generic LOINC HCV Ab Panel code, 75886-2, found in the value set title, "HCV Antibody Test".

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

DENOMINATOR STATEMENT

All patients, regardless of age, who are seen twice for any visit or who had at least one preventive care visit within the 12-month reporting period who are active injection drug users

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

DENOMINATOR DEFINITION:

Active injection drug users – Those who have injected any drug(s) within the 12-month reporting period

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

EXCLUSIONS

Denominator Exclusions:

Patients with a diagnosis of chronic hepatitis C

Denominator Exceptions:

Documentation of medical reason(s) for not receiving annual screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not receiving annual screening for HCV infection (eg, patient declined, other patient reasons)

EXCLUSION DETAILS

Time Period for Data Collection: During the measurement period

The PCPI distinguishes between measure exceptions and measure exclusions. Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users, exclusions include patients with a diagnosis of chronic hepatitis C. Exclusions, including applicable value sets, are included in the measure specifications.

Measure Exceptions

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users, exceptions may include documentation of medical reason(s) for not receiving annual screening for HCV infection, (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons), or patient reason(s) (eg, patient declined, other patient reasons). Where examples of exceptions are included in the

measure language, value sets for these examples are developed and are included in the eCQM. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

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

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. Find the patients who qualify for denominator exclusions and subtract from the denominator.
4. From the patients within the denominator (after denominator exclusions have been subtracted from 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.
5. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons) or patient reason(s) (eg, patient declined, other patient reasons) for the patient not receiving annual screening for HCV infection)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage

of patients with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 140560

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Appendix E1: Related and Competing Measures (tabular version)

Comparison of NQF 0563, 0086e, and 0086

	0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care	0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
Steward	American Academy of Ophthalmology	PCPI Foundation	PCPI Foundation
Description	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months
Type	Process	Process	Process
Data Source	Claims, Electronic Health Records, Other, Paper Medical Records, Registry Data No data collection instrument provided No data dictionary	Electronic Health Records Not applicable No data collection instrument provided Attachment CMS143_NQF0086_ValueSets_20180917.xlsx	Claims, Registry Data Not applicable. No data collection instrument provided Attachment NQF0086_I9toI10_conversion.xlsx
Level	Clinician : Group/Practice, Clinician : Individual	Clinician : Group/Practice, Clinician : Individual	Clinician : Group/Practice, Clinician : Individual
Setting	Outpatient Services, Post-Acute Care	Other, Outpatient Services, Post-Acute Care Domiciliary	Other, Outpatient Services, Post-Acute Care Domiciliary
Numerator Statement	Patients whose glaucoma treatment has not failed (the most recent intraocular pressure (IOP) was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months Plan of care may include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist Plan to recheck: in the event certain factors do not allow for the IOP to be measured (e.g., patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported. Glaucoma treatment not failed: the most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.	Patients who have an optic nerve head evaluation during one or more office visits within 12 months	Patients who have an optic nerve head evaluation during one or more office visits within 12 months
Numerator Details	Patients whose glaucoma treatment has not failed (the IOP was reduced by at least 15% from the pre-intervention level) OR if the IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months Plan of care may include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist Plan to recheck: in the event certain factors do not allow for the IOP to be measured (e.g., patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported. Glaucoma treatment not failed: the most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes. CPT Category II code: 3284F- Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level OR A. CPT Category II code: 3285F- Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level AND	Time Period for Data Collection: At least once during the measurement period GUIDANCE: Optic nerve head evaluation includes examination of the cup to disc ratio and identification of optic disc or retinal nerve abnormalities. Both of these components of the optic nerve head evaluation are examined using ophthalmoscopy. The measure, as written, does not specifically require documentation of laterality. Coding limitations in particular clinical terminologies do not currently allow for that level of specificity (ICD-10-CM includes laterality, but ICD-9-CM and SNOMED-CT do not uniformly include this distinction). Therefore, at this time, it is not a requirement of this measure to indicate laterality of the diagnoses, findings or procedures. Available coding to capture the data elements specified in this measure has been provided. It is assumed that the eligible professional or eligible clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.	Time Period for Data Collection: At least once during the measurement period Report CPT Category II Code, 2027F: Optic nerve head evaluation performed

	0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care	0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
	B. CPT Category II code: 0517F- Glaucoma plan of care documented		
Denominator Statement	All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma	All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma	All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma
Denominator Details	All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma Patients aged 18 years and older AND ICD-9 diagnosis codes: 365.10, 365.11, 365.12, 365.15 ICD-10 diagnosis codes: H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.151, H40.152, H40.153, H40.159 AND CPT E/M Codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 92214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337	Time Period for Data Collection: 12 consecutive months HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.	Time Period for Data Collection: 12 consecutive months Patients aged >= 18 years on date of encounter AND Diagnosis for primary open-angle glaucoma (ICD-10-CM): H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.1110, H40.1111, H40.1112, H40.1113, H40.1114, H40.1120, H40.1121, H40.1122, H40.1123, H40.1124, H40.1130, H40.1131, H40.1132, H40.1133, H40.1134, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.151, H40.152, H40.153 AND Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02
Exclusions	Not applicable.	Denominator Exceptions: Documentation of medical reason(s) for not performing an optic nerve head evaluation	Denominator Exceptions: Documentation of medical reason(s) for not performing an optic nerve head evaluation
Exclusion Details	Not applicable.	Time Period for Data Collection: During the encounter within the 12-month period Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation, exceptions may include medical reason(s) for not performing an optic nerve head evaluation. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.	Time Period for Data Collection: During the encounter within the 12-month period Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation, exceptions may include medical reason(s) for not performing an optic nerve head evaluation. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Append a modifier to CPT Category II Code, 2027F-1P: Documentation of medical reason(s) for not performing an optic nerve head evaluation
Risk Adjustment	No risk adjustment or risk stratification 117076| 109921| 140560| 135810| 137170 117076| 109921| 140560| 135810| 137170	No risk adjustment or risk stratification 139260| 140560| 141015| 149320 139260| 140560| 141015| 149320	No risk adjustment or risk stratification 140560| 135810| 139260 140560| 135810| 139260
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, primary language, and administrative sex.	Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) and NQF to standardize	Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) and NQF to standardize

	0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care	0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
		the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.	the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Calculation for performance: For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator Numerator (A) includes: Patients whose glaucoma treatment has not failed (the most recent intraocular pressure (IOP) was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months Denominator (PD) includes: All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma Performance calculation: A (# of patients meeting numerator criteria) / PD (# of patients in denominator) Calculation for Reporting: For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator Reporting Numerator includes each of the following instances: A. Patients whose glaucoma treatment has not failed (the most recent intraocular pressure (IOP) was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months C. Patients whose intraocular pressure was reduced by a value of less than 15% from the pre-intervention level AND a glaucoma plan of care was not documented, reason not otherwise specified OR Patients who did not have an intraocular pressure documented, reason not otherwise specified Reporting Denominator (RD) includes: All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma Reporting Calculation: A (# patients meeting numerator criteria) + C (# of patients NOT meeting numerator criteria) / RD (# of patients in denominator) 117076| 109921| 140560| 135810| 137170	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. 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not performing an optic nerve head evaluation]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 139260| 140560| 141015| 149320	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. 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not performing an optic nerve head evaluation]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 140560| 135810| 139260
Submission items	5.1 Identified measures: 0086 : Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: Not applicable.	5.1 Identified measures: 0563 : Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care 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: Although the populations are similar, NQF #0563 measures the reduction in intraocular pressure from the pre-intervention level, while NQF #0086e measures the evaluation of the optic nerve to establish glaucoma disease status and presence of optic nerve damage. This measure intends to monitor, detect, and prevent disease progression among POAG patients. In addition, degeneration of the optic nerve, even while intraocular pressure remains in the normal range, can occur amongst a subtype of open-angle glaucoma patients (normal or low-tension glaucoma). This measure would	5.1 Identified measures: 0563 : Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care 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: Although the populations are similar, NQF #0563 measures the reduction in intraocular pressure from the pre-intervention level, while NQF #0086 measures the evaluation of the optic nerve to establish glaucoma disease status and presence of optic nerve damage. This measure intends to monitor, detect, and prevent disease progression among POAG patients. In addition, degeneration of the optic nerve, even while intraocular pressure remains in the normal range, can occur amongst a subtype of open-angle glaucoma patients (normal or

	0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care	0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
		capture those patients, whereas NQF #0563 would not apply to that patient group. Additionally, NQF #0086e is electronically specified, further distinguishing the two measures.	low-tension glaucoma). This measure would capture those patients, whereas NQF #0563 would not apply to that patient group.

Comparison of NQF 0055, 0089, and 0089e

	0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed	0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
Steward	National Committee for Quality Assurance	PCPI Foundation	PCPI Foundation
Description	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months
Type	Process	Process	Process
Data Source	Claims, Electronic Health Data, Paper Medical Records This measure uses a combination of administrative claims data and medical records. Eye screening for diabetic retinal disease can be identified by the following administrative data: -Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. -A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. -Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year Codes in the following value sets will meet these criteria: -Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year. -Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional during the year prior to the measurement year, with a negative result (negative for retinopathy). -Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications -Any code in the Diabetic Retinal Screening with Eye Care Professional Value Set billed by any provider type during the measurement year. -Any code in the Diabetic Retinal Screening with Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy). -Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year. -Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (Bilateral Modifer Value Set) -Two unilateral eye enucleations (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more part. -Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) and right unilateral eye enucleation (Unilateral Eye	Claims, Registry Data Not applicable. No data collection instrument provided Attachment NQF0089_I9toI10_conversion.xlsx	Electronic Health Records Not applicable. No data collection instrument provided Attachment CMS142_NQF0089_ValueSets_20180917.xlsx

	0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed	0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
	Enucleation Right Value Set) on the same or different dates of service The minimum medical record documentation includes one of the following: - A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results. - A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. -Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year. -Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings). Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria. No data collection instrument provided Attachment 0055_CDC_Eye_Exam_Value_Sets.xlsx		
Level	Clinician : Group/Practice, Health Plan, Clinician : Individual	Clinician : Group/Practice, Clinician : Individual	Clinician : Group/Practice, Clinician : Individual
Setting	Outpatient Services	Other, Outpatient Services, Post-Acute Care Domiciliary	Other, Outpatient Services, Post-Acute Care Domiciliary
Numerator Statement	Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following: -a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year –a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. -Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year For exams performed in the year prior to the measurement year, a result must be available.	Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care	Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care
Numerator Details	Time period for data: a measurement year (12 months) ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b. MEDICAL RECORD: At a minimum, documentation in the medical record must include one of the following: - A note or letter prepared by an ophthalmologist, optometrist, PCP or	Time Period for Data Collection: At least once during the measurement period DEFINITIONS: Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's	Time Period for Data Collection: At least once during the measurement period DEFINITIONS: Communication - May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (eg, verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

	0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed	0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
	other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results. - A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. -Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year. -Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings). Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria. The patient is numerator compliant if the eye exam was performed in the measurement year or a negative eye exam was documented in the year prior to the measurement year. The patient is not numerator compliant if the eye exam or negative result are missing. Ranges and thresholds do not meet criteria for this measure.	diabetic care outlining the findings of the dilated macular or fundus exam. Findings – Includes level of severity of retinopathy (e.g., mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema. Report CPT Category II Code, 5010F: Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care AND Report Quality Data Code, G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy	Findings - Includes level of severity of retinopathy (eg, mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema. GUIDANCE: The measure, as written, does not specifically require documentation of laterality. Coding limitations in particular clinical terminologies do not currently allow for that level of specificity (ICD-10-CM includes laterality, but ICD-9-CM and SNOMED-CT do not uniformly include this distinction). Therefore, at this time, it is not a requirement of this measure to indicate laterality of the diagnoses, findings or procedures. Available coding to capture the data elements specified in this measure has been provided. It is assumed that the eligible professional or eligible clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality. The communication of results to the primary care physician providing ongoing care of a patient's diabetes should be completed soon after the dilated exam is performed. Eligible professionals or eligible clinicians reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, eligible professionals or eligible clinicians who see patients towards the end of the reporting period (ie, December in particular), should communicate the results of the dilated macular exam as soon as possible in order for those patients to be counted in the measure numerator. Communicating the results as soon as possible after the date of the exam will ensure the data are included in the submission to CMS. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.
Denominator Statement	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed	All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed
Denominator Details	Patients with diabetes can be identified two ways: -CLAIM/ENCOUNTER DATA: Patients who had two face-to-face encounters, in an outpatient setting, observations visits, ED setting on different dates of service, or nonacute inpatient setting with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. Organizations may count services that occur over both years. *SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B -PHARMACY DATA: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (TABLE CDC-A): Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations: Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin,	Time Period for Data Collection: 12 consecutive months Patients aged >= 18 years on date of encounter AND Diagnosis of diabetic retinopathy (ICD-10-CM): E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.311, E10.319,	Time Period for Data Collection: 12 consecutive months HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

	0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed	0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
	Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metaformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metaformin-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, Sitagliptin	E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593 AND Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02	
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. Exclusions (optional): -Exclude patients who did not have a diagnosis of diabetes, in any setting, AND who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year -Exclude patients 65 and older with an advanced illness condition and frailty	Denominator Exceptions: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes. Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes.	Denominator Exceptions: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes. Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.
Exclusion Details	ADMINISTRATIVE CLAIMS: 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). ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b. MEDICAL RECORD:	Time Period for Data Collection: During the encounter within the 12-month period Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the	Time Period for Data Collection: During the encounter within the 12-month period Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system

	0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed	0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
	-Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and had a diagnosis of polycystic ovaries any time in the patient's history through December 31 of the measurement year. OR -Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.	denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, exceptions may include medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Append a modifier to CPT Category II Code: 5010F-1P: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes OR 5010F-2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes AND Report Quality Data Code, G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy	reason. For measure Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, exceptions may include medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.
Risk Adjustment	No risk adjustment or risk stratification 123834| 118571| 140881| 141015| 143426 123834| 118571| 140881| 141015| 143426	No risk adjustment or risk stratification 136432| 140560| 135810| 109218| 141015| 149320 136432| 140560| 135810| 109218| 141015| 149320	No risk adjustment or risk stratification 136432| 140560| 135810| 109218| 149320 136432| 140560| 135810| 109218| 149320
Stratification	N/A	Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) and NQF, the PCPI encourages collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.	Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) and NQF, the PCPI encourages collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria. -AGES: 18-75 years as of December 31 of the measurement year.	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).	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).

	0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed	0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
	-EVENT/DIAGNOSIS: Identify patients with diabetes in two ways: by claim/encounter data and by pharmacy data. Claim/Encounter Data: -Patients who had at least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits. -Patients with at least one acute inpatient encounter with a diagnosis of diabetes. *SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. *SEE PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES IN QUESTION S.7 STEP 2. Determine the number of patients in the eligible population who had a recent eye exam (retinal) performed during the measurement year through the search of administrative data systems. STEP 3. Identify patients with a most recent eye exam (retinal) performed and the result. STEP 4. Identify the most recent eye exam (retinal) during the measurement year or a negative result prior to the measurement year (numerator compliant). Identify missing eye exam or missing eye exam result (not numerator compliant). STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured. *SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.8 STEP 6. Calculate the rate (number of patients with an eye exam (retinal) performed during the measurement year or negative result prior to the measurement year). 123834| 118571| 140881| 141015| 143426	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. 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 136432| 140560| 135810| 109218| 141015| 149320	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. 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 136432| 140560| 135810| 109218| 149320
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: 0055 : Comprehensive Diabetes Care: Eye Exam (retinal) performed 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Measure #0055 evaluates the percentage of patients 18-75 years of age with diabetes who had an eye exam (retinal) performed. While the population is similar, the PCPI measure requires that a dilated macular or fundus exam be performed, and the results communicated to the physician who manages the ongoing care of the patient with diabetes so as to facilitate the coordination of care. 5b.1 If competing, why superior or rationale for additive value: not applicable	5.1 Identified measures: 0055 : Comprehensive Diabetes Care: Eye Exam (retinal) performed 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Measure #0055 evaluates the percentage of patients 18-75 years of age with diabetes who had an eye exam (retinal) performed. While the population is similar, the PCPI measure requires that a dilated macular or fundus exam be performed, and the results communicated to the physician who manages the ongoing care of the patient with diabetes so as to facilitate the coordination of care. 5b.1 If competing, why superior or rationale for additive value: not applicable

Comparison of NQF 0541 and 1879

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
Steward	Pharmacy Quality Alliance	Centers for Medicare and Medicaid Services
Description	The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement year. Report a rate for each of the following: • Diabetes All Class (PDC-DR) • Renin Angiotensin System Antagonists (PDC-RASA) • Statins (PDC-STA) A higher rate indicates better performance.	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	Process
Data Source	Claims, Enrollment Data Administrative claims (i.e., prescription claims), ICD codes, prescription drug hierarchical condition categories (RxHCC), enrollment data No data collection instrument provided Attachment 2019_PQA_ESRD_ICD_Codes_20190221.xlsx	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
Level	Health Plan	Clinician: Group/Practice, Health Plan, Population: Regional and State
Setting	Outpatient Services	Outpatient Services
Numerator Statement	The number of individuals who met the PDC threshold of 80 percent during the measurement year.	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 number of individuals who met the PDC threshold of 80 percent for medications within the specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table PCD-STA-A: Statins for the PDC-STA rate) during the measurement year. Follow the steps below for each patient to determine whether the patient meets the PDC threshold. Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment, or death. Step 2: Within the treatment period, count the days the individual 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 target 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 individual. Step 4: Count the number of individuals who had a PDC of 80% or greater. This is the numerator. *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 target drugs is common. Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin) chlorpropamide glimepiride (+/- pioglitazone) glipizide (+/- metformin) glyburide (+/- metformin) tolazamide tolbutamide pioglitazone (+/- alogliptin, glimepiride, metformin) rosiglitazone (+/- metformin) alogliptin (+/- metformin, pioglitazone) linagliptin (+/- empagliflozin, metformin) saxagliptin (+/- metformin, dapagliflozin)) sitagliptin (+/- metformin, ertugliflozin) albiglutide dulaglutide	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.

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
	exenatide liraglutide lixisenatide semaglutide nateglinide repaglinide (+/- metformin) canagliflozin (+/- metformin) dapagliflozin (+/- metformin, saxagliptin) empagliflozin (+/- metformin, linagliptin) ertugliflozin (+/- sitagliptin, metformin) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products. Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists aliskiren (+/- hydrochlorothiazide) azilsartan (+/- chlorthalidone) candesartan (+/- hydrochlorothiazide) eprosartan (+/- hydrochlorothiazide) irbesartan (+/- hydrochlorothiazide) losartan (+/- hydrochlorothiazide) olmesartan (+/- amlodipine, hydrochlorothiazide) telmisartan (+/- amlodipine, hydrochlorothiazide) valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol) benazepril (+/- amlodipine, hydrochlorothiazide) captopril (+/- hydrochlorothiazide) enalapril (+/- hydrochlorothiazide) fosinopril (+/- hydrochlorothiazide) lisinopril (+/- hydrochlorothiazide) moexipril (+/- hydrochlorothiazide) perindopril (+/- amlodipine) quinapril (+/- hydrochlorothiazide) ramipril trandolapril (+/- verapamil) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products. Table PCD-STA-A: Statins atorvastatin (+/- amlodipine, ezetimibe) fluvastatin lovastatin (+/- niacin) pitavastatin pravastatin rosuvastatin simvastatin (+/-ezetimibe, niacin) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.	
Denominator Statement	Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (Diabetes; RASA; Statins) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period. Note: The IPSD is the earliest date of service for a target medication during the measurement year Exclusions for the Diabetes rate: - Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the RASA rate: - Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the Statins rate: - Individuals in hospice or with End-Stage Renal Disease	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	Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table PCD-STA-A: Statins for the PDC-STA rate) on different dates of service during the treatment period and are continuously enrolled during the	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,

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
	treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period. Exclusions for the Diabetes rate: - Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the RASA rate: - Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the Statins rate: - Individuals in hospice or with End-Stage Renal Disease Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin) chlorpropamide glimepiride (+/- pioglitazone) glipizide (+/- metformin) glyburide (+/- metformin) tolazamide tolbutamide pioglitazone (+/- alogliptin, glimepiride, metformin) rosiglitazone (+/- metformin) alogliptin (+/- metformin, pioglitazone) linagliptin (+/- empagliflozin, metformin) saxagliptin (+/- metformin, dapagliflozin)) sitagliptin (+/- metformin, ertugliflozin) albiglutide dulaglutide exenatide liraglutide lixisenatide semaglutide nateglinide repaglinide (+/- metformin) canagliflozin (+/- metformin) dapagliflozin (+/- metformin, saxagliptin) empagliflozin (+/- metformin, linagliptin) ertugliflozin (+/- sitagliptin, metformin) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products. Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists aliskiren (+/- hydrochlorothiazide) azilsartan (+/- chlorthalidone) candesartan (+/- hydrochlorothiazide) eprosartan (+/- hydrochlorothiazide) irbesartan (+/- hydrochlorothiazide) losartan (+/- hydrochlorothiazide) olmesartan (+/- amlodipine, hydrochlorothiazide) telmisartan (+/- amlodipine, hydrochlorothiazide) valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol) benazepril (+/- amlodipine, hydrochlorothiazide) captopril (+/- hydrochlorothiazide) enalapril (+/- hydrochlorothiazide) fosinopril (+/- hydrochlorothiazide) lisinopril (+/- hydrochlorothiazide) moexipril (+/- hydrochlorothiazide) perindopril (+/- amlodipine) quinapril (+/- hydrochlorothiazide) ramipril trandolapril (+/- verapamil) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products. Table PCD-STA-A: Statins atorvastatin (+/- amlodipine) fluvastatin lovastatin (+/- niacin) pitavastatin pravastatin rosuvastatin	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

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	simvastatin (+/-ezetimibe, niacin) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.	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	Exclusions for the Diabetes rate: - Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) - Individuals in hospice or with end-stage renal disease during the measurement year Exclusions for the RASA rate: - Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the Statins rate: - Individuals in hospice or with End-Stage Renal Disease	Individuals with any diagnosis of dementia during the measurement period.
Exclusion Details	Exclusions for the Diabetes rate:	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

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	- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) - Individuals in hospice or with end-stage renal disease during the measurement year Exclusions for the RASA rate: - Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion) - Individuals in hospice or with end-stage renal disease during the measurement year Exclusions for the Statins rate: - Individuals in hospice or with end-stage renal disease during the measurement year Hospice exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA Individuals in hospice care at any time during the measurement year, identified with a hospice indicator from the enrollment database, where available (e.g., Medicare) or place of service code 34 where a hospice indicator is not available (e.g., Commercial, Medicaid). End-Stage Renal Disease (ESRD) exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA Individuals with an ESRD diagnosis at any time during the measurement year. - See PQA ICD Value Set, ESRD Exclusion (file name, 2019_PQA_ESRD_ICD_Codes_20190221.xlsx attached in S.2b.) - An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. - Medicare Data (if ICD codes not available): RxHCC 261 - Dialysis Status for Payment Years 2017 or 2018. Insulin exclusion: Applies to PDC-DR Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) Table PDC-H: Insulin Exclusion insulin aspart (+/-insulin aspart protamine) insulin degludec (+/- liraglutide) insulin detemir insulin glargine (+/- lixisenatide) insulin glulisine insulin isophane (+/- regular insulin) insulin lispro (+/- insulin lispro protamine) insulin regular (including inhalation powder) Note: Active ingredients are limited to inhaled and injectable formulations only. Sacubitril/valsartan exclusion: Applies to PDC-RASA Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion). Table PDC-RASA-B: Sacubitril/Valsartan Exclusion sacubitril/valsartan	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	Statistical risk model 114349| 135329| 135614 114349| 135329| 135614	No risk adjustment or risk stratification
Stratification	Commercial, Medicaid, Medicare (report each product line separately). For Medicare, rates should be stratified by the following to allow health plans to identify disparities and understand how their patient population mix is affecting their risk-adjusted measure rates: -Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+) -Gender (Male; Female) -LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual) -Disability status (Disability as reason for Medicare entitlement; Other)	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	Rate/proportion
Algorithm	For EACH PDC rate, identify the Denominator: Step 1: Identify the eligible population, which includes individuals 18 years and older as of the first day of the measurement year who are continuously enrolled during the treatment period. Exclude patients who dis-enroll and re-enroll in the same plan more than one day later (i.e., >1 day gap in enrollment) after a valid treatment period, but prior to the end of the measurement year. Step 2: Identify those individuals in Step 1 that have two or more prescription claims for the target class of medication (either Diabetes medication; or RAS Antagonist; or Statin) Step 3: Exclude any individual in hospice or with end-stage renal disease.	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.

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	Step 3a: For the PDC-DR rate: Also exclude any individual with one or more prescription claims for insulin during the treatment period. Step 3b: For the PDC-RASA rate: Also exclude any individual with one or more prescription claims for the medication sacubitril/valsartan during the treatment period. For EACH PDC rate, calculate the Numerator: Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment or death. Step 2: Within the treatment period, count the days the individual was covered by at least one drug in the class (Diabetes; RASA; Statins) based on the prescription fill date and days of supply. If prescriptions for the same target 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 individual. Step 4: Count the number of individuals who had a PDC of 80% or greater for medications within the specific therapeutic category. *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 target drugs is common. Measure Rate: Report a rate for each of the following: • Diabetes All Class (PDC-DR) • Renin Angiotensin System Antagonists (PDC-RASA) • Statins (PDC-STA) Divide each numerator by the corresponding denominator and multiply by 100 to calculate each rate as a percentage. Risk Adjustment (for Medicare- calculated separately for each therapeutic category) -identify and categorize the variables for risk adjustment: • Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+) • Gender (Male; Female) • LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual) • Disability status (Disability as reason for Medicare entitlement; Other) -Using a random-effects multivariable logistic regression model controlling for the plan-contract (generalized linear mixed model), the patient predicted probability of adherence is calculated after adjusting for the covariates identified above -for each plan-contract, the expected measure rate is calculated as the average of the patient predicted probability of adherence based on the multivariable logistic regression model -The risk-adjusted measure rate for each plan-contract is calculated as the ratio of the unadjusted measure scores to the expected score, multiplied by the aggregate unadjusted score for all Part D contracts. 114349| 135329| 135614	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

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		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

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		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

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		*Provider specialty codes specific to this measure
Submission items	5.1 Identified measures: 1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia 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: Although the measures address adherence using the same methodology (i.e., proportion of days covered [PDC]), they have different areas of focus and different target populations. 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category 0542 : Adherence to Chronic Medications 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease 0544 : Use and Adherence to Antipsychotics among members with Schizophrenia 0545 : Adherence to Statins for Individuals with Diabetes Mellitus 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:

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
		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.

Comparison of NQF 0541 and 1880

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
Steward	Pharmacy Quality Alliance	Centers for Medicare & Medicaid Services
Description	The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement year. Report a rate for each of the following: • Diabetes All Class (PDC-DR) • Renin Angiotensin System Antagonists (PDC-RASA) • Statins (PDC-STA) A higher rate indicates better performance.	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, Enrollment Data Administrative claims (i.e., prescription claims), ICD codes, prescription drug hierarchical condition categories (RxHCC), enrollment data No data collection instrument provided Attachment 2019_PQA_ESRD_ICD_Codes_20190221.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

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
		• 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	The number of individuals who met the PDC threshold of 80 percent during the measurement year.	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 number of individuals who met the PDC threshold of 80 percent for medications within the specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table PCD-STA-A: Statins for the PDC-STA rate) during the measurement year. Follow the steps below for each patient to determine whether the patient meets the PDC threshold. Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment, or death. Step 2: Within the treatment period, count the days the individual 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 target 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 individual. Step 4: Count the number of individuals who had a PDC of 80% or greater. This is the numerator. *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 target drugs is common. Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin) chlorpropamide glimepiride (+/- pioglitazone) glipizide (+/- metformin) glyburide (+/- metformin) tolazamide tolbutamide pioglitazone (+/- alogliptin, glimepiride, metformin) rosiglitazone (+/- metformin) alogliptin (+/- metformin, pioglitazone) linagliptin (+/- empagliflozin, metformin) saxagliptin (+/- metformin, dapagliflozin)) sitagliptin (+/- metformin, ertugliflozin) albiglutide dulaglutide exenatide liraglutide lixisenatide semaglutide nateglinide repaglinide (+/- metformin) canagliflozin (+/- metformin) dapagliflozin (+/- metformin, saxagliptin) empagliflozin (+/- metformin, linagliptin) ertugliflozin (+/- sitagliptin, metformin) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products. Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists aliskiren (+/- hydrochlorothiazide) azilsartan (+/- chlorthalidone) candesartan (+/- hydrochlorothiazide) eprosartan (+/- hydrochlorothiazide) irbesartan (+/- hydrochlorothiazide) losartan (+/- hydrochlorothiazide) olmesartan (+/- amlodipine, hydrochlorothiazide) telmisartan (+/- amlodipine, hydrochlorothiazide) valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol)	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	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
	benazepril (+/- amlodipine, hydrochlorothiazide) captopril (+/- hydrochlorothiazide) enalapril (+/- hydrochlorothiazide) fosinopril (+/- hydrochlorothiazide) lisinopril (+/- hydrochlorothiazide) moexipril (+/- hydrochlorothiazide) perindopril (+/- amlodipine) quinapril (+/- hydrochlorothiazide) ramipril trandolapril (+/- verapamil) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products. Table PCD-STA-A: Statins atorvastatin (+/- amlodipine, ezetimibe) fluvastatin lovastatin (+/- niacin) pitavastatin pravastatin rosuvastatin simvastatin (+/-ezetimibe, niacin) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.	
Denominator Statement	Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (Diabetes; RASA; Statins) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period. Note: The IPSD is the earliest date of service for a target medication during the measurement year Exclusions for the Diabetes rate: - Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the RASA rate: - Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the Statins rate: - Individuals in hospice or with End-Stage Renal Disease	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	Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table PCD-STA-A: Statins for the PDC-STA rate) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period. Exclusions for the Diabetes rate: - Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the RASA rate: - Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the Statins rate: - Individuals in hospice or with End-Stage Renal Disease Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin) chlorpropamide glimepiride (+/- pioglitazone) glipizide (+/- metformin)	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

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
	glyburide (+/- metformin) tolazamide tolbutamide pioglitazone (+/- alogliptin, glimepiride, metformin) rosiglitazone (+/- metformin) alogliptin (+/- metformin, pioglitazone) linagliptin (+/- empagliflozin, metformin) saxagliptin (+/- metformin, dapagliflozin)) sitagliptin (+/- metformin, ertugliflozin) albiglutide dulaglutide exenatide liraglutide lixisenatide semaglutide nateglinide repaglinide (+/- metformin) canagliflozin (+/- metformin) dapagliflozin (+/- metformin, saxagliptin) empagliflozin (+/- metformin, linagliptin) ertugliflozin (+/- sitagliptin, metformin) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products. Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists aliskiren (+/- hydrochlorothiazide) azilsartan (+/- chlorthalidone) candesartan (+/- hydrochlorothiazide) eprosartan (+/- hydrochlorothiazide) irbesartan (+/- hydrochlorothiazide) losartan (+/- hydrochlorothiazide) olmesartan (+/- amlodipine, hydrochlorothiazide) telmisartan (+/- amlodipine, hydrochlorothiazide) valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol) benazepril (+/- amlodipine, hydrochlorothiazide) captopril (+/- hydrochlorothiazide) enalapril (+/- hydrochlorothiazide) fosinopril (+/- hydrochlorothiazide) lisinopril (+/- hydrochlorothiazide) moexipril (+/- hydrochlorothiazide) perindopril (+/- amlodipine) quinapril (+/- hydrochlorothiazide) ramipril trandolapril (+/- verapamil) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products. Table PCD-STA-A: Statins atorvastatin (+/- amlodipine) fluvastatin lovastatin (+/- niacin) pitavastatin pravastatin rosuvastatin simvastatin (+/-ezetimibe, niacin) NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.	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

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
		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	Exclusions for the Diabetes rate: - Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) - Individuals in hospice or with end-stage renal disease during the measurement year Exclusions for the RASA rate: - Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion) - Individuals in hospice or with End-Stage Renal Disease Exclusions for the Statins rate: - Individuals in hospice or with End-Stage Renal Disease	Not Applicable
Exclusion Details	Exclusions for the Diabetes rate: - Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) - Individuals in hospice or with end-stage renal disease during the measurement year Exclusions for the RASA rate: - Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion) - Individuals in hospice or with end-stage renal disease during the measurement year Exclusions for the Statins rate: - Individuals in hospice or with end-stage renal disease during the measurement year Hospice exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA Individuals in hospice care at any time during the measurement year, identified with a hospice indicator from the enrollment database, where available (e.g., Medicare) or place of service code 34 where a hospice indicator is not available (e.g., Commercial, Medicaid). End-Stage Renal Disease (ESRD) exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA Individuals with an ESRD diagnosis at any time during the measurement year. - See PQA ICD Value Set, ESRD Exclusion (file name, 2019_PQA_ESRD_ICD_Codes_20190221.xlsx attached in S.2b.) - An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. - Medicare Data (if ICD codes not available): RxHCC 261 - Dialysis Status for Payment Years 2017 or 2018. Insulin exclusion: Applies to PDC-DR Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion) Table PDC-H: Insulin Exclusion insulin aspart (+/-insulin aspart protamine) insulin degludec (+/- liraglutide) insulin detemir	Not Applicable

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
	insulin glargine (+/- lixisenatide) insulin glulisine insulin isophane (+/- regular insulin) insulin lispro (+/- insulin lispro protamine) insulin regular (including inhalation powder) Note: Active ingredients are limited to inhaled and injectable formulations only. Sacubitril/valsartan exclusion: Applies to PDC-RASA Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion). Table PDC-RASA-B: Sacubitril/Valsartan Exclusion sacubitril/valsartan	
Risk Adjustment	Statistical risk model 114349| 135329| 135614 114349| 135329| 135614	No risk adjustment or risk stratification 119011| 120823| 140881| 123834| 141592| 141015| 142428 119011| 120823| 140881| 123834| 141592| 141015| 142428
Stratification	Commercial, Medicaid, Medicare (report each product line separately). For Medicare, rates should be stratified by the following to allow health plans to identify disparities and understand how their patient population mix is affecting their risk-adjusted measure rates: -Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+) -Gender (Male; Female) -LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual) -Disability status (Disability as reason for Medicare entitlement; Other)	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	Rate/proportion better quality = higher score
Algorithm	For EACH PDC rate, identify the Denominator: Step 1: Identify the eligible population, which includes individuals 18 years and older as of the first day of the measurement year who are continuously enrolled during the treatment period. Exclude patients who dis-enroll and re-enroll in the same plan more than one day later (i.e., >1 day gap in enrollment) after a valid treatment period, but prior to the end of the measurement year. Step 2: Identify those individuals in Step 1 that have two or more prescription claims for the target class of medication (either Diabetes medication; or RAS Antagonist; or Statin) Step 3: Exclude any individual in hospice or with end-stage renal disease. Step 3a: For the PDC-DR rate: Also exclude any individual with one or more prescription claims for insulin during the treatment period. Step 3b: For the PDC-RASA rate: Also exclude any individual with one or more prescription claims for the medication sacubitril/valsartan during the treatment period. For EACH PDC rate, calculate the Numerator: Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment or death. Step 2: Within the treatment period, count the days the individual was covered by at least one drug in the class (Diabetes; RASA; Statins) based on the prescription fill date and days of supply. If prescriptions for the same target 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 individual. Step 4: Count the number of individuals who had a PDC of 80% or greater for medications within the specific therapeutic category. *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 target drugs is common. Measure Rate: Report a rate for each of the following: • Diabetes All Class (PDC-DR) • Renin Angiotensin System Antagonists (PDC-RASA) • Statins (PDC-STA) Divide each numerator by the corresponding denominator and multiply by 100 to calculate each rate as a percentage.	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

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
	Risk Adjustment (for Medicare- calculated separately for each therapeutic category) -identify and categorize the variables for risk adjustment: • Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+) • Gender (Male; Female) • LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual) • Disability status (Disability as reason for Medicare entitlement; Other) -Using a random-effects multivariable logistic regression model controlling for the plan-contract (generalized linear mixed model), the patient predicted probability of adherence is calculated after adjusting for the covariates identified above -for each plan-contract, the expected measure rate is calculated as the average of the patient predicted probability of adherence based on the multivariable logistic regression model -The risk-adjusted measure rate for each plan-contract is calculated as the ratio of the unadjusted measure scores to the expected score, multiplied by the aggregate unadjusted score for all Part D contracts. 114349| 135329| 135614	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.

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
		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

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
		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 119011| 120823| 140881| 123834| 141592| 141015| 142428
Submission items	5.1 Identified measures: 1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia 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: Although the measures address adherence using the same methodology (i.e., proportion of days covered [PDC]), they have different areas of focus and different target populations. 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: 0003 : Bipolar Disorder: Assessment for diabetes 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 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category 0542 : Adherence to Chronic Medications 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease 0545 : Adherence to Statins for Individuals with Diabetes Mellitus 0580 : Bipolar antimanic agent 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

	0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
		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.

Appendix E2: Related and Competing Measures (narrative version)

Comparison of NQF 0563, 0086e, and 0086

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care
0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Steward

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

American Academy of Ophthalmology

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

PCPI Foundation

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

PCPI Foundation

Description

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

Type

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Process

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Process

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Process

Data Source

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Claims, Electronic Health Records, Other, Paper Medical Records, Registry Data

No data collection instrument provided No data dictionary

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Electronic Health Records Not applicable

No data collection instrument provided Attachment CMS143_NQF0086_ValueSets_20180917.xlsx

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Claims, Registry Data Not applicable.

No data collection instrument provided Attachment NQF0086_I9toI10_conversion.xlsx

Level

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Clinician : Group/Practice, Clinician : Individual

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Clinician : Group/Practice, Clinician : Individual

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Clinician : Group/Practice, Clinician : Individual

Setting

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Outpatient Services, Post-Acute Care

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Other, Outpatient Services, Post-Acute Care Domiciliary

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Other, Outpatient Services, Post-Acute Care Domiciliary

Numerator Statement

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Patients whose glaucoma treatment has not failed (the most recent intraocular pressure (IOP) was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months

Plan of care may include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist

Plan to recheck: in the event certain factors do not allow for the IOP to be measured (e.g., patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported.

Glaucoma treatment not failed: the most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Patients who have an optic nerve head evaluation during one or more office visits within 12 months

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Patients who have an optic nerve head evaluation during one or more office visits within 12 months

Numerator Details

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Patients whose glaucoma treatment has not failed (the IOP was reduced by at least 15% from the pre-intervention level) OR if the IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months

Plan of care may include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist

Plan to recheck: in the event certain factors do not allow for the IOP to be measured (e.g., patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported.

Glaucoma treatment not failed: the most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

CPT Category II code: 3284F- Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level

OR

A. CPT Category II code: 3285F- Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

AND

B. CPT Category II code: 0517F- Glaucoma plan of care documented

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Time Period for Data Collection: At least once during the measurement period

GUIDANCE:

Optic nerve head evaluation includes examination of the cup to disc ratio and identification of optic disc or retinal nerve abnormalities. Both of these components of the optic nerve head evaluation are examined using ophthalmoscopy.

The measure, as written, does not specifically require documentation of laterality. Coding limitations in particular clinical terminologies do not currently allow for that level of specificity (ICD-10-CM includes laterality, but ICD-9-CM and SNOMED-CT do not uniformly include this distinction). Therefore, at this time, it is not a requirement of this measure to indicate laterality of the diagnoses, findings or procedures. Available coding to capture the data elements specified in this measure has been provided. It is assumed that the eligible professional or eligible clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality.

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

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Time Period for Data Collection: At least once during the measurement period

Report CPT Category II Code, 2027F: Optic nerve head evaluation performed

Denominator Statement

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Denominator Details

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Patients aged 18 years and older

AND

ICD-9 diagnosis codes: 365.10, 365.11, 365.12, 365.15

ICD-10 diagnosis codes: H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.151, H40.152, H40.153, H40.159

AND

CPT E/M Codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 92214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Time Period for Data Collection: 12 consecutive months

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

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Time Period for Data Collection: 12 consecutive months

Patients aged >= 18 years on date of encounter

AND

Diagnosis for primary open-angle glaucoma (ICD-10-CM): H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.1110, H40.1111, H40.1112, H40.1113, H40.1114, H40.1120, H40.1121, H40.1122, H40.1123, H40.1124, H40.1130, H40.1131, H40.1132, H40.1133, H40.1134, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.151, H40.152, H40.153

AND

Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

Exclusions

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Not applicable.

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Denominator Exceptions:

Documentation of medical reason(s) for not performing an optic nerve head evaluation

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Denominator Exceptions:

Documentation of medical reason(s) for not performing an optic nerve head evaluation

Exclusion Details

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Not applicable.

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Time Period for Data Collection: During the encounter within the 12-month period

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the

denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation, exceptions may include medical reason(s) for not performing an optic nerve head evaluation. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

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

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Time Period for Data Collection: During the encounter within the 12-month period

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation, exceptions may include medical reason(s) for not performing an optic nerve head evaluation. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Append a modifier to CPT Category II Code, 2027F-1P: Documentation of medical reason(s) for not performing an optic nerve head evaluation

Risk Adjustment

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

No risk adjustment or risk stratification

117076| 109921| 140560| 135810| 137170

117076| 109921| 140560| 135810| 137170

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

No risk adjustment or risk stratification

139260| 140560| 141015| 149320

139260| 140560| 141015| 149320

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

No risk adjustment or risk stratification

140560| 135810| 139260

140560| 135810| 139260

Stratification

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

We encourage the results of this measure to be stratified by race, ethnicity, primary language, and administrative sex.

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) 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.

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) 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.

Type Score

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Rate/proportion better quality = higher score

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Rate/proportion better quality = higher score

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Rate/proportion better quality = higher score

Algorithm

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

Calculation for performance:

For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator

Numerator (A) includes:

Patients whose glaucoma treatment has not failed (the most recent intraocular pressure (IOP) was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months

Denominator (PD) includes:

All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Performance calculation:

A (# of patients meeting numerator criteria) / PD (# of patients in denominator)

Calculation for Reporting:

For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator

Reporting Numerator includes each of the following instances:

A. Patients whose glaucoma treatment has not failed (the most recent intraocular pressure (IOP) was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months

C. Patients whose intraocular pressure was reduced by a value of less than 15% from the pre-intervention level AND a glaucoma plan of care was not documented, reason not otherwise specified

OR

Patients who did not have an intraocular pressure documented, reason not otherwise specified

Reporting Denominator (RD) includes:

All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Reporting Calculation:

A (# patients meeting numerator criteria) + C (# of patients NOT meeting numerator criteria) / RD (# of patients in denominator) 117076| 109921| 140560| 135810| 137170

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

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.
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not performing an optic nerve head evaluation]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 139260| 140560| 141015| 149320

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

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.
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not performing an optic nerve head evaluation]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 140560| 135810| 139260

Submission items

0563 Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

5.1 Identified measures: 0086 : Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: Not applicable.

0086e Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

5.1 Identified measures: 0563 : Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

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: Although the populations are similar, NQF #0563 measures the reduction in intraocular pressure from the pre-intervention level, while NQF #0086e measures the evaluation of the optic nerve to establish glaucoma disease status and presence of optic nerve damage. This measure intends to monitor, detect, and prevent disease progression among POAG patients. In addition, degeneration of the optic nerve, even while intraocular pressure remains in the normal range, can occur amongst a subtype of open-angle glaucoma patients (normal or

low-tension glaucoma). This measure would capture those patients, whereas NQF #0563 would not apply to that patient group. Additionally, NQF #0086e is electronically specified, further distinguishing the two measures.

0086 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

5.1 Identified measures: 0563 : Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care

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: Although the populations are similar, NQF #0563 measures the reduction in intraocular pressure from the pre-intervention level, while NQF #0086 measures the evaluation of the optic nerve to establish glaucoma disease status and presence of optic nerve damage. This measure intends to monitor, detect, and prevent disease progression among POAG patients. In addition, degeneration of the optic nerve, even while intraocular pressure remains in the normal range, can occur amongst a subtype of open-angle glaucoma patients (normal or low-tension glaucoma). This measure would capture those patients, whereas NQF #0563 would not apply to that patient group.

Comparison of NQF 0055, 0089, and 0089e

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed
0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Steward

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

National Committee for Quality Assurance

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

PCPI Foundation

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

PCPI Foundation

Description

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

Type

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Process

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Process

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Process

Data Source

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Claims, Electronic Health Data, Paper Medical Records This measure uses a combination of administrative claims data and medical records. Eye screening for diabetic retinal disease can be identified by the following administrative data:

- Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

Codes in the following value sets will meet these criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications
- Any code in the Diabetic Retinal Screening with Eye Care Professional Value Set billed by any provider type during the measurement year.
- Any code in the Diabetic Retinal Screening with Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year.
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (Bilateral Modifer Value Set)
- Two unilateral eye enucleations (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more part.
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) and right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service

The minimum medical record documentation includes one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a

qualified reading center that operates under the direction of a medical director who is a retinal specialist.

- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).

Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

No data collection instrument provided Attachment 0055_CDC_Eye_Exam_Value_Sets.xlsx

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Claims, Registry Data Not applicable.

No data collection instrument provided Attachment NQF0089_I9toI10_conversion.xlsx

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Electronic Health Records Not applicable.

No data collection instrument provided Attachment CMS142_NQF0089_ValueSets_20180917.xlsx

Level

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Clinician : Group/Practice, Health Plan, Clinician : Individual

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Clinician : Group/Practice, Clinician : Individual

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Clinician : Group/Practice, Clinician : Individual

Setting

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Outpatient Services

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Other, Outpatient Services, Post-Acute Care Domiciliary

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Other, Outpatient Services, Post-Acute Care Domiciliary

Numerator Statement

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following:

- a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year
- a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

For exams performed in the year prior to the measurement year, a result must be available.

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Numerator Details

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Time period for data: a measurement year (12 months)

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD: At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).

Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

The patient is numerator compliant if the eye exam was performed in the measurement year or a negative eye exam was documented in the year prior to the measurement year. The patient is not numerator compliant if the eye exam or negative result are missing. Ranges and thresholds do not meet criteria for this measure.

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Time Period for Data Collection: At least once during the measurement period

DEFINITIONS:

Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Findings – Includes level of severity of retinopathy (e.g., mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema.

Report CPT Category II Code, 5010F: Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care

AND

Report Quality Data Code, G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Time Period for Data Collection: At least once during the measurement period

DEFINITIONS:

Communication - May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (eg, verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Findings - Includes level of severity of retinopathy (eg, mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema.

GUIDANCE:

The measure, as written, does not specifically require documentation of laterality. Coding limitations in particular clinical terminologies do not currently allow for that level of specificity (ICD-10-CM includes laterality, but ICD-9-CM and SNOMED-CT do not uniformly include this distinction). Therefore, at this time, it is not a requirement of this measure to indicate laterality of the diagnoses, findings or procedures. Available coding to capture the data elements specified in this measure has been provided. It is assumed that the eligible professional or eligible clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality.

The communication of results to the primary care physician providing ongoing care of a patient's diabetes should be completed soon after the dilated exam is performed. Eligible professionals or eligible clinicians reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, eligible professionals or eligible clinicians who see patients towards the end of the reporting period (ie, December in particular), should communicate the results of the dilated macular exam as soon as possible in order for those patients to be counted in the measure numerator. Communicating the results as soon as possible after the date of the exam will ensure the data are included in the submission to CMS.

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

Denominator Statement

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

Denominator Details

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Patients with diabetes can be identified two ways:

-CLAIM/ENCOUNTER DATA: Patients who had two face-to-face encounters, in an outpatient setting, observations visits, ED setting on different dates of service, or nonacute inpatient setting with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. Organizations may count services that occur over both years.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

-PHARMACY DATA: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (TABLE CDC-A):

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-metaformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metaformin-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, Sitagliptin

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Time Period for Data Collection: 12 consecutive months

Patients aged >= 18 years on date of encounter

AND

Diagnosis of diabetic retinopathy (ICD-10-CM): E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532,

E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593

AND

Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Time Period for Data Collection: 12 consecutive months

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

Exclusions

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

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.

Exclusions (optional):

- Exclude patients who did not have a diagnosis of diabetes, in any setting, AND who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year
- Exclude patients 65 and older with an advanced illness condition and frailty

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Denominator Exceptions:

Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes.

Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes.

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Denominator Exceptions:

Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes.

Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

Exclusion Details

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

ADMINISTRATIVE CLAIMS:

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).

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD:

Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and had a diagnosis of polycystic ovaries any time in the patient's history through December 31 of the measurement year.

OR

Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Time Period for Data Collection: During the encounter within the 12-month period

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology

uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, exceptions may include medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Append a modifier to CPT Category II Code:

5010F-1P: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes

OR

5010F-2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes

AND

Report Quality Data Code, G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Time Period for Data Collection: During the encounter within the 12-month period

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, exceptions may include medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional who manages the ongoing care of the patient with

diabetes. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

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

Risk Adjustment

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

No risk adjustment or risk stratification

123834| 118571| 140881| 141015| 143426

123834| 118571| 140881| 141015| 143426

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

No risk adjustment or risk stratification

136432| 140560| 135810| 109218| 141015| 149320

136432| 140560| 135810| 109218| 141015| 149320

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

No risk adjustment or risk stratification

136432| 140560| 135810| 109218| 149320

136432| 140560| 135810| 109218| 149320

Stratification

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

N/A

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) and NQF, the PCPI encourages collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now NASEM) and NQF, the PCPI encourages collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

Type Score

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

Rate/proportion better quality = higher score

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Rate/proportion better quality = higher score

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Rate/proportion better quality = higher score

Algorithm

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria.

- AGES: 18-75 years as of December 31 of the measurement year.
- EVENT/DIAGNOSIS: Identify patients with diabetes in two ways: by claim/encounter data and by pharmacy data.

Claim/Encounter Data:

- Patients who had at least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.
- Patients with at least one acute inpatient encounter with a diagnosis of diabetes.

*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

Pharmacy Data:

Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

*SEE PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES IN QUESTION S.7

STEP 2. Determine the number of patients in the eligible population who had a recent eye exam (retinal) performed during the measurement year through the search of administrative data systems.

STEP 3. Identify patients with a most recent eye exam (retinal) performed and the result.

STEP 4. Identify the most recent eye exam (retinal) during the measurement year or a negative result prior to the measurement year (numerator compliant). Identify missing eye exam or missing eye exam result (not numerator compliant).

STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured.

*SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.8

STEP 6. Calculate the rate (number of patients with an eye exam (retinal) performed during the measurement year or negative result prior to the measurement year). 123834| 118571| 140881| 141015| 143426

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

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.
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 136432| 140560| 135810| 109218| 141015| 149320

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

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.
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes, or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes]. If the patient meets any

exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 136432| 140560| 135810| 109218| 149320

Submission items

0055 Comprehensive Diabetes Care: Eye Exam (retinal) performed

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

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

5.1 Identified measures: 0055 : Comprehensive Diabetes Care: Eye Exam (retinal) performed

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Measure #0055 evaluates the percentage of patients 18-75 years of age with diabetes who had an eye exam (retinal) performed. While the population is similar, the PCPI measure requires that a dilated macular or fundus exam be performed, and the results communicated to the physician who manages the ongoing care of the patient with diabetes so as to facilitate the coordination of care.

5b.1 If competing, why superior or rationale for additive value: not applicable

0089e Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

5.1 Identified measures: 0055 : Comprehensive Diabetes Care: Eye Exam (retinal) performed

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Measure #0055 evaluates the percentage of patients 18-75 years of age with diabetes who had an eye exam (retinal) performed. While the population is similar, the PCPI measure requires that a dilated macular or fundus exam be performed, and the results communicated to the physician who manages the ongoing care of the patient with diabetes so as to facilitate the coordination of care.

5b.1 If competing, why superior or rationale for additive value: not applicable

Comparison of NQF 0541 and 1879

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Steward

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 and Medicaid Services

Description

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement year.

Report a rate for each of the following:

- Diabetes All Class (PDC-DR)
- Renin Angiotensin System Antagonists (PDC-RASA)
- Statins (PDC-STA)

A higher rate indicates better performance.

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).

Type

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Process

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Process

Data Source

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Claims, Enrollment Data Administrative claims (i.e., prescription claims), ICD codes, prescription drug hierarchical condition categories (RxHCC), enrollment data

No data collection instrument provided Attachment 2019_PQA_ESRD_ICD_Codes_20190221.xlsx

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

Level

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Health Plan

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

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

Setting

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Outpatient Services

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Outpatient Services

Numerator Statement

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

The number of individuals who met the PDC threshold of 80 percent during the measurement year.

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.

Numerator Details

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

The number of individuals who met the PDC threshold of 80 percent for medications within the specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table PCD-STA-A: Statins for the PDC-STA rate) during the measurement year. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.

Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment, or death.

Step 2: Within the treatment period, count the days the individual 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 target 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 individual.

Step 4: Count the number of individuals who had a PDC of 80% or greater. This is the numerator.

*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 target drugs is common.

Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications

metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

chlorpropamide

glimepiride (+/- pioglitazone)

glipizide (+/- metformin)

glyburide (+/- metformin)

tolazamide

tolbutamide

pioglitazone (+/- alogliptin, glimepiride, metformin)

rosiglitazone (+/- metformin)

alogliptin (+/- metformin, pioglitazone)

linagliptin (+/- empagliflozin, metformin)

saxagliptin (+/- metformin, dapagliflozin))

sitagliptin (+/- metformin, ertugliflozin)

albiglutide

dulaglutide

exenatide

liraglutide

lixisenatide

semaglutide

nateglinide

repaglinide (+/- metformin)

canagliflozin (+/- metformin)

dapagliflozin (+/- metformin, saxagliptin)

empagliflozin (+/- metformin, linagliptin)

ertugliflozin (+/- sitagliptin, metformin)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists

aliskiren (+/- hydrochlorothiazide)

azilsartan (+/- chlorthalidone)

candesartan (+/- hydrochlorothiazide)

eprosartan (+/- hydrochlorothiazide)

irbesartan (+/- hydrochlorothiazide)

losartan (+/- hydrochlorothiazide)

olmesartan (+/- amlodipine, hydrochlorothiazide)

telmisartan (+/- amlodipine, hydrochlorothiazide)

valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol)

benazepril (+/- amlodipine, hydrochlorothiazide)

captopril (+/- hydrochlorothiazide)

enalapril (+/- hydrochlorothiazide)

fosinopril (+/- hydrochlorothiazide)

lisinopril (+/- hydrochlorothiazide)

moexipril (+/- hydrochlorothiazide)

perindopril (+/- amlodipine)

quinapril (+/- hydrochlorothiazide)

ramipril

trandolapril (+/- verapamil)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

Table PCD-STA-A: Statins

atorvastatin (+/- amlodipine, ezetimibe)

fluvastatin

lovastatin (+/- niacin)

pitavastatin

pravastatin

rosuvastatin

simvastatin (+/-ezetimibe, niacin)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

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.

Denominator Statement

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (Diabetes; RASA; Statins) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period.

Note: The IPSD is the earliest date of service for a target medication during the measurement year

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)
- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)
- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

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).

Denominator Details

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table

PCD-STA-A: Statins for the PDC-STA rate) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period.

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)
- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)
- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications

metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

chlorpropamide

glimepiride (+/- pioglitazone)

glipizide (+/- metformin)

glyburide (+/- metformin)

tolazamide

tolbutamide

pioglitazone (+/- alogliptin, glimepiride, metformin)

rosiglitazone (+/- metformin)

alogliptin (+/- metformin, pioglitazone)

linagliptin (+/- empagliflozin, metformin)

saxagliptin (+/- metformin, dapagliflozin))

sitagliptin (+/- metformin, ertugliflozin)

albiglutide

dulaglutide

exenatide

liraglutide

lixisenatide

semaglutide

nateglinide

repaglinide (+/- metformin)

canagliflozin (+/- metformin)

dapagliflozin (+/- metformin, saxagliptin)

empagliflozin (+/- metformin, linagliptin)

ertugliflozin (+/- sitagliptin, metformin)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists

aliskiren (+/- hydrochlorothiazide)

azilsartan (+/- chlorthalidone)

candesartan (+/- hydrochlorothiazide)

eprosartan (+/- hydrochlorothiazide)

irbesartan (+/- hydrochlorothiazide)

losartan (+/- hydrochlorothiazide)

olmesartan (+/- amlodipine, hydrochlorothiazide)

telmisartan (+/- amlodipine, hydrochlorothiazide)

valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol)

benazepril (+/- amlodipine, hydrochlorothiazide)

captopril (+/- hydrochlorothiazide)

enalapril (+/- hydrochlorothiazide)

fosinopril (+/- hydrochlorothiazide)

lisinopril (+/- hydrochlorothiazide)

moexipril (+/- hydrochlorothiazide)

perindopril (+/- amlodipine)

quinapril (+/- hydrochlorothiazide)

ramipril

trandolapril (+/- verapamil)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

Table PCD-STA-A: Statins

atorvastatin (+/- amlodipine)

fluvastatin

lovastatin (+/- niacin)

pitavastatin

pravastatin

rosuvastatin

simvastatin (+/-ezetimibe, niacin)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

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

Exclusions

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)
- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)
- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with any diagnosis of dementia during the measurement period.

Exclusion Details

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)
- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)
- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the Statins rate:

- Individuals in hospice or with end-stage renal disease during the measurement year

Hospice exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA

Individuals in hospice care at any time during the measurement year, identified with a hospice indicator from the enrollment database, where available (e.g., Medicare) or place of service code 34 where a hospice indicator is not available (e.g., Commercial, Medicaid).

End-Stage Renal Disease (ESRD) exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA

Individuals with an ESRD diagnosis at any time during the measurement year.

- See PQA ICD Value Set, ESRD Exclusion (file name, 2019_PQA_ESRD_ICD_Codes_20190221.xlsx attached in S.2b.)
- An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
- Medicare Data (if ICD codes not available): RxHCC 261 - Dialysis Status for Payment Years 2017 or 2018.

Insulin exclusion: Applies to PDC-DR

Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

Table PDC-H: Insulin Exclusion

insulin aspart (+/-insulin aspart protamine)

insulin degludec (+/- liraglutide)

insulin detemir

insulin glargine (+/- lixisenatide)

insulin glulisine

insulin isophane (+/- regular insulin)

insulin lispro (+/- insulin lispro protamine)

insulin regular (including inhalation powder)

Note: Active ingredients are limited to inhaled and injectable formulations only.

Sacubitril/valsartan exclusion: Applies to PDC-RASA

Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion).

Table PDC-RASA-B: Sacubitril/Valsartan Exclusion

sacubitril/valsartan

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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

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Statistical risk model

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No risk adjustment or risk stratification

Stratification

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Commercial, Medicaid, Medicare (report each product line separately).

For Medicare, rates should be stratified by the following to allow health plans to identify disparities and understand how their patient population mix is affecting their risk-adjusted measure rates:

- Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+)
- Gender (Male; Female)
- LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual)
- Disability status (Disability as reason for Medicare entitlement; Other)

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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

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

Algorithm

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

For EACH PDC rate, identify the Denominator:

Step 1: Identify the eligible population, which includes individuals 18 years and older as of the first day of the measurement year who are continuously enrolled during the treatment period. Exclude patients who dis-enroll and re-enroll in the same plan more than one day

later (i.e., >1 day gap in enrollment) after a valid treatment period, but prior to the end of the measurement year.

Step 2: Identify those individuals in Step 1 that have two or more prescription claims for the target class of medication (either Diabetes medication; or RAS Antagonist; or Statin)

Step 3: Exclude any individual in hospice or with end-stage renal disease.

Step 3a: For the PDC-DR rate: Also exclude any individual with one or more prescription claims for insulin during the treatment period.

Step 3b: For the PDC-RASA rate: Also exclude any individual with one or more prescription claims for the medication sacubitril/valsartan during the treatment period.

For EACH PDC rate, calculate the Numerator:

Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment or death.

Step 2: Within the treatment period, count the days the individual was covered by at least one drug in the class (Diabetes; RASA; Statins) based on the prescription fill date and days of supply. If prescriptions for the same target 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 individual.

Step 4: Count the number of individuals who had a PDC of 80% or greater for medications within the specific therapeutic category.

*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 target drugs is common.

Measure Rate:

Report a rate for each of the following:

- Diabetes All Class (PDC-DR)
- Renin Angiotensin System Antagonists (PDC-RASA)
- Statins (PDC-STA)

Divide each numerator by the corresponding denominator and multiply by 100 to calculate each rate as a percentage.

Risk Adjustment (for Medicare- calculated separately for each therapeutic category)

- -identify and categorize the variables for risk adjustment:
    - Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+)
    - Gender (Male; Female)
    - LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual)
    - Disability status (Disability as reason for Medicare entitlement; Other)
- -Using a random-effects multivariable logistic regression model controlling for the plan-contract (generalized linear mixed model), the patient predicted probability of adherence is calculated after adjusting for the covariates identified above

- -for each plan-contract, the expected measure rate is calculated as the average of the patient predicted probability of adherence based on the multivariable logistic regression model
- -The risk-adjusted measure rate for each plan-contract is calculated as the ratio of the unadjusted measure scores to the expected score, multiplied by the aggregate unadjusted score for all Part D contracts. 114349| 135329| 135614

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.
4. 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.
5. 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

Submission items

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

5.1 Identified measures: 1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia

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: Although the measures address adherence using the same methodology (i.e., proportion of days covered [PDC]), they have different areas of focus and different target populations.

5b.1 If competing, why superior or rationale for additive value: N/A

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

5.1 Identified measures: 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

0542 : Adherence to Chronic Medications

0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease

0544 : Use and Adherence to Antipsychotics among members with Schizophrenia

0545 : Adherence to Statins for Individuals with Diabetes Mellitus

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.

Comparison of NQF 0541 and 1880

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Steward

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Pharmacy Quality Alliance

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Centers for Medicare & Medicaid Services

Description

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement year.

Report a rate for each of the following:

• Diabetes All Class (PDC-DR)

• Renin Angiotensin System Antagonists (PDC-RASA)

• Statins (PDC-STA)

A higher rate indicates better performance.

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

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Process

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Process

Data Source

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Claims, Enrollment Data Administrative claims (i.e., prescription claims), ICD codes, prescription drug hierarchical condition categories (RxHCC), enrollment data

No data collection instrument provided Attachment 2019_PQA_ESRD_ICD_Codes_20190221.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

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

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

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Outpatient Services

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Outpatient Services

Numerator Statement

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

The number of individuals who met the PDC threshold of 80 percent during the measurement year.

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

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

The number of individuals who met the PDC threshold of 80 percent for medications within the specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table PCD-STA-A: Statins for the PDC-STA rate) during the measurement year. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.

Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment, or death.

Step 2: Within the treatment period, count the days the individual 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 target 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 individual.

Step 4: Count the number of individuals who had a PDC of 80% or greater. This is the numerator.

*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 target drugs is common.

Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications

metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

chlorpropamide

glimepiride (+/- pioglitazone)

glipizide (+/- metformin)

glyburide (+/- metformin)

tolazamide

tolbutamide

pioglitazone (+/- alogliptin, glimepiride, metformin)

rosiglitazone (+/- metformin)

alogliptin (+/- metformin, pioglitazone)

linagliptin (+/- empagliflozin, metformin)

saxagliptin (+/- metformin, dapagliflozin))

sitagliptin (+/- metformin, ertugliflozin)

albiglutide

dulaglutide

exenatide

liraglutide
lixisenatide
semaglutide
nateglinide
repaglinide (+/- metformin)
canagliflozin (+/- metformin)
dapagliflozin (+/- metformin, saxagliptin)
empagliflozin (+/- metformin, linagliptin)
ertugliflozin (+/- sitagliptin, metformin)
NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.
Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists
aliskiren (+/- hydrochlorothiazide)
azilsartan (+/- chlorthalidone)
candesartan (+/- hydrochlorothiazide)
eprosartan (+/- hydrochlorothiazide)
irbesartan (+/- hydrochlorothiazide)
losartan (+/- hydrochlorothiazide)
olmesartan (+/- amlodipine, hydrochlorothiazide)
telmisartan (+/- amlodipine, hydrochlorothiazide)
valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol)
benazepril (+/- amlodipine, hydrochlorothiazide)
captopril (+/- hydrochlorothiazide)
enalapril (+/- hydrochlorothiazide)
fosinopril (+/- hydrochlorothiazide)
lisinopril (+/- hydrochlorothiazide)
moexipril (+/- hydrochlorothiazide)
perindopril (+/- amlodipine)
quinapril (+/- hydrochlorothiazide)
ramipril
trandolapril (+/- verapamil)
NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.
Table PCD-STA-A: Statins
atorvastatin (+/- amlodipine, ezetimibe)
fluvastatin
lovastatin (+/- niacin)
pitavastatin
pravastatin

rosuvastatin

simvastatin (+/-ezetimibe, niacin)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

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

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (Diabetes; RASA; Statins) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period.

Note: The IPSD is the earliest date of service for a target medication during the measurement year

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)
- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)
- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

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

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Individuals age 18 years and older as of the first day of the measurement year, with at least two prescription claims for medication(s) within a specific therapeutic category (see Tables PDC-DR-A through Table PDC-DR-G: Diabetes Medications for the PDC-DR rate; see Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists for the PDC-RASA rate; see Table PCD-STA-A: Statins for the PDC-STA rate) on different dates of service during the treatment period and are continuously enrolled during the treatment period, which begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of the measurement year, death or disenrollment. The IPSD should occur at least 91 days before the end of the enrollment period.

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)
- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)
- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

Table PDC-DR-A through Table PDC-DR-G: Diabetes Medications

metformin (+/- alogliptin, canagliflozin, dapagliloflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

chlorpropamide

glimepiride (+/- pioglitazone)

glipizide (+/- metformin)

glyburide (+/- metformin)

tolazamide

tolbutamide

pioglitazone (+/- alogliptin, glimepiride, metformin)

rosiglitazone (+/- metformin)

alogliptin (+/- metformin, pioglitazone)

linagliptin (+/- empagliflozin, metformin)

saxagliptin (+/- metformin, dapagliflozin))

sitagliptin (+/- metformin, ertugliflozin)
albiglutide
dulaglutide
exenatide
liraglutide
lixisenatide
semaglutide
nateglinide
repaglinide (+/- metformin)
canagliflozin (+/- metformin)
dapagliflozin (+/- metformin, saxagliptin)
empagliflozin (+/- metformin, linagliptin)
ertugliflozin (+/- sitagliptin, metformin)
NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.
Table PDC-RASA-A: Renin Angiotensin System (RAS) Antagonists
aliskiren (+/- hydrochlorothiazide)
azilsartan (+/- chlorthalidone)
candesartan (+/- hydrochlorothiazide)
eprosartan (+/- hydrochlorothiazide)
irbesartan (+/- hydrochlorothiazide)
losartan (+/- hydrochlorothiazide)
olmesartan (+/- amlodipine, hydrochlorothiazide)
telmisartan (+/- amlodipine, hydrochlorothiazide)
valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol)
benazepril (+/- amlodipine, hydrochlorothiazide)
captopril (+/- hydrochlorothiazide)
enalapril (+/- hydrochlorothiazide)
fosinopril (+/- hydrochlorothiazide)
lisinopril (+/- hydrochlorothiazide)
moexipril (+/- hydrochlorothiazide)
perindopril (+/- amlodipine)
quinapril (+/- hydrochlorothiazide)
ramipril
trandolapril (+/- verapamil)
NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.
Table PCD-STA-A: Statins
atorvastatin (+/- amlodipine)

fluvastatin

lovastatin (+/- niacin)

pitavastatin

pravastatin

rosuvastatin

simvastatin (+/-ezetimibe, niacin)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

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

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)

- Individuals in hospice or with End-Stage Renal Disease

Exclusions for the Statins rate:

- Individuals in hospice or with End-Stage Renal Disease

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Not Applicable

Exclusion Details

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Exclusions for the Diabetes rate:

- Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the RASA rate:

- Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion)

- Individuals in hospice or with end-stage renal disease during the measurement year

Exclusions for the Statins rate:

- Individuals in hospice or with end-stage renal disease during the measurement year

Hospice exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA

Individuals in hospice care at any time during the measurement year, identified with a hospice indicator from the enrollment database, where available (e.g., Medicare) or place of service code 34 where a hospice indicator is not available (e.g., Commercial, Medicaid).

End-Stage Renal Disease (ESRD) exclusion: Applies to PDC-DR, PDC-RASA, and PDC-STA

Individuals with an ESRD diagnosis at any time during the measurement year.

- See PQA ICD Value Set, ESRD Exclusion (file name, 2019_PQA_ESRD_ICD_Codes_20190221.xlsx attached in S.2b.)

- An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.

- Medicare Data (if ICD codes not available): RxHCC 261 - Dialysis Status for Payment Years 2017 or 2018.

Insulin exclusion: Applies to PDC-DR

Individuals with one or more prescription claims for insulin during the treatment period (See Medication Table PDC-H: Insulin Exclusion)

Table PDC-H: Insulin Exclusion

insulin aspart (+/-insulin aspart protamine)

insulin degludec (+/- liraglutide)

insulin detemir

insulin glargine (+/- lixisenatide)

insulin glulisine

insulin isophane (+/- regular insulin)

insulin lispro (+/- insulin lispro protamine)

insulin regular (including inhalation powder)

Note: Active ingredients are limited to inhaled and injectable formulations only.

Sacubitril/valsartan exclusion: Applies to PDC-RASA

Individuals with one or more prescription claims for the medication, sacubitril/valsartan during the treatment period (See Medication Table PDC-RASA-B: Sacubitril/Valsartan Exclusion).

Table PDC-RASA-B: Sacubitril/Valsartan Exclusion

sacubitril/valsartan

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Not Applicable

Risk Adjustment

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Statistical risk model

114349| 135329| 135614

114349| 135329| 135614

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

No risk adjustment or risk stratification

119011| 120823| 140881| 123834| 141592| 141015| 142428

119011| 120823| 140881| 123834| 141592| 141015| 142428

Stratification

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Commercial, Medicaid, Medicare (report each product line separately).

For Medicare, rates should be stratified by the following to allow health plans to identify disparities and understand how their patient population mix is affecting their risk-adjusted measure rates:

-Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+)

-Gender (Male; Female)

-LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual)

-Disability status (Disability as reason for Medicare entitlement; Other)

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

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

Rate/proportion better quality = higher score

1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

Rate/proportion better quality = higher score

Algorithm

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

For EACH PDC rate, identify the Denominator:

Step 1: Identify the eligible population, which includes individuals 18 years and older as of the first day of the measurement year who are continuously enrolled during the treatment period. Exclude patients who dis-enroll and re-enroll in the same plan more than one day later (i.e., >1 day gap in enrollment) after a valid treatment period, but prior to the end of the measurement year.

Step 2: Identify those individuals in Step 1 that have two or more prescription claims for the target class of medication (either Diabetes medication; or RAS Antagonist; or Statin)

Step 3: Exclude any individual in hospice or with end-stage renal disease.

Step 3a: For the PDC-DR rate: Also exclude any individual with one or more prescription claims for insulin during the treatment period.

Step 3b: For the PDC-RASA rate: Also exclude any individual with one or more prescription claims for the medication sacubitril/valsartan during the treatment period.

For EACH PDC rate, calculate the Numerator:

Step 1: Determine the individual's treatment period, defined as the Index Prescription Start Date to the end of the measurement year, disenrollment or death.

Step 2: Within the treatment period, count the days the individual was covered by at least one drug in the class (Diabetes; RASA; Statins) based on the prescription fill date and days of supply. If prescriptions for the same target 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 individual.

Step 4: Count the number of individuals who had a PDC of 80% or greater for medications within the specific therapeutic category.

*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 target drugs is common.

Measure Rate:

Report a rate for each of the following:

- Diabetes All Class (PDC-DR)
- Renin Angiotensin System Antagonists (PDC-RASA)
- Statins (PDC-STA)

Divide each numerator by the corresponding denominator and multiply by 100 to calculate each rate as a percentage.

Risk Adjustment (for Medicare- calculated separately for each therapeutic category)

- -identify and categorize the variables for risk adjustment:
    - Age (18-54; 55-64; 65-69; 70-74; 75-79; 80+)
    - Gender (Male; Female)
    - LIS/Dual Status (LIS and/or Dual eligible; Non-LIS/non-dual)
    - Disability status (Disability as reason for Medicare entitlement; Other)
- -Using a random-effects multivariable logistic regression model controlling for the plan-contract (generalized linear mixed model), the patient predicted probability of adherence is calculated after adjusting for the covariates identified above
- -for each plan-contract, the expected measure rate is calculated as the average of the patient predicted probability of adherence based on the multivariable logistic regression model
- -The risk-adjusted measure rate for each plan-contract is calculated as the ratio of the unadjusted measure scores to the expected score, multiplied by the aggregate unadjusted score for all Part D contracts. 114349| 135329| 135614

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 119011| 120823| 140881| 123834| 141592| 141015| 142428

Submission items

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

5.1 Identified measures: 1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia

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: Although the measures address adherence using the same methodology (i.e., proportion of days covered [PDC]), they have different areas of focus and different target populations.

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: 0003 : Bipolar Disorder: Assessment for diabetes

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

0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

0542 : Adherence to Chronic Medications

0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease

0545 : Adherence to Statins for Individuals with Diabetes Mellitus

0580 : Bipolar antimanic agent

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.

Appendix F: Pre-Evaluation Comments

Comment received as of June 12, 2019.

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

Submitted by Susan Funk on behalf of Sharon Sprenger, The Joint Commission

The value set for Rheumatoid Arthritis DMARD Therapy (2.16.840.1.113883.3.1564.2722) includes Brand Name Drugs. The Joint Commission recommends removing Brand Name TTYs, and use Semantic Clinical Drugs (SCDs). According to the CMS Measures Blueprint (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf), "...authoring guidance has encouraged developers NOT to included branded term types because changes in branded identifiers for any single "general drug" (such as Semantic Clinical Drug [SCD]) occur throughout the year and, even with the inclusion of value set addendum releases, there can be value sets that are out of synch with some implementer system content. Given that RxNorm application content (and all drug information vendor products) can be used to map from the more stable general identifier to a branded identifier, and from other code systems such as National Drug Code (NDC) or proprietary code systems, the branded RxNorm TTYs were often not included under the assumption that if an implementer had a different identifier, they could map from the more stable general identifier to a branded identifier, and from other code systems such as National Drug Code (NDC) or proprietary code systems, the branded RxNorm TTYs were often not included under the assumption that if an implementer had a different identifier, they could map to the included SCD RXCUI or GPCK RXCUI or any other TTY and ID according to the intention."

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