Measure Information Form

Measure Name

Specifications Tab

Descriptive Information

Measure Name (Measure Title De.2.)

NQF 2379: Adherence to Antiplatelet Therapy after Stent Implantation

Measure Type De.1.

Process

Brief Description of Measure De.3.

Average proportion of days covered (PDC) for individuals with antiplatelet therapy during the 12 months following implantation of a coronary artery drug-eluting stent (DES) regardless of indication or a bare-metal stent (BMS) for acute coronary syndrome (ACS).

If Paired or Grouped De.4.

Not applicable

Subject/Topic Areas De.5.

Cardiovascular: Cardiovascular
Cross-Cutting Areas: Disparities, Safety: Medication Safety

Measure Specifications

Measure-Specific Web Page S.1.

Not applicable

If This is an eMeasure S.2a.

Not applicable

Data Dictionary Code Table S.2b.

ICD-9 to ICD-10 Crosswalk and National Drug Code (NDC) Table are available in the attached file.

For Endorsement Maintenance S.3.

Not applicable

Numerator Statement S.4.

The sum of the days covered by the days' supply of all antiplatelet prescription drug claims during the days measured in the denominator

Time Period for Data S.5.

The measure requires 24 consecutive months of data.
Numerator time window: The time period is defined as the 12 consecutive months following earliest implantation of the coronary artery DES or the BMS or until the death date if the individual died within the 12 months following

earliest implantation of the coronary artery stent.

Numerator Details S.6.

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

Following are the antiplatelet medications ($P2Y_{12}$ receptor inhibitors). The route of administration includes all oral formulations of the medications listed below.

Table 1. $P2Y_{12}$ Receptor Inhibitors
clopidogrel
prasugrel
ticagrelor

Note: Obsolete drug products are excluded from NDCs with an inactive date more than three years prior to the beginning of the measurement period or look-back period, if applicable.

Denominator Statement S.7.

The sum of the days measured for all individuals who undergo a coronary artery DES regardless of indication or BMS for ACS at any time during the first 12 months of the 24-month measurement period and have at least two prescription drug claims for antiplatelet therapy during the 12 months following stent placement

Target Population Category S.8.

Populations at Risk: Populations at Risk
Populations at Risk: Dual eligible beneficiaries
Senior Care

Denominator Details S.9.

Target population meets the following conditions:
1. Continuously enrolled in Part D with no more than a one-month gap in enrollment during the measurement year and during the previous year;
2. Continuously enrolled in Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement year and the previous year; and,
3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement year and the previous year.

Index Event: Placement of coronary artery DES regardless of indication or BMS for ACS identified using a procedure code within the hospital inpatient or hospital outpatient claims data during the first 12 months of the 24-month measurement period

Days Measured: 365 days following placement of the stent or the number of days between stent placement and the individual's death

Table 2. Codes Used to Identify BMS Placement
Acute Inpatient Setting:
ICD-9-CM: 36.06
ICD-10-CM: 02700D6, 02700DZ, 02700T6, 02700TZ, 02703D6, 02703DZ, 02703T6, 02703TZ, 02704D6, 02704DZ, 02704T6, 02704TZ, 02710D6, 02710DZ, 02710T6, 02710TZ, 02713D6, 02713DZ, 02713T6, 02713TZ, 02714D6, 02714DZ, 02714T6, 02714TZ, 02720D6, 02720DZ, 02720T6, 02720TZ, 02723D6, 02723DZ, 02723T6, 02723TZ, 02724D6, 02724DZ, 02724T6, 02724TZ, 02730D6, 02730DZ, 02730T6, 02730TZ, 02733D6, 02733DZ, 02733T6,

02733TZ, 02734D6, 02734DZ, 02734T6, 02734TZ

Hospital Outpatient Department Setting:
ICD-9-CM: 36.06

ICD-10-CM: 02700D6, 02700DZ, 02700T6, 02700TZ, 02703D6, 02703DZ, 02703T6, 02703TZ, 02704D6, 02704DZ, 02704T6, 02704TZ, 02710D6, 02710DZ, 02710T6, 02710TZ, 02713D6, 02713DZ, 02713T6, 02713TZ, 02714D6, 02714DZ, 02714T6, 02714TZ, 02720D6, 02720DZ, 02720T6, 02720TZ, 02723D6, 02723DZ, 02723T6, 02723TZ, 02724D6, 02724DZ, 02724T6, 02724TZ, 02730D6, 02730DZ, 02730T6, 02730TZ, 02733D6, 02733DZ, 02733T6, 02733TZ, 02734D6, 02734DZ, 02734T6, 02734TZ

Other Outpatient Setting:
HCPCS: C1876, C1877CPT: 92980, 92981, 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944

Note: Effective January 1, 2013, 92980 and 92981 are replaced by 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, and 92944.

Table 3. Codes Used to Identify DES Placement
Acute Inpatient Setting:
ICD-9-CM: 36.07

ICD-10-CM: 0270046, 027004Z, 0270346, 027034Z, 0270446, 027044Z, 0271046, 027104Z, 0271346, 027134Z, 0271446, 027144Z, 0272046, 027204Z, 0272346, 027234Z, 0272446, 027244Z, 0273046, 027304Z, 0273346, 027334Z, 0273446, 027344Z

Hospital Outpatient Department Setting:
ICD-9-CM: 36.07

ICD-10-CM: 0270046, 027004Z, 0270346, 027034Z, 0270446, 027044Z, 0271046, 027104Z, 0271346, 027134Z, 0271446, 027144Z, 0272046, 027204Z, 0272346, 027234Z, 0272446, 027244Z, 0273046, 027304Z, 0273346, 027334Z, 0273446, 027344Z

Other Outpatient Setting:
HCPCS: C1874, C1875, C9600, C9601, C9602, C9603, C9604, C9605, C9606, C9607, C9608, G0290, G0291

Note: Effective January 1, 2013, G0290 and G0291 are replaced by C9600, C9601, C9602, C9603, C9604, C9605, C9606, C9607, and C9608.

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10.

1. Placements of a coronary artery BMS for a non-ACS indication are excluded.
2. Individuals with a history of contraindication(s) to antiplatelet therapy are excluded. Contraindications include peptic ulcer disease, intracranial hemorrhage, and gastrointestinal (GI) bleed.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.

Acute coronary syndrome is identified with any diagnosis listed below any time during the measurement period (24 months).

Table 4. Codes Indicating ACS
ICD-9-CM: 410.xx, 411.xx

ICD-10-CM*:* I20.0, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, 124.1, I24.8, I24.9, I25.110, I25.700, I25.710, I25.720, I25.730, I25.750, I25.760, I25.790

Contraindications are identified by any diagnosis listed below any time during the measurement period (24 months).

Table 5. Codes Indicating Contraindication to Antiplatelet Therapy

Peptic Ulcer Disease:
ICD-9-CM: V12.71, 531.xx, 532.xx, 533.xx

ICD-10-CM: K25.0, K25.1, K25.2, K25.3, K25.4, K25.5, K25.6, K25.7, K25.9, K26.0, K26.1, K26.2, K26.3, K26.4, K26.5, K26.6, K26.7, K26.9, K27.0, K27.1, K27.2, K27.3, K27.4, K27.5, K27.6, K27.7, K27.9, Z87.11

Intracranial Hemorrhage:
ICD-9-CM: 094.87, 430, 431, 432.x, 800.1x, 800.2x, 800.3x, 800.6x, 800.7x, 800.8x, 801.1x,801.2x, 801.3x, 801.6x, 801.7x, 801.8x, 803.1x, 803.2x, 803.3x, 803.6x, 803.7x, 803.8x, 804.1x,804.2x, 804.3x, 804.6x, 804.7x, 804.8x, 851.xx, 852.xx, 853.xx, 854.1x, 997.02

ICD-10-CM: A52.19, G97.31, G97.32, I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I97.810, I97.811, I97.820, I97.821, S01.90XA, S02.0XXA, S02.0XXB, S02.10XA, S02.10XB, S02.91XA, S02.91XB, S06.310A, S06.311A, S06.312A, S06.313A, S06.314A, S06.315A, S06.316A, S06.317A, S06.318A, S06.319A, S06.320A, S06.321A, S06.322A, S06.323A, S06.324A, S06.325A, S06.326A, S06.327A, S06.328A, S06.329A, S06.330A, S06.331A, S06.332A, S06.333A, S06.334A, S06.335A, S06.336A, S06.337A, S06.338A, S06.339A, S06.340A, S06.341A, S06.342A, S06.343A, S06.344A, S06.345A, S06.346A, S06.347A, S06.348A, S06.349A, S06.350A, S06.351A, S06.352A, S06.353A, S06.354A, S06.355A, S06.356A, S06.357A, S06.358A, S06.359A, S06.360A, S06.361A, S06.362A, S06.363A, S06.364A, S06.365A, S06.366A, S06.367A, S06.368A, S06.369A, S06.370A, S06.371A, S06.372A, S06.373A, S06.374A, S06.375A, S06.376A, S06.377A, S06.378A, S06.379A, S06.380A, S06.381A, S06.382A, S06.383A, S06.384A, S06.385A, S06.386A, S06.387A, S06.388A, S06.389A, S06.4X0A, S06.4X1A, S06.4X2A, S06.4X3A, S06.4X4A, S06.4X5A, S06.4X6A, S06.4X7A, S06.4X8A, S06.4X9A, S06.5X0A, S06.5X1A, S06.5X2A, S06.5X3A, S06.5X4A, S06.5X5A, S06.5X6A, S06.5X7A, S06.5X8A, S06.5X9A, S06.6X0A, S06.6X1A, S06.6X2A, S06.6X3A, S06.6X4A, S06.6X5A, S06.6X6A, S06.6X7A, S06.6X8A, S06.6X9A, S06.890A, S06.891A, S06.892A, S06.893A, S06.894A, S06.895A, S06.896A, S06.897A, S06.898A, S06.899A

Gastrointestinal Tract Hemorrhage:
ICD-9-CM: 456.0, 456.20, 530.7, 530.82, 534.xx, 537.83, 537.84, 562.02, 562.03, 562.12, 562.13, 569.3, 569.85, 569.86, 578.x

ICD-10-CM: I85.01, I85.11, K22.6, K22.8, K28.0, K28.1, K28.2, K28.3, K28.4, K28.5, K28.6, K28.7, K28.9, K31.811, K31.82, K55.21, K57.01, K57.11, K57.13, K57.21, K57.31, K57.33, K57.41, K57.51, K57.53, K57.81, K57.91, K57.93, K62.5, K63.81, K92.0, K92.1, K92.2

Stratification Details/Variables S.12.

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

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

*ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers.
See **Calculation Algorithm/Measure Logic S.18 below for physician group attribution methodology used for this measure.

Risk Adjustment Type S.13.

No risk adjustment or risk stratification

Statistical Risk Model and Variables S.14.

Not applicable

Detailed Risk Model Specifications S.15.

Not applicable

Type of Score S.16.

Rate/proportion

Interpretation of Score S.17.

Better quality = higher score

Calculation Algorithm/Measure Logic S.18.

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

Denominator: The sum of the days measured for all individuals who undergo a coronary artery DES regardless of indication or BMS for ACS at any time during the first 12 months of the 24-month measurement period and have at least two prescription drug claims for antiplatelet therapy during the 12 months following stent placement

Create Denominator:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.
2. Include eligible individuals who were continuously enrolled in Part D coverage during the measurement year and the previous year, meaning those individuals with no more than a one-month gap in enrollment during the measurement year and no more than a one-month gap in enrollment during the previous year.
3. Include fee-for-service (FFS) individuals only, meaning those who had no more than a one-month gap in Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during both the current measurement year and the previous year.
4. Pull all Part A claims with a procedure code indicating a coronary artery DES or BMS implantation that occurred during the first 12 months of the 24-month measurement period.
5. If the DES or BMS procedure is identified by only a HCPCS code, then use the discharge date as the procedure date.
6. Pull all Parts A and B claims for ACS during the measurement period.
7. For each individual who had claims for stent placements and ASC, identify the BMS claims with a procedure date on or between the start and end dates of the ACS claims. If the date of the ACS claim encompassed the date of the stent procedure, then the ACS diagnosis was considered to be associated with the stent. Otherwise, the stent was considered to be for a non-ACS indication.
8. Identify and exclude BMS claims with a non-ACS indication.
9. If there are multiple DES or BMS procedures for an individual, keep the claim with the earliest procedure date. Identify the date of the earliest stent implantation procedure as the index date.
10. Merge with the eligibility file from Step 3 to keep only those eligible individuals with a coronary artery stent implantation during the first 12 months of the 24-month measurement period.
11. Pull all Parts A and Part B claims for the 24-month period that indicated a contraindication to antiplatelet therapy. Use all diagnosis codes for identifying contraindications to pull the data.
12. Exclude individuals with a contraindication to antiplatelet therapy (Step 11 dataset) from the eligible individuals with a coronary artery stent implantation (Step 10 dataset).
13. Pull all Part D claims for the 24-month period for $P2Y_{12}$ receptor inhibitors and attach the drug ID and the generic name to the dataset.
14. Retain eligible Individuals with at least two Part D claims for $P2Y_{12}$ receptor inhibitors within the one-year period

after index stent implantation date.

15. For each individual, calculate the measurable days as the number of days from the index date (the earliest DES or BMS) to one year following the index date (365 days) or up until death, if death occurred within one year from the index date.
16. The denominator is the sum of the days measured for each individual.

Numerator: The sum of the days covered by the days' supply of all antiplatelet prescription drug claims during the days measured in the denominator

Create Numerator:

1. For each individual in the denominator, calculate the days covered by $P2Y_{12}$ receptor inhibitors during the year (365 days) following the index date or until death, without adjusting for hospitalization:
    a. Use the dataset from Step 15 of the denominator logic, sort and de-duplicate claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.
    b. Calculate the number of days covered by $P2Y_{12}$ receptor inhibitor therapy per individual.
        i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.
        ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.
        iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.
2. The measure numerator is the sum of the days covered for all eligible individuals.

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

Physician Group Attribution:

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

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all Part B claims in the measurement year and the prior year. Keep records with valid NPIs. Valid NPIs have 10 numeric characters (no alpha characters).
2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.
3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.
4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).
5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)
    a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.
    b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.
    c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

   d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.
6. Identify TINs that are not solo practices.
   a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.
   b. Count unique NPIs per TIN.
   c. Keep only those TINs having two or more providers.
   d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.
7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).
8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.
9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.
   a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.
   b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.
    a. Pull individuals with 11+ months of Parts A, B, & D during the measurement year.
    b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:
       - A = working-age individual/spouse with an employer group health plan (EGHP)
       - B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP
       - G = working disabled for any month of the year
    c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.
    d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.
    e. Exclude individuals who died during the measurement year.
11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.
    a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.
    b. Exclude claims with no npi_prfrmg.
12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Part B office claims from Step 12 with specialties indicating primary care, cardiology, or cardiac surgery (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.
    a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.
    b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.
14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.
15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.
16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

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

01—General practice*
02—General surgery

03—Allergy/immunology
04—Otolaryngology
05—Anesthesiology
06—Cardiology*
07—Dermatology
08—Family practice*
09—Interventional pain management
10—Gastroenterology
11—Internal medicine*
12—Osteopathic manipulative therapy
13—Neurology
14—Neurosurgery
16—Obstetrics/gynecology*
18—Ophthalmology
20—Orthopedic surgery
22—Pathology
24—Plastic and reconstructive surgery
25—Physical medicine and rehabilitation
26—Psychiatry
28—Colorectal surgery
29—Pulmonary disease
30—Diagnostic radiology
33—Thoracic surgery
34—Urology
36—Nuclear medicine
37—Pediatric medicine
38—Geriatric medicine*
39—Nephrology
40—Hand surgery
44—Infectious disease
46—Endocrinology
50—Nurse practitioner*
66—Rheumatology
70—Multi-specialty clinic or group practice*
72—Pain management
76—Peripheral vascular disease
77—Vascular surgery
78—Cardiac surgery*
79—Addiction medicine
81—Critical care (intensivists)
82—Hematology
83—Hematology/oncology
84—Preventive medicine*
85—Maxillofacial surgery
86—Neuropsychiatry
90—Medical oncology
91—Surgical oncology
92—Radiation oncology
93—Emergency medicine
94—Interventional radiology
97—Physician assistant*
98—Gynecologist/oncologist
99—Unknown physician specialty

Other—NA
*Provider specialty codes specific to this measure

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.

Not applicable

Sampling S.20.

Not applicable; this measure does not use a sample or survey.

Survey/Patient-Reported Data S.21.

Not applicable; this measure does not use a sample or survey.

Missing Data S.22.

To reduce the potential for measure result bias, patients who have prescription drug claims with missing days' supply are excluded from the analysis.

Data Source S.23.

Administrative claims
Electronic Clinical Data: Pharmacy
Other: Please see next section for further details

Data Source or Collection Instrument S.24.

For measure calculation, the following Medicare files are required:

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

For ACO attribution, the following are required:

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

For physician group attribution, the following are required:

- Non-institutional claims (Part B)—physician carrier/non-DME
- Denominator tables to determine individual enrollment
- Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payer status
- CMS physician and physician specialty tables

Payer Source

- Medicare fee-for-service
- Prescription Drug Plans (PDP)

Data Source or Collection Instrument (Reference) S.25.

Not applicable

Level of Analysis S.26.

Clinician: Group/Practice

Health Plan
Integrated Delivery System
Population: State

Care Setting S.27.

Ambulatory Care: Clinician Office/Clinic

Composite Performance Measure S.28.

Not applicable

Version Number and Effective Date

Version 3.0
January 1, 2013 – December 31, 2013

Measure Steward

Centers for Medicare & Medicaid Services (CMS)
Point of Contact: CMS Measures Management System, CMS.Measures.Inventory@hsag.com
Measure Developer: FMQAI, 5201 W. Kennedy Blvd., Suite 900, Tampa, Florida, 33609

Copyright/Disclaimer