Diabetes

## Comprehensive Diabetes Care (CDC)

Summary of Changes to HEDIS 2016

* Added a method and value sets to identify discharges for the applicable required exclusions for the *HbA1c Control (<7.0%) for a Selected Population* indicator.
* Revised the requirements for urine protein testing for the *Medical Attention for Nephropathy* indicator; a screening or monitoring test meets criteria, whether the result is positive or negative.
* Removed the optional exclusion for polycystic ovaries.
* Added a *Note* clarifying optional exclusions.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

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| * Hemoglobin A1c (HbA1c) testing. * HbA1c poor control (>9.0%). * HbA1c control (<8.0%). * HbA1c control (<7.0%) for a selected population**\***. | * Eye exam (retinal) performed. * Medical attention for nephropathy. * BP control (<140/90 mm Hg). |

*\* Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.*

Eligible Population

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| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 18–75 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage  (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/ diagnosis | There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. |

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|  | *Claim/encounter data.* Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):   * At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. * At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).   *Pharmacy data*. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A). |

Table CDC-A: Prescriptions to Identify Members With Diabetes

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| Description | Prescription | | |
| Alpha-glucosidase inhibitors | * Acarbose | * Miglitol | |
| Amylin analogs | * Pramlinitide |  | |
| Antidiabetic combinations | * Alogliptin-metformin * Alogliptin-pioglitazone * Canagliflozin-metformin * Glimepiride-pioglitazone * Glimepiride-rosiglitazone * Glipizide-metformin | * Glyburide-metformin * Linagliptin-metformin * Metformin-pioglitazone * Metformin-repaglinide * Metformin-rosiglitazone * Metformin-saxagliptin | * Metformin-sitagliptin * Sitagliptin-simvastatin |
| Insulin | * Insulin aspart * Insulin aspart-insulin aspart protamine * Insulin detemir * Insulin glargine * Insulin glulisine | * Insulin isophane human * Insulin isophane-insulin regular * Insulin lispro * Insulin lispro-insulin lispro protamine * Insulin regular human | |
| Meglitinides | * Nateglinide | * Repaglinide | |
| Glucagon-like peptide-1 (GLP1) agonists | * Exenatide | * Liraglutide | * Albiglutide |
| Sodium glucose cotransporter 2 (SGLT2) inhibitor | * Canagliflozin | * Dapagliflozin | * Empagliflozin |
| Sulfonylureas | * Chlorpropamide * Glimepiride | * Glipizide * Glyburide | * Tolazamide * Tolbutamide |
| Thiazolidinediones | * Pioglitazone | * Rosiglitazone |  |
| Dipeptidyl peptidase-4 (DDP-4) inhibitors | * Alogliptin * Linagliptin | * Saxagliptin * Sitaglipin |  |

**Note:** Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Administrative Specification

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| Denominator | The eligible population.  **Note:** The eligible population for the HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied. |
| *Required exclusions for HbA1c Control  <7% for a Selected Population indicator* | Exclude members who meet any of the following criteria:   * 65 years of age and older as of December 31 of the measurement year. * *CABG.* Members discharged for CABG (CABG Value Set) during the measurement year or the year prior to the measurement year. To identify discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.  * *PCI*. Members who had PCI (PCI Value Set), in any setting, during the measurement year or the year prior to the measurement year. * *IVD.* Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. * At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set). * At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set). * *Thoracic aortic aneurysm.* Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. * At least one outpatient visit (Outpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set). * At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set). * Any of the following, in any setting, any time during the member’s history through December 31 of the measurement year. * *Chronic heart failure*. A diagnosis of chronic heart failure (Chronic Heart Failure Value Set). * *Prior MI*. A diagnosis of MI (MI Value Set). * *ESRD*. ESRD (ESRD Value Set; ESRD Obsolete Value Set). * *Chronic kidney disease (stage 4)*. Stage 4 chronic kidney disease (CKD Stage 4 Value Set). * *Dementia*. A diagnosis of dementia (Dementia Value Set; Frontotemporal Dementia Value Set). * *Blindness*. A diagnosis of blindness (Blindness Value Set). * *Amputation (lower extremity)*. Lower extremity amputation (Lower Extremity Amputation Value Set). |

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| Numerators |  |
| *HbA1c Testing* | An HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. |
| *HbA1c Poor Control >9%* | Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.  Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant. |

|  |  |
| --- | --- |
| Value Set | Numerator Compliance |
| HbA1c Level Less Than 7.0 Value Set | Not compliant |
| HbA1c Level 7.0–9.0 Value Set | Not compliant |
| HbA1c Level Greater Than 9.0 Value Set | Compliant |

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|  | **Note:** A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care). |
| *HbA1c Control <8%* | Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.  Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant. |

|  |  |
| --- | --- |
| Value Set | Numerator Compliance |
| HbA1c Level Less Than 7.0 Value Set | Compliant |
| HbA1c Level 7.0–9.0 Value Set | Not compliant\* |
| HbA1c Level Greater Than 9.0 Value Set | Not compliant |

**\*** The CPT Category II code (3045F) in this value set indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization must use other sources (laboratory data, hybrid reporting method) to identify the actual value and determine if the HbA1c result was <8%. Because providers assign the Category II code after reviewing test results, the date of service for the Category II code may not match the date of service for the HbA1c test found in other sources; if dates differ, use the date of service when the test was performed.

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| *HbA1c Control <7% for a Selected Population* | Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥7.0% or is missing a result, or if an HbA1c test was not performed during the measurement year.  Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant. |

|  |  |
| --- | --- |
| Value Set | Numerator Compliance |
| HbA1c Level Less Than 7.0 Value Set | Compliant |
| HbA1c Level 7.0–9.0 Value Set | Not compliant |
| HbA1c Level Greater Than 9.0 Value Set | Not compliant |

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|  | **Note:** This indicator uses the eligible population with additional eligible population criteria (e.g., removing members with required exclusions). |
| *Eye Exam* | An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:   * A 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.   Any of the following meet 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 (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy). * 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. |

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| *Medical Attention for Nephropathy* | A nephropathy screening or monitoring test ***or*** evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:   * A nephropathy screening or monitoring test (Urine Protein Tests Value Set). * Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set). * Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set). * Evidence of ESRD (ESRD Value Set). * Evidence of kidney transplant (Kidney Transplant Value Set). * A visit with a nephrologist, as identified by the organization’s specialty provider codes (no restriction on the diagnosis or procedure code submitted). * At least one ACE inhibitor or ARB dispensing event (Table CDC-L).   **Note:** A process flow diagram is included at the end of this specification to help implement this measure. |

Table CDC-L: ACE Inhibitors/ARBs

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| Description | Prescription | | | | | | |
| Angiotensin converting enzyme inhibitors | * Benazepril * Captopril | * Enalapril * Fosinopril | | * Lisinopril * Moexipril | * Perindopril * Quinapril | | * Ramipril * Trandolapril |
| Angiotensin II inhibitors | * Azilsartan * Candesartan | * Eprosartan * Irbesartan | | * Losartan * Olmesartan | * Telmisartan * Valsartan | |  |
| Antihypertensive combinations | * Aliskiren-valsartan * Amlodipine-benazepril * Amlodipine-hydrochlorothiazide-valsartan * Amlodipine-hydrochlorothiazide-olmesartan * Amlodipine-olmesartan * Amlodipine-telmisartan * Amlodipine-valsartan | | * Azilsartan-chlorthalidone * Benazepril-hydrochlorothiazide * Candesartan-hydrochlorothiazide * Captopril-hydrochlorothiazide * Enalapril-hydrochlorothiazide * Eprosartan-hydrochlorothiazide * Fosinopril-hydrochlorothiazide * Hydrochlorothiazide-irbesartan | | | * Hydrochlorothiazide-lisinopril * Hydrochlorothiazide-losartan * Hydrochlorothiazide-moexipril * Hydrochlorothiazide-olmesartan * Hydrochlorothiazide-quinapril * Hydrochlorothiazide-telmisartan * Hydrochlorothiazide-valsartan * Trandolapril-verapamil | |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

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| *BP Control <140/90 mm Hg* | Use automated data to identify the most recent BP reading taken during an outpatient visit (Outpatient Value Set) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.  The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. |

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|  | Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels. |

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| --- | --- |
| Value Set | Numerator Compliance |
| Systolic Less Than 140 Value Set | Systolic compliant |
| Systolic Greater Than/Equal To 140 Value Set | Systolic not compliant |
| Diastolic Less Than 80 Value Set | Diastolic compliant |
| Diastolic 80–89 Value Set | Diastolic compliant |
| Diastolic Greater Than/Equal To 90 Value Set | Diastolic not compliant |

Exclusions *(optional)*

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

Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the *HbA1c Control (<7.0%) for a Selected Population* denominator.

If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Hybrid Specification

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| Denominator | A systematic sample of 548 drawn from the eligible population for each product line. A sample size of 548 is based on the goal of achieving a sample of at least 411 for the HbA1c <7% denominator after required exclusions. The *HbA1c Control <7% for a Selected Population* indicator is not collected or reported for the Medicare product line. Organizations should use a sample size of 411 for the Medicare product line or if they do not report the *HbA1c Control <7% for a Selected Population* indicator.  Members who meet the required exclusion criteria for the *HbA1c Control <7% for a Selected Population* indicator are excluded from the denominator of the *HbA1c Control <7% for a Selected Population* indicator. Report this indicator as 548 minus the required exclusions.  If the sample drops below 411, use members from the oversample to maintain the MRSS. If the oversample was underestimated and all auxiliary members have been exhausted without satisfying the MRSS, per the *Guidelines for Calculations and Sampling*, the organization must contact NCQA to determine next steps.  **Note:** The eligible population for the HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied. |

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|  | The organization may reduce the sample size using the current year’s administrative rate or the prior year’s audited, product line-specific rate for the lowest rate among all the reported CDC indicators. The lowest rate for all reported indicators must be used when reducing the sample size.  If the organization chooses to reduce the sample size and report the *HbA1c Control <7% for a Selected Population* indicator, the sample size for this indicator must still be the appropriate sample size as specified in Table 1: Sample Sizes When Data Are Available on the Product Line Being Measured (in the *Guidelines for Calculations and Sampling)* after the required exclusions are removed. |
| *Required exclusions for HbA1c Control <7% for a Selected Population* |  |
| Administrative | Refer to *Administrative Specification* to identify required exclusions from administrative data. |
| Medical record | Exclude members who meet any of the following criteria:   * 65 years of age and older as of December 31 of the measurement year. * *CABG .* Dated documentation of CABG in the measurement year or the year before the measurement year. * *PCI.* Dated documentation of PCI in the measurement year or the year before the measurement year. * *IVD.* Documentation of an IVD diagnosis. Look as far back as possible in the member’s history through December 31 of the measurement year. Appropriate diagnoses include: * IVD. * Ischemic heart disease. * Angina. * Coronary atherosclerosis. * Coronary artery occlusion. * Cardiovascular disease. * Occlusion or stenosis of precerebral arteries (including basilar, carotid and vertebral arteries). * Atherosclerosis of renal artery. * Atherosclerosis of native arteries of the extremities. * Chronic total occlusion of artery of the extremities. * Arterial embolism and thrombosis. * Atheroembolism. * *Thoracoabdominal or thoracic aortic aneurysm.* Documentation of thoracoabdominal aneurysm or thoracic aortic aneurysm. Look as far back as possible in the member’s history through December 31 of the measurement year. * *CHF.* Documentation of CHFor cardiomyopathy diagno*sis.* Look as far back as possible in the member’s history through December 31 of the measurement year. |

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|  | * *Prior MI.* Documentation of prior MI. Look as far back as possible in the member’s history through December 31 of the measurement year. * *ESRD.* Documentation of stage 5 chronic kidney disease, ESRD or dialysis. Look as far back as possible in the member’s history through December 31 of the measurement year. * *Chronic kidney disease (stage 4).* Documentation of stage 4 chronic kidney disease. Look as far back as possible in the member’s history through December 31 of the measurement year. * *Dementia.* Documentation of dementia. Look as far back as possible in the member’s history through December 31 of the measurement year. * *Blindness.* Documentation of blindness in one or both eyes. Look as far back as possible in the member’s history through December 31 of the measurement year. * *Amputation (lower extremity).* Documentation of lower extremity amputation. Look as far back as possible in the member’s history through December 31 of the measurement year. |

**Note:** For Hybrid reporting, search the medical record for required exclusions and apply them before determining if the member has a numerator hit. Organizations are not required to search for required exclusions if a member has an administrative hit for the indicator, but must exclude these members if they are discovered during medical record review.

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| Numerators |  | | |
| *HbA1c Testing* | An HbA1c test performed during the measurement year as identified by administrative data or medical record review. | | |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. | | |
| Medical record | At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notation of the following in the medical record: | | |
|  | * A1c. * HbA1c. | * Hemoglobin A1c. * Glycohemoglobin A1c. | * HgbA1c. |
| *HbA1c Poor Control >9%* | The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review.  **Note:** A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care). | | |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. | | |
| Medical record | At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.  Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. | | |

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| *HbA1c Control <8%* | The *most recent* HbA1c level (performed during the measurement year) is <8.0% as identified by automated laboratory data or medical record review. |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. |
| Medical record | At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.  Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. |
| *HbA1c Control <7% for a Selected Population* | The *most recent* HbA1c level (performed during the measurement year) is <7.0% as identified by automated laboratory data or medical record review.  **Note:** This indicator uses the eligible population with additional eligible population criteria (i.e., removing members with comorbid conditions). |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. |
| Medical record | At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥7.0% or is missing, or if an HbA1c test was not performed during the measurement year.  Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. |
| *Eye Exam* | An eye screening for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:   * A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. * A *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year. |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. |
| 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 of retinal abnormalities 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. |

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|  | | * 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 for a dilated or retinal eye exam performed by an eye care professional (optometrist or ophthalmologist) meets criteria). | | |
| *Medical Attention for Nephropathy* | | A nephropathy screening or monitoring test during the measurement year ***or*** evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.  **Note:** A process flow diagram is included at the end of this specification to help implement this measure. | | |
| Administrative | | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. | | |
| Medical record | | Any of the following meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy.   * A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria: * 24-hour urine for albumin or protein. * Timed urine for albumin or protein. * Spot urine for albumin or protein. * Urine for albumin/creatinine ratio. * 24-hour urine for total protein. * Random urine for protein/creatinine ratio. * Documentation of a visit to a nephrologist. * Documentation of a renal transplant. * Documentation of medical attention for any of the following (no restriction on provider type): * Diabetic nephropathy. * ESRD. * Chronic renal failure (CRF). * Chronic kidney disease (CKD). * Renal insufficiency. * Proteinuria. * Albuminuria. * Renal dysfunction. * Acute renal failure (ARF). * Dialysis, hemodialysis or peritoneal dialysis. * Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year. | |
| *BP Control <140/90 mm Hg* | | The *most recent* BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review. |
| Administrative | | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. |

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| Medical record | | The organization should use the medical record from which it abstracts data for the other CDC indicators. If the organization does not abstract for other indicators, it should use the medical record of the provider that manages the member’s diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from whom the member receives care.  To determine if BP is adequately controlled, the organization must identify the representative BP following the steps below. |
| *Step 1* | | Identify the most recent BP reading noted during the measurement year. Do not include BP readings that meet the following criteria:   * Taken during an acute inpatient stay or an ED visit. * Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole). * Obtained the same day as a major diagnostic or surgical procedure (e.g., EKG/ECG, stress test, administration of IV contrast for a radiology procedure, endoscopy). * Reported by or taken by the member. |
| *Step 2* | Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading when multiple readings are recorded for a single date.  The member is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing). |

Exclusions *(optional)*

Refer to *Administrative* Specification for exclusion criteria. Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

*Note*

* *Organizations may select a data collection method (Administrative vs. Hybrid) at the indicator level, but the method used for HbA1c testing and control rates must be consistent.*
* *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*
* *Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting the eye exam indicator; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of the eye exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.*
* *If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*
* *If an organization chooses to apply the optional exclusions, members must be numerator negative for at least one indicator, with the exception of HbA1c Poor Control (>9%). Remove members from the eligible population who are numerator negative for any indicator (other than for HbA1c Poor Control [>9%]) and substitute members from the oversample. Do not exclude members who are numerator compliant for all indicators except HbA1c Poor Control (>9%), because a lower rate indicates better performance for this indicator.*

**Monitoring for Diabetic Nephropathy**

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CDC-1/2/3: Data Elements for Comprehensive Diabetes Care

|  |  |  |
| --- | --- | --- |
|  | Administrative | Hybrid |
| Measurement year | *Each of the 7 rates* | *Each of the 7 rates* |
| Data collection methodology (Administrative or Hybrid) | *Each of the 7 rates* | *Each of the 7 rates* |
| Eligible population with required exclusions applied | *Each of the 7 rates* | *Each of the 7 rates* |
| Number of numerator events by administrative data in eligible population  (before optional exclusions) |  | *Each of the 7 rates* |
| Current year’s administrative rate (before optional exclusions) |  | *Each of the 7 rates* |
| Minimum required sample size (MRSS) or other sample size |  | *Each of the 7 rates* |
| Oversampling rate |  | *Each of the 7 rates* |
| Final sample size (FSS) |  | *Each of the 7 rates* |
| Number of numerator events by administrative data in FSS |  | *Each of the 7 rates* |
| Administrative rate on FSS |  | *Each of the 7 rates* |
| Number of original sample records excluded because of valid data errors |  | *Each of the 7 rates* |
| Number of optional administrative data records excluded |  | *Each of the 7 rates* |
| Number of optional medical records excluded |  | *Each of the 7 rates* |
| Number of employee/dependent medical records excluded |  | *Each of the 7 rates* |
| Number of HbA1c <7 required medical records excluded |  | *HbA1c <7 Rate* |
| Number of HbA1c <7 required administrative data records excluded |  | *HbA1c <7 Rate* |
| Records added from the oversample list |  | *Each of the 7 rates* |
| Denominator |  | *Each of the 7 rates* |
| Numerator events by administrative data | *Each of the 7 rates* | *Each of the 7 rates* |
| Numerator events by medical records |  | *Each of the 7 rates* |
| Numerator events by supplemental data | *Each of the 7 rates* | *Each of the 7 rates* |
| Reported rate | *Each of the 7 rates* | *Each of the 7 rates* |
| Lower 95% confidence interval | *Each of the 7 rates* | *Each of the 7 rates* |
| Upper 95% confidence interval | *Each of the 7 rates* | *Each of the 7 rates* |

## Statin Therapy for Patients With Diabetes (SPD)

## Summary of Changes to HEDIS 2016

* First-year measure.

Description

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Definitions

|  |  |
| --- | --- |
| IPSD | Index prescription start date. The earliest prescription dispensing date for any statin medication of any intensity during the measurement year. |
| Treatment period | The period of time beginning on the IPSD through the last day of the measurement year. |
| PDC | Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period. |
| Calculating number of days covered for multiple prescriptions | If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.  If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year.  Use the drug ID provided by the NDC to determine if the prescriptions are the same or different. |

Eligible Population: *Rate 1*—Received Statin Therapy

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 40–75 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year and the year prior to the measurement year. |

|  |  |  |
| --- | --- | --- |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). | |
| Anchor date | December 31 of the measurement year. | |
| Benefit | Medical. Pharmacy during the measurement year. | |
| Event/ diagnosis | Follow the steps below to identify the eligible population. | |
| *Step 1* | There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.  *Claim/encounter data.* Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):   * At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or non-acute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. * At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).   *Pharmacy data*. Members who were dispensed insulin or hypoglycemics/ anti-hyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A). | |
| *Step 2:  Required exclusions* | Exclude members who meet any of the following criteria:   * Members with cardiovascular disease are identified in two ways: by event or by diagnosis. The organization must use *both* methods to identify this population, but a member only needs to be identified by one method to be excluded from the measure. * *Event.* Any of the following during the year prior to the measurement year meet criteria: * MI. Discharged from an inpatient setting with an MI (MI Value Set). To identify discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.  * CABG. Discharged from an inpatient setting with a CABG (CABG Value Set). To identify discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. |

|  |  |
| --- | --- |
|  | * PCI. Members who had PCI (PCI Value Set) in any setting. * Other revascularization. Members who had any other revascularization procedure (Other Revascularization Value Set) in any setting. * *Diagnosis.* Identify members as having ischemic vascular disease (IVD) who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. * At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set), ***or*** * At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set). * Pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. * In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year. * Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year. * ESRD (ESRD Value Set) during the measurement year or the year prior to the measurement year. * Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. * Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. |

Administrative Specification: *Rate 1*—Received Statin Therapy

|  |  |
| --- | --- |
| Denominator | The Rate 1 eligible population. |
| Numerator | The number of members who had at least one dispensing event for a statin medication of any intensity (Table SPD-A) during the measurement year. |

### Table SPD-A: High, Moderate and Low-Intensity Statin Prescriptions

|  |  |  |
| --- | --- | --- |
| Description | Prescription | |
| High-intensity statin therapy | * Atorvastatin 40–80 mg * Amlodipine-atorvastatin 40–80 mg * Ezetimibe-atorvastatin 40–80 mg | * Rosuvastatin 20–40 mg * Simvastatin 80 mg * Ezetimibe-simvastatin 80 mg |
| Moderate-intensity statin therapy | * Atorvastatin 10–20 mg * Amlodipine-atorvastatin 10–20 mg * Ezetimibe-atorvastatin 10–20 mg * Rosuvastatin 5–10 mg * Simvastatin 20–40 mg * Ezetimibe-simvastatin 20–40 mg * Niacin-simvastatin 20–40 mg * Sitagliptin-simvastatin 20–40 mg | * Pravastatin 40–80 mg * Aspirin-pravastatin 40–80 mg * Lovastatin 40 mg * Niacin-lovastatin 40 mg * Fluvastatin XL 80 mg * Fluvastatin 40 mg bid * Pitavastatin 2–4 mg |
| Low-intensity statin therapy | * Simvastatin 10 mg * Ezetimibe-simvastatin 10 mg * Sitagliptin-simvastatin 10 mg * Pravastatin 10–20 mg * Aspirin-pravastatin 20 mg | * Lovastatin 20 mg * Niacin-lovastatin 20 mg * Fluvastatin 20–40 mg * Pitavastatin 1 mg |

Eligible Population: *Rate 2*—Statin Adherence 80%

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Age | 40–75 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year and the year prior to the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical during the measurement year and the year prior. Pharmacy during the measurement year. |
| Event/diagnosis | All members who meet the numerator criteria for Rate 1. |

Administrative Specification: *Rate 2*—Statin Adherence 80%

|  |  |
| --- | --- |
| Denominator | The Rate 2 eligible population. |
| Numerator | The number of members who achieved a PDC of at least 80% during the treatment period. |
|  | Follow the steps below to identify numerator compliance. |
| *Step 1* | Identify the IPSD. The IPSD is the earliest dispensing event for any intensity statin medication (Table SPD-A) during the measurement year. |

|  |  |
| --- | --- |
| *Step 2* | To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year. |
| *Step 3* | Count the days covered by at least one prescription for statin medication during the treatment period. To ensure the measure does not give credit for supply that extends beyond the measurement year, subtract any days supply that extends beyond December 31 of the measurement year. |
| *Step 4* | Calculate the member’s PDC using the following equation.Round (using the .5 rule) to two decimal places.  Total Days Covered by a Statin Medication in the Treatment Period (step 3)  Total Days in Treatment Period (step 2) |
| *Step 5* | Sum the number of members whose PDC is ≥80% for the treatment period. |

Exclusion *(optional)*

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

If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SPD-1/2/3: Data Elements for Statin Therapy for Patients With Diabetes

|  |  |
| --- | --- |
| Data Elements | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | *Each of the 2 rates* |
| Number of required exclusions | *Rate 1* |
| Numerator events by administrative data | *Each of the 2 rates* |
| Numerator events by supplemental data | *Each of the 2 rates* |
| Reported rate | *Each of the 2 rates* |
| Lower 95% confidence interval | *Each of the 2 rates* |
| Upper 95% confidence interval | *Each of the 2 rates* |

Musculoskeletal Conditions

## Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Summary of Changes to HEDIS 2016

* Added a method and value sets to identify nonacute inpatient discharges for the event/diagnosis.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 18 years and older as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefits | Medical and pharmacy. |
| Event/ diagnosis | Two of the following with different dates of service on or between January 1 and November 30 of the measurement year. Visit type need not be the same for the two visits.   * Outpatient visit (Outpatient Value Set), with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set). * Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set). To identify nonacute inpatient discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the discharge date for the stay. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | Members who had at least one ambulatory prescription dispensed for a DMARD during the measurement year. There are two ways to identify members who received a DMARD: by claim/encounter data and by pharmacy data. The organization may use both methods to identify the numerator, but a member need only be identified by one method to be included in the numerator.  *Claim/encounter data*. A DMARD prescription (DMARD Value Set) during the measurement year.  *Pharmacy data*. Members who were dispensed a DMARD during the measurement year on an ambulatory basis (Table ART-C). |

Table ART-C: DMARDs

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | |
| 5-Aminosalicylates | * Sulfasalazine | | |
| Alkylating agents | * Cyclophosphamide | | |
| Aminoquinolines | * Hydroxychloroquine | | |
| Anti-rheumatics | * Auranofin * Gold sodium thiomalate | * Leflunomide * Methotrexate | * Penicillamine |
| Immunomodulators | * Abatacept * Adalimumab * Anakinra * Certolizumab | * Certolizumab pegol * Etanercept * Golimumab * Infliximab | * Rituximab * Tocilizumab |
| Immunosuppressive agents | * Azathioprine | * Cyclosporine | * Mycophenolate |
| Janus kinase (JAK) inhibitor | * Tofacitinib | | |
| Tetracyclines | * Minocycline | | |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org   
by November 2, 2015.

Exclusions *(optional)*

* A diagnosis of HIV (HIV Value Set) any time during the member’s history through December 31 of the measurement year.
* A diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table ART-1/2/3: Data Elements for DMARD Therapy for Rheumatoid Arthritis

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | ✓ |
| Number of optional exclusions | ✓ |
| Numerator events by administrative data | ✓ |
| Numerator events by supplemental data | ✓ |
| Reported rate | ✓ |
| Lower 95% confidence interval | ✓ |
| Upper 95% confidence interval | ✓ |

## Osteoporosis Management in Women Who Had a Fracture (OMW)

Summary of Changes to HEDIS 2016

* Defined “active prescription.”
* Revised the method and value sets to identify acute and nonacute inpatient events for steps 1 and 2 of the event/diagnosis.
* Clarified when to use admission or discharge dates when determining Negative Diagnosis History.
* Clarified that bone mineral density tests that occur in an inpatient setting (either during an inpatient IESD or during the 180-day (6-month) period after the IESD) meet numerator criteria.
* Added long-acting osteoporosis therapy administered during an inpatient IESD to the numerator.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Definitions

|  |  |
| --- | --- |
| Intake Period | A 12-month (1 year) window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture the first fracture. |
| IESD | Index Episode Start Date. The earliest date of service for any encounter during the Intake Period with a diagnosis of fracture.  *For an outpatient or ED visit,* the IESD is date of service.  *For an inpatient encounter,* the IESD is the date of discharge.  *For direct transfers,* the IESD is the discharge date from the last admission. |
| Negative Diagnosis History | A period of 60 days (2 months) prior to the IESD when the member had no diagnosis of fracture.  *For fractures requiring an inpatient stay,* use the date of admission to determine Negative Diagnosis History.  *For direct transfers,* use the first admission to determine the Negative Diagnosis History. |
| Active prescription | A prescription is considered active if the “days supply” indicated on the date the member filled the prescription is the number of days or more between that date and the relevant service date. |

Eligible Population

|  |  |
| --- | --- |
| Product line | Medicare. |
| Age | Women 67–85 years as of December 31 of the measurement year. |
| Continuous enrollment | 12 months (1 year) before the IESD through 180 days (6 months) after the IESD. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the continuous enrollment period. |
| Anchor date | IESD. |
| Benefits | Medical and pharmacy. |
| Event/ diagnosis | The earliest fracture during the Intake Period.  Follow the steps below to identify the eligible population. |
| *Step 1* | Identify all members who had either of the following during the Intake Period.   * An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set), for a fracture (Fractures Value Set). * An acute or nonacute inpatient discharge for a fracture (Fractures Value Set).  To identify acute and nonacute inpatient discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.   If the member had more than one fracture, include only the first fracture. |
| *Step 2* | Test for Negative Diagnosis History. Exclude members who had either of the following during the 60-day (2 months) period prior to the IESD.   * An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) for a fracture (Fractures Value Set). * An acute or nonacute inpatient discharge for a fracture (Fractures Value Set). To identify acute and nonacute inpatient discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.   *For an acute or nonacute inpatient IESD,* use the IESD date of admission to determine the 60-day period.  *For direct transfers,* use the first admission to determine the Negative Diagnosis History. |
| *Step 3* | Calculate continuous enrollment. Members must be continuously enrolled during the 12 months prior to the fracture through 180 days (6 months) post-fracture. |

|  |  |
| --- | --- |
| *Step 4: Required exclusions* | Exclude members who met any of the following criteria:   * Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the IESD. * Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medications Value Set) during the 365 days (12 months) prior to the IESD. * Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Table OMW-C) during the 365 days (12 months) prior to the IESD.   *For an acute or nonacute inpatient IESD,* use the IESD date of admission to determine the number of days prior to the IESD. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:   * A BMD test (Bone Mineral Density Tests Value Set), in any setting, on the IESD or in the 180-day (6-month) period after the IESD. * If the IESD was an inpatient stay, a BMD test (Bone Mineral Density Tests Value Set) during the inpatient stay. * Osteoporosis therapy (Osteoporosis Medications Value Set) on the IESD or in the 180-day (6-month) period after the IESD. * If the IESD was an inpatient stay, long-acting osteoporosis therapy (Long-Acting Osteoporosis Medications Value Set) during the inpatient stay. * A dispensed prescription to treat osteoporosis (Table OMW-C) on the IESD or in the 180-day (6-month) period after the IESD. |

Table OMW-C: Osteoporosis Therapies

|  |  |  |
| --- | --- | --- |
| Description | Prescription | |
| Biphosphonates | * Alendronate * Alendronate-cholecalciferol * Ibandronate | * Risedronate * Zoledronic acid |
| Other agents | * Calcitonin * Denosumab | * Raloxifene * Teriparatide |

**Note:** NCQA will post a comprehensive list of medications and NDC codes   
to www.ncqa.org by November 2, 2015.

*Note*

* *Fractures of finger, toe, face and skull are not included in this measure.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table OMW-3: Data Elements for Osteoporosis Management   
in Women Who Had a Fracture

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | ✓ |
| Number of required exclusions | ✓ |
| Numerator events by administrative data | ✓ |
| Numerator events by supplemental data | ✓ |
| Reported rate | ✓ |
| Lower 95% confidence interval | ✓ |
| Upper 95% confidence interval | ✓ |

Behavioral Health

## Antidepressant Medication Management (AMM)

Summary of Changes to HEDIS 2016

* Added a method and value sets to identify acute and nonacute inpatient discharges for required exclusions (step 2).
* Changed the description of “SSNRI antidepressants” to “SNRI antidepressants” in Table AMM-C.
* Added levomilnacipran to the description of “SNRI antidepressants” in TableAMM-C.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions

|  |  |
| --- | --- |
| Intake Period | The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year. |
| IPSD | Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the Intake Period. |
| Negative Medication History | A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication. |
| Treatment days | The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval. |

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 18 years and older as of April 30 of the measurement year. |
| Continuous enrollment | 105 days prior to the IPSD through 231 days after the IPSD. |
| Allowable gap | One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not  have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |

|  |  |
| --- | --- |
| **Anchor date** | IPSD. |
| **Benefits** | Medical and pharmacy. |
| Event/diagnosis | Follow the steps below to identify the eligible population, which is used for both rates. |
| *Step 1* | Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period. |
| *Step 2: Required exclusion* | Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:   * An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria: * AMM Stand Alone Visits Value Set ***with*** Major Depression Value Set. * AMM Visits Value Set ***with*** AMM POS Value Set ***and*** Major Depression Value Set. * An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set). * An acute or nonacute inpatient discharge with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.   *For a direct transfer*, use the discharge date from the last discharge. |
| *Step* *3* | Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD. |
| *Step* 4 | Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerators |  |
| *Effective Acute Phase Treatment* | At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) beginning on the IPSD through 114 days after the IPSD (115 total days). Continuous treatment allows gaps in medication treatment up to a total of  30 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.  Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days). |

Table AMM-C: Antidepressant Medications

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | |
| Miscellaneous antidepressants | * Bupropion | * Vilazodone | * Vortioxetine |
| Monoamine oxidase inhibitors | * Isocarboxazid * Phenelzine | * Selegiline * Tranylcypromine | |
| Phenylpiperazine antidepressants | * Nefazodone | * Trazodone | |
| Psychotherapeutic combinations | * Amitriptyline-chlordiazepoxide * Amitriptyline-perphenazine | | * Fluoxetine-olanzapine |
| SNRI antidepressants | * Desvenlafaxine * Duloxetine | * Levomilnacipran * Venlafaxine |  |
| SSRI antidepressants | * Citalopram * Escitalopram | * Fluoxetine * Fluvoxamine | * Paroxetine * Sertraline |
| Tetracyclic antidepressants | * Maprotiline | * Mirtazapine | |
| Tricyclic antidepressants | * Amitriptyline * Amoxapine * Clomipramine | * Desipramine * Doxepin (>6 mg) * Imipramine | * Nortriptyline * Protriptyline * Trimipramine |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to   
www.ncqa.org by November 2, 2015.

|  |  |
| --- | --- |
| *Effective Continuation Phase Treatment* | At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) beginning on the IPSD through 231 days after the IPSD (232 total days).  Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.  Regardless of the number of gaps, there may be no more than 51 gap days. Count any combination of gaps (e.g., two washout gaps of 25 days each, or two washout gaps of 10 days each and one treatment gap of 10 days). |

*Note*

* *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period specified.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AMM-1/2/3: Data Elements for Antidepressant Medication Management

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | ✓ |
| Number of required exclusions | ✓ |
| Numerator events by administrative data | *Each of the 2 rates* |
| Numerator events by supplemental data | *Each of the 2 rates* |
| Reported rate | *Each of the 2 rates* |
| Lower 95% confidence interval | *Each of the 2 rates* |
| Upper 95% confidence interval | *Each of the 2 rates* |

## Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Summary of Changes to HEDIS 2016

* Added value sets to identify acute inpatient encounters for step 4 of the event/diagnosis (for both Initiation and C&M Phase).
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

* *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
* *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of   
  the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Definitions

|  |  |
| --- | --- |
| Intake Period | The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year. |
| Negative Medication History | A period of 120 days (4 months) prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions. |
| IPSD | Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History. |
| Initiation Phase | The 30 days following the IPSD. |
| C&M Phase | The 300 days following the IPSD (10 months). |
| New Episode | The member must have a 120-day (4-month) Negative Medication History on or before the IPSD. |
| Continuous Medication Treatment | The number of medication treatment days during the 10-month follow-up period must be ≥210 days (i.e., 300 treatment days – 90 gap days). |
| Treatment days (covered days) | The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval). |

Eligible Population: *Rate 1—Initiation Phase*

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid(report each product line separately). |
| Ages | Six years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year. |
| Continuous enrollment | 120 days (4 months) prior to the IPSD through 30 days after the IPSD. |
| Allowable gap | None. |
| Anchor date | None. |
| Benefits | Medical and pharmacy. |
| Event/ diagnosis | Follow the steps below to identify the eligible population for the Initiation Phase. |
| *Step 1* | Identify all children in the specified age range who were dispensed an ADHD medication (Table ADD-A) during the 12-month Intake Period. |

Table ADD-A: ADHD Medications

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | |
| CNS stimulants | * Amphetamine-dextroamphetamine * Dexmethylphenidate | * Dextroamphetamine * Lisdexamfetamine | * Methylphenidate * Methamphetamine |
| Alpha-2 receptor agonists | * Clonidine | * Guanfacine |  |
| Miscellaneous ADHD medications | * Atomoxetine |  |  |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org   
by November 2, 2015.

|  |  |
| --- | --- |
| *Step 2* | Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History. |
| *Step 3* | Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD. |
| *Step 4* | Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. Any of the following meet criteria:   * An acute inpatient encounter (Acute Inpatient Value Set) with a principal mental health diagnosis (Mental Health Diagnosis Value Set). * An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of chemical dependency (Chemical Dependency Value Set). |

Administrative Specification: *Rate 1—Initiation Phase*

|  |  |
| --- | --- |
| Denominator | The Rate 1 eligible population. |
| Numerator | An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:   * ADD Stand Alone Visits Value Set. * ADD Visits Group 1 Value Set ***with*** ADD POS Group 1 Value Set. * ADD Visits Group 2 Value Set ***with*** ADD POS Group 2 Value Set.   **Note:** Do not count a visit on the IPSD as the Initiation Phase visit. |

Eligible Population: *Rate 2—C&M Phase*

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | Six years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year. |
| Continuous enrollment | Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.  Members who switch product lines between the Rate 1 and Rate 2 continuous enrollment periods are only included in Rate 1. |
| Allowable gap | One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | None. |
| Benefits | Medical and pharmacy. |
| Event/ diagnosis | Follow the steps below to identify the eligible population for the C&M Phase. |
| *Step 1* | Identify all members who meet the eligible population criteria for Rate 1—Initiation Phase. |
| *Step 2* | Calculate continuous enrollment. Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD. |
| *Step 3* | Calculate the continuous medication treatment. Using the members in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSD. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)  Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. |

|  |  |
| --- | --- |
|  | Regardless of the number of gaps, the total gap days may be no more than 90. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays). |
| *Step 4* | Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the IPSD. Any of the following meet criteria:   * An acute inpatient encounter (Acute Inpatient Value Set) with a principal mental health diagnosis (Mental Health Diagnosis Value Set). * An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of chemical dependency (Chemical Dependency Value Set). |

Administrative Specification: *Rate 2—C&M Phase*

|  |  |
| --- | --- |
| Denominator | The Rate 2 eligible population. |
| Numerator | Identify all members who meet the following criteria:   * Numerator compliant for *Rate 1—Initiation Phase,* ***and*** * At least two follow-up visits with any practitioner, from 31–300 days (9 months) after the IPSD.   One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:   * ADD Stand Alone Visits Value Set. * ADD Visits Group 1 Value Set ***with*** ADD POS Group 1 Value Set. * ADD Visits Group 2 Value Set ***with*** ADD POS Group 2 Value Set. * Telephone Visits Value Set. |

Exclusions *(optional)*

Exclude from the denominator for both rates, members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year.

*Note*

* *For members who have multiple overlapping prescriptions, count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).*
* *Refer to Appendix 3 for the definition of* prescribing practitioner*.*
* *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table ADD-1/2: Data Elements for Follow-Up Care for Children   
Prescribed ADHD Medication

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | *Each of the 2 rates* |
| Number of optional exclusions | *Each of the 2 rates* |
| Numerator events by administrative data | *Each of the 2 rates* |
| Numerator events by supplemental data | *Each of the 2 rates* |
| Reported rate | *Each of the 2 rates* |
| Lower 95% confidence interval | *Each of the 2 rates* |
| Upper 95% confidence interval | *Each of the 2 rates* |

## Follow-Up After Hospitalization for Mental Illness (FUH)

Summary of Changes to HEDIS 2016

* Added value sets to identify acute inpatient discharges, readmissions and transfer settings for the Event/ diagnosis.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days of discharge.
2. The percentage of discharges for which the member received follow-up within 7 days of discharge.

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 6 years and older as of the date of discharge. |
| Continuous enrollment | Date of discharge through 30 days after discharge. |
| Allowable gap | No gaps in enrollment. |
| Anchor date | None. |
| Benefits | Medical and mental health (inpatient and outpatient). |
| Event/ diagnosis | An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:   1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay.   The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. |
| *Acute readmission or direct transfer* | If the discharge is followed by readmission or direct transfer to an *acute inpatient care setting* for a principal mental health diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. |

|  |  |
| --- | --- |
|  | To identify readmissions to an acute inpatient care setting:   1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay.   Organizations must identify “transfers” using their own methods and then confirm the acute inpatient care setting using the steps above. |
| *Exclusions* | Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting:   1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay.   Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting:   1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay.   Organizations must identify “transfers” using their own methods and then confirm the acute inpatient care setting using the steps above.  These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerators |  |
| *30-Day  Follow-Up* | An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. |
| *7-Day  Follow-Up* | An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.  For both indicators, any of the following meet criteria for a follow-up visit:   * A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner. * A visit (FUH Visits Group 1 Value Set ***and*** FUH POS Group 1 Value Set) with a mental health practitioner. |

|  |  |
| --- | --- |
|  | * A visit (FUH Visits Group 2 Value Set ***and*** FUH POS Group 2 Value Set) with a mental health practitioner. * A visit in a behavioral healthcare setting (FUH RevCodes Group 1 Value Set). * A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a mental health practitioner. * A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set). * Transitional care management services (TCM 7 Day Value Set), where the date of service on the claim is 29 days after the eligible population event/diagnosis date of discharge.   The following meets criteria for only the 30-Day Follow-Up indicator:   * Transitional care management services (TCM 14 Day Value Set), where the date of service on the claim is 29 days after the event/diagnosis date of discharge.   **Note:** Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit. |

*Note*

* *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*
* *Refer to Appendix 3 for the definition of* mental health practitioner*.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-1/2/3: Data Elements for Follow-Up After   
Hospitalization for Mental Illness

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | ✓ |
| Numerator events by administrative data | *Each of the 2 rates* |
| Numerator events by supplemental data | *Each of the 2 rates* |
| Reported rate | *Each of the 2 rates* |
| Lower 95% confidence interval | *Each of the 2 rates* |
| Upper 95% confidence interval | *Each of the 2 rates* |

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

Summary of Changes to HEDIS 2016

* Added Other Bipolar Disorders Value Set to step 1 of the event/diagnosis.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

Eligible Population

|  |  |
| --- | --- |
| Product lines | Medicaid. |
| Ages | 18–64 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage  (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefits | Medical and pharmacy. |
| Event/ diagnosis | Follow the steps below to identify the eligible population. |
| *Step 1* | Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.   * At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria: * BH Stand Alone Acute Inpatient Value Set ***with*** Schizophrenia Value Set. * BH Stand Alone Acute Inpatient Value Set ***with*** Bipolar Disorder Value Set. * BH Stand Alone Acute Inpatient Value Set ***with*** Other Bipolar Disorder Value Set. * BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Schizophrenia Value Set. * BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Bipolar Disorder Value Set. * BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Other Bipolar Disorder Value Set. |

|  |  |  |
| --- | --- | --- |
|  | * At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: * BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Schizophrenia Value Set. * BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Schizophrenia Value Set. * ED Value Set ***with*** Schizophrenia Value Set. * BH ED Value Set ***with*** BH ED POS Value Set ***and*** Schizophrenia Value Set. * BH Stand Alone Nonacute Inpatient Value Set ***with*** Schizophrenia Value Set. * BH Nonacute Inpatient Value Set ***with*** BH Nonacute Inpatient POS Value Set ***and*** Schizophrenia Value Set. * At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria: * BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Bipolar Disorder Value Set. * BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Other Bipolar Disorder Value Set. * BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Bipolar Disorder Value Set. * BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Other Bipolar Disorder Value Set. * ED Value Set ***with*** Bipolar Disorder Value Set. * ED Value Set ***with*** Other Bipolar Disorder Value Set. * BH ED Value Set ***with*** BH ED POS Value Set ***and*** Bipolar Disorder Value Set. * BH ED Value Set ***with*** BH ED POS Value Set ***and*** Other Bipolar Disorder Value Set. * BH Stand Alone Nonacute Inpatient Value Set ***with*** Bipolar Disorder Value Set. * BH Stand Alone Nonacute Inpatient Value Set ***with*** Other Bipolar Disorder Value Set. * BH Nonacute Inpatient Value Set ***with*** BH Nonacute Inpatient POS Value Set ***and*** Bipolar Disorder Value Set. * BH Nonacute Inpatient Value Set ***with*** BH Nonacute Inpatient POS Value Set ***and*** Other Bipolar Disorder Value Set. | |
| *Step 2: Required exclusions* | Exclude members who met any of the following criteria:   * Members with diabetes. There are two ways to identify members with diabetes:  by claim/encounter data and by pharmacy data. The organization must use both methods to identify members with diabetes, but a member need only be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. * *Claim/encounter data.* Members who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years).   + At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. |

|  |  |
| --- | --- |
|  | * + At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). * *Pharmacy data.* Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table CDC-A). * Members who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/ encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. * *Claim/encounter data*. An antipsychotic medication (Long-Acting Injections Value Set). * *Pharmacy data*. Dispensed an antipsychotic medication (Table SSD-D) on an ambulatory basis. |

Table SSD-D: Antipsychotic Medications

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | |
| Miscellaneous antipsychotic agents | * Aripiprazole * Asenapine * Clozapine * Haloperidol * Iloperidone * Loxapine | * Lurisadone * Molindone * Olanzapine * Paliperidone * Pimozide * Quetiapine | * Quetiapine fumarate * Risperidone * Ziprasidone |
| Phenothiazine antipsychotics | * Chlorpromazine * Fluphenazine * Perphenazine | * Perphenazine-amitriptyline * Prochlorperazine | * Thioridazine * Trifluoperazine |
| Psychotherapeutic combinations | * Fluoxetine-olanzapine |  |  |
| Thioxanthenes | * Thiothixene |  |  |
| Long-acting injections | * Aripiprazole * Fluphenazine decanoate * Haloperidol decanoate | * Olanzapine * Paliperidone palmitate * Risperidone |  |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org   
by November 2, 2015.

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator |  |
| *Diabetes Screening* | A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. |

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SSD-1: Data Elements for Diabetes Screening for People With Schizophrenia or   
Bipolar Disorder Who Are Using Antipsychotic Medications

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | ✓ |
| Number of required exclusions | ✓ |
| Numerator events by administrative data | ✓ |
| Numerator events by supplemental data | ✓ |
| Reported rate | ✓ |
| Lower 95% confidence interval | ✓ |
| Upper 95% confidence interval | ✓ |

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

Summary of Changes to HEDIS 2016

* Removed the optional exclusion for polycystic ovaries.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

Eligible Population

|  |  |
| --- | --- |
| Product lines | Medicaid. |
| Ages | 18–64 years of age as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefits | Medical. |
| Event/ diagnosis | Follow the steps below to identify the eligible population. |
| *Step 1* | Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year:   * At least one acute inpatient encounter, with any diagnosis of schizophrenia. Either of the following code combinations meets criteria: * BH Stand Alone Acute Inpatient Value Set ***with*** Schizophrenia Value Set. * BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Schizophrenia Value Set. * At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: * BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Schizophrenia Value Set. * BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Schizophrenia Value Set. * ED Value Set ***with*** Schizophrenia Value Set. |

|  |  |
| --- | --- |
|  | * BH ED Value Set ***with*** BH ED POS Value Set ***and*** Schizophrenia Value Set. * BH Stand Alone Nonacute Inpatient Value Set ***with*** Schizophrenia Value Set. * BH Nonacute Inpatient Value Set ***with*** BH Nonacute Inpatient POS Value Set ***and*** Schizophrenia Value Set. |
| *Step 2* | Identify members from step 1 who also have diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member need only be identified by one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.  *Claim/encounter data.* Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):   * At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. * At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set).   *Pharmacy data*. Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A). |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | An HbA1c test (HbA1c Tests Value Set) and an LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. The member must have had both tests to be included in the numerator. The organization may use a calculated or direct LDL. |

Exclusions *(optional)*

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

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SMD-1: Data Elements for Diabetes Monitoring for People   
With Diabetes and Schizophrenia

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | ✓ |
| Number of optional exclusions | ✓ |
| Numerator events by administrative data | ✓ |
| Numerator events by supplemental data | ✓ |
| Reported rate | ✓ |
| Lower 95% confidence interval | ✓ |
| Upper 95% confidence interval | ✓ |

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

Summary of Changes to HEDIS 2016

* Added a method and value sets to identify discharges for step 2 of the event/diagnosis.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

Eligible Population

|  |  |
| --- | --- |
| Product lines | Medicaid. |
| Ages | 18–64 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year and the year prior to the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefits | Medical. |
| Event/ diagnosis | Follow the steps below to identify the eligible population. |
| *Step 1* | Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year:   * At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria: * BH Stand Alone Acute Inpatient Value Set ***with*** Schizophrenia Value Set. * BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Schizophrenia Value Set. * At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: * BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Schizophrenia Value Set. * BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Schizophrenia Value Set. * ED Value Set ***with*** Schizophrenia Value Set. |

|  |  |
| --- | --- |
|  | * BH ED Value Set ***with*** BH ED POS Value Set ***and*** Schizophrenia Value Set. * BH Stand Alone Nonacute Inpatient Value Set ***with*** Schizophrenia Value Set. * BH Nonacute Inpatient Value Set ***with*** BH Nonacute Inpatient POS Value Set ***and*** Schizophrenia Value Set. |
| *Step 2* | Identify members from step 1 who also have cardiovascular disease. Members are identified as having cardiovascular disease in two ways: by event or by diagnosis. The organization must use both methods to identify the eligible population, but a member need only be identified by one to be included in the measure.  *Event.* Any of the following during the year prior to the measurement year meet criteria:   * *AMI*. Discharged from an inpatient setting with an AMI (AMI Value Set). To identify discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.  * *CABG*. Discharged from an inpatient setting with a CABG (CABG Value Set). To identify discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.  * *PCI*. Members who had PCI (PCI Value Set) in any setting (e.g., inpatient, outpatient, ED).   *Diagnosis*. Identify members with IVD as those who met at least either of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.   * At least one outpatient visit (Outpatient Value Set) with a diagnosis of IVD (IVD Value Set). * At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of IVD (IVD Value Set). |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator |  |
| *LDL-C Test* | An LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.  The organization may use a calculated or direct LDL. |

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SMC-1: Data Elements for Cardiovascular Monitoring for   
People With Cardiovascular Disease and Schizophrenia

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | ✓ |
| Numerator events by administrative data | ✓ |
| Numerator events by supplemental data | ✓ |
| Reported rate | ✓ |
| Lower 95% confidence interval | ✓ |
| Upper 95% confidence interval | ✓ |

## Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)\*

\**This CMS measure has been adapted for use in HEDIS.*

Summary of Changes to HEDIS 2016

* Revised the IPSD time frame.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Definitions

|  |  |
| --- | --- |
| IPSD | Index prescription start date. The earliest prescription dispensing date for any antipsychotic medication during the measurement year. |
| Treatment period | The period of time beginning on the IPSD through the last day of the measurement year. |
| PDC | Proportion of days covered. The number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period. |
| Oral medication dispensing event | One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events.  Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the Drug ID to determine if the prescriptions are the same or different. |
| Long-acting injections dispensing event | Injections count as one dispensing event. Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event. |
| Calculating number of days covered for oral medications | *If multiple prescriptions for the same or different oral medications are dispensed on the same day,* calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.  *If multiple prescriptions for different oral medications are dispensed on different days,* count each day within the treatment period only once toward the numerator.  *If multiple prescriptions for the same oral medication are dispensed on different days,* sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic |

|  |  |
| --- | --- |
|  | prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap).  Use the Drug ID provided on the NDC list to determine if the prescriptions are the same or different. |
| Calculating number of days covered for long-acting injections | Calculate number of days covered (for the numerator) for long-acting injections using the days supply specified for the medication in Table SAA-A or in the value set name.  *For multiple J Codes or NDCs for the same or different medications on the same day,* use the medication with the longest days supply.  *For multiple J Codes or NDCs for the same or different medications on different days* with overlapping days supply, count each day within the treatment period only once toward the numerator. |

Eligible Population

|  |  |
| --- | --- |
| Product lines | Medicaid. |
| Ages | 19–64 years of age as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year.  To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage  (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefits | Medical and pharmacy. |
| Event/ diagnosis | Follow the steps below to identify the eligible population. |
| *Step 1* | Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year:   * At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria: * BH Stand Alone Acute Inpatient Value Set ***with*** Schizophrenia Value Set. * BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Schizophrenia Value Set. * At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: * BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Schizophrenia Value Set. * BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Schizophrenia Value Set. * ED Value Set ***with*** Schizophrenia Value Set. |

|  |  |  |
| --- | --- | --- |
|  | * BH ED Value Set ***with*** BH ED POS Value Set ***and*** Schizophrenia Value Set. * BH Stand Alone Nonacute Inpatient Value Set ***with*** Schizophrenia Value Set. * BH Nonacute Inpatient Value Set ***with*** BH Nonacute Inpatient POS Value Set ***and*** Schizophrenia Value Set*.* | |
| *Step 2: Required exclusions* | Exclude members who met at least one of the following during the measurement year.   * A diagnosis of dementia (Dementia Value Set). * *Did not* have at least two antipsychotic medication dispensing events, with at least one of the events occurring on or between January 1 and September 30. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. * *Claim/encounter data*. An antipsychotic medication (Long-Acting Injections 14 Days Supply Value Set or Long-Acting Injections 28 Days Supply Value Set). * *Pharmacy data*. Dispensed an antipsychotic medication (Table SAA-A) on an ambulatory basis. |

Table SAA-A: Antipsychotic Medications

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | Days Supply |
| Miscellaneous antipsychotic agents (oral) | * Aripiprazole * Asenapine * Clozapine * Haloperidol * Iloperidone * Loxapine * Lurisadone * Molindone | * Olanzapine * Paliperidone * Pimozide * Quetiapine * Quetiapine fumarate * Risperidone * Ziprasidone |  |
| Phenothiazine antipsychotics (oral) | * Chlorpromazine * Fluphenazine * Perphenazine * Perphenazine-amitriptyline | * Prochlorperazine * Thioridazine * Trifluoperazine |  |
| Psychotherapeutic combinations (oral) | * Fluoxetine-olanzapine |  |  |
| Thioxanthenes (oral) | * Thiothixene |  |  |
| Long-acting injections | * Aripiprazole * Fluphenazine decanoate * Haloperidol decanoate | * Olanzapine * Paliperidone palmitate | * 28 days supply |
| * Risperidone |  | * 14 days supply |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org  
by November 2, 2015.

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | The number of members who achieved a PDC of at least 80% for their antipsychotic medications (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the measurement year.  Follow the steps below to identify numerator compliance. |
| *Step 1* | Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the measurement year. |
| *Step 2* | To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year. |
| *Step 3* | Count the days covered by at least one antipsychotic medications (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the treatment period. To ensure that days supply that extend beyond the measurement year are not counted, subtract any days supply that extends beyond December 31 of the measurement year. |
| *Step 4* | Calculate the member’s PDC using the following equation. Round to two decimal places, using the .5 rule. |
|  | Total Days Covered by an Antipsychotic Medication in the Treatment Period (step 3) |
|  | Total Days in Treatment Period (step 2) |
| *Step 5* | Sum the number of members whose PDC is ≥80% for their treatment period. |

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SAA-1: Data Elements for Adherence to Antipsychotic   
Medications for Individuals With Schizophrenia

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | ✓ |
| Number of required exclusions | ✓ |
| Numerator events by administrative data | ✓ |
| Numerator events by supplemental data | ✓ |
| Reported rate | ✓ |
| Lower 95% confidence interval | ✓ |
| Upper 95% confidence interval | ✓ |

## Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Summary of Changes to HEDIS 2016

* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Eligible Population

|  |  |  |
| --- | --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). | |
| Ages | 1–17 years as of December 31 of the measurement year. Report three age stratifications and a total rate: | |
|  | * 1–5 years. * 6–11 years. | * 12–17 years. * Total. |
|  | The total is the sum of the age stratifications. | |
| Continuous enrollment | The measurement year. | |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. | |
| Anchor date | December 31 of the measurement year. | |
| Benefit | Medical and pharmacy. | |
| Event/ diagnosis | At least two antipsychotic medication dispensing events (Table APM-A) of the same or different medications, on different dates of service during the measurement year. | |

Table APM-A: Antipsychotic Medications

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | |
| First-generation antipsychotic medications | * Chlorpromazine HCL * Fluphenazine HCL * Fluphenazine decanoate * Haloperidol * Haloperidol decanoate | * Haloperidol lactate * Loxapine HCL * Loxapine succinate * Molindone HCL * Perphenazine | * Pimozide * Thioridazine HCL * Thiothixene * Trifluoperazine HCL |
| Second generation antipsychotic medications | * Aripiprazole * Clozapine * Iloperidone * Lurasidone * Olanzapine | * Olanzapine pamoate * Paliperidone * Paliperidone palmitate * Quetiapine fumarate * Risperidone | * Risperidone microspheres * Ziprasidone HCL * Ziprasidone mesylate |
| Combinations | * Olanzapine-fluoxetine HCL (Symbyax) | * Perphenazine-amitriptyline  HCL (Etrafon, Triavil [various]) | |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | Both of the following during the measurement year.   * At least one test for blood glucose (Glucose Tests Value Set) or HbA1c (HbA1c Tests Value Set). * At least one test for LDL-C (LDL-C Tests Value Set) or cholesterol (Cholesterol Tests Other Than LDL Value Set). |

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table APM-1/2: Data Elements for Metabolic Monitoring for Children and   
Adolescents on Antipsychotics

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | *For each age stratification and total* |
| Numerator events by administrative data | *For each age stratification and total* |
| Numerator events by supplemental data | *For each age stratification and total* |
| Reported rate | *For each age stratification and total* |
| Lower 95% confidence interval | *For each age stratification and total* |
| Upper 95% confidence interval | *For each age stratification and total* |