Measure Information Form

Measure Name

Specifications Tab

Descriptive Information

Measure Name (Measure Title De.2.)

NQF 2467: Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus

Measure Type De.1.

Process

Brief Description of Measure De.3.

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with diabetes mellitus who had at least two prescription drug claims for angiotensin converting enzyme inhibitors (ACEIs)/angiotensin receptor blockers (ARBs) and had a Proportion of Days Covered (PDC) of at least 0.8 for ACEIs/ARBs during the measurement period (12 consecutive months)

If Paired or Grouped De.4.

This measure is paired with

- NQF 0545: Adherence to Statins for Individuals with Diabetes Mellitus
- NQF 2468: Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus

Diabetic patients often require chronic treatment with oral diabetes agents, statins, and/or ACEIs/ARBs to lower their risk of diabetic complications, adverse cardiovascular disease outcomes, and mortality. Adherence to chronic medication regimens has been documented in the literature to be less than optimal. Poor adherence can reduce the effectiveness of treatment, and interventions to improve adherence can provide opportunities for quality improvement.

Subject/Topic Areas De.5.

Endocrine: Endocrine
Endocrine: Diabetes
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.

Date Endorsed: September 23, 2011
Previously endorsed as a submeasure of NQF 545: Adherence to Chronic Medications for Individuals with Diabetes Mellitus.

The age requirement for the target population was changed from 18 years of age or older as of the end of the measurement period to 18 years of age or older as of the beginning of the measurement period to harmonize with other measures in the portfolio. ICD-9-CM, ICD-10-CM, and National Drug Codes have been updated annually. Optional criteria to stratify the measure between new and continuous users were removed to harmonize with other NQF-endorsed measures. The new drugs on the market that are applicable to the measure have been added to the medication list, and agents that have been discontinued for more than three years have been removed.

Numerator Statement S.4.

Individuals with diabetes mellitus who had at least two prescription drug claims for ACEIs/ARBs and have a PDC of at least 0.8 for ACEIs/ARBs

Time Period for Data S.5.

The time period for data is defined as any time during the measurement period (12 consecutive months).

Numerator Details S.6.

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

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

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

Denominator Statement S.7.

Individuals at least 18 years of age as of the beginning of the measurement period with diabetes mellitus and at least two prescription drug claims for ACEIs/ARBs during the measurement period (12 consecutive months)

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

IDENTIFICATION OF DIABETES MELLITUS

Individuals with diabetes mellitus are identified using diagnosis codes and/or drug proxy to identify diabetes mellitus within the inpatient or outpatient claims data.*

Individuals must have:
At least two encounters with a principal or secondary diagnosis of diabetes with different dates of service in an outpatient setting or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a principal or secondary diagnosis of diabetes in an acute inpatient or emergency department setting during the measurement period;

OR

At least one prescription drug claim for insulin or other oral diabetes medication dispensed during the measurement period.

*Adapted from NCQA HEDIS 2012 (2012). Note: HEDIS uses a look-back period of one year for both the prescription data and diagnosis.

Table 1. Codes Used to Identify Diabetes Mellitus Diagnosis

ICD-9-CM: 250.xx, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

ICD-10-CM: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.40, E08.42, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.40, E09.42, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13, O24.311, O24.312, O24.313, O24.319, O24.32, O24.33, O24.811, O24.812, O24.813, O24.819, O24.82, O24.83, O24.911, O24.912, O24.913, O24.919, O24.92, O24.93

DRG: 637,638

CODES USED TO IDENTIFY ENCOUNTER TYPE

Table 2.1. Outpatient Setting

CPT: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

UB-92 revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983

Table 2.2 Non-Acute Inpatient

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

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x

Table 2.3 Acute Inpatient

CPT: 99221-99223, 99224-99226, 99231-99233, 99238, 99239, 99251-99255, 99291

UB-92 revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987

Table 2.4 Emergency Department
CPT: 99281-99285
UB-92 revenue: 045x, 0981

The following are the diabetic medications by class for the denominator. The route of administration includes all oral and injectable formulations of the medications listed below.

Table 3. Codes Used to Identify Diabetic Individuals

Alpha-Glucosidase Inhibitors:
acarbose
miglitol

Anti-Diabetic Amylin Analogs:
pramlintide

Anti-Diabetic Combinations:
alogliptin-metformin
alogliptin-pioglitazone
glipizide-metformin
glyburide-metformin
pioglitazone-glimepiride
pioglitazone-metformin
rosiglitazone-glimepiride
rosiglitazone-metformin
saxagliptin-metformin
sitagliptin-metformin
repaglinide-metformin
sitagliptin-simvastatin
linagliptin- metformin

Dipeptidyl Peptidase-4 (dpp-4) Inhibitors:
alogliptin
sitagliptin
saxagliptin
linagliptin

Incretin Mimetics:
exenatide
liraglutide

Insulin:
insulin aspart
insulin aspart
protamine & aspart (human)
insulin detemir
insulin glargine
insulin glulisine
insulin isophane & reg (human)
insulin isophane (human)
insulin lispro (human)
insulin lispro protamine & lispro (human)
insulin regular (human)

Meglitinides:
nateglinide
repaglinide

Sodium-Glucose Co-Transporter 2 Inhibitors:
canagliflozin

Sulfonylureas:
chlorpropamide
glimepiride
glipizide
glyburide
tolazamide
tolbutamide
glyburide micronized

Thiazolidinediones:
pioglitazone
rosiglitazone

The following are the ACEI/ARB medications by class for the denominator. The route of administration includes all oral formulations of the medications listed below.

Table 4. ACEI/ARB Medications
Angiotensin-Converting Enzyme Inhibitors (ACEIs):
benazepril
captopril
enalapril
fosinopril
lisinopril
moexipril
perindopril
quinapril
ramipril
trandolapril

Angiotensin II Receptor Blockers (ARBs):
candesartan
eprosartan
irbesartan
losartan
olmesartan
telmisartan
valsartan
azilsartan

Antihypertensive Combinations:
aliskiren-valsartan
amlodipine-benazepril
amlodipine-olmesartan
amlodipine -valsartan
amlodipine-valsartan-hydrochlorothiazide
benazepril-hydrochlorothiazide
candesartan-hydrochlorothiazide

captopril-hydrochlorothiazide
enalapril maleate-hydrochlorothiazide
eprosartan-hydrochlorothiazide
fosinopril-hydrochlorothiazide
irbesartan-hydrochlorothiazide
lisinopril- hydrochlorothiazide
lisinopril-dietary management product
losartan-hydrochlorothiazide
moexipril-hydrochlorothiazide
olmesartan-hydrochlorothiazide
olmesartan medoxomil-amlodipine-hydrochlorothiazide
quinapril-hydrochlorothiazide
telmisartan-amlodipine
telmisartan-hydrochlorothiazide
trandolapril-verapamil
valsartan-hydrochlorothiazide
amlodipine-olmesartan-hydrochlorothiazide
azilsartan medoxomil-chlorthalidone

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

1. Individuals with a diagnosis of polycystic ovaries who do not have a visit with a diagnosis of diabetes in any setting during the measurement period*
2. Individuals with a diagnosis of gestational diabetes or steroid-induced diabetes who do not have a visit with a diagnosis of diabetes mellitus in any setting during the measurement period

*Adapted from NCQA HEDIS 2013 (2013). Note: HEDIS uses a look-back period of one year prior to the measurement period for both the prescription data and diagnosis.

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

Table 5. Diagnostic Exclusions for Diabetes Denominator

Polycystic Ovaries:
ICD-9-CM: 256.4
ICD-10-CM: E28.2

Steroid-Induced Diabetes:
ICD-9-CM: 249.xx, 251.8, 962.0
ICD-10-CM: E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.41, E08.42, E08.43, E08.44, E08.49, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E16.8, T38.0X1A, T38.0X2A, T38.0X3A, T38.0X4A, T50.0X1A, T50.0X2A, T50.0X3A, T50.0X4A

Gestational Diabetes:
ICD-9-CM: 648.80, 648.81, 648.82, 648.83, 648.84
ICD-10-CM: O24.410, O24.414, O24.419, O24.420, O24.424, O24.429, O24.430, O24.434, O24.439, O99.810, O99.814, O99.815

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: Individuals at least 18 years of age as of the beginning of the measurement period with diabetes mellitus and at least two prescription drug claims for ACEIs/ARBs during the measurement period (12 consecutive months)

Create Denominator:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.
2. Include individuals who were continuously enrolled in Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.
3. Include individuals who had no more than a one-month gap in Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).
4. Of those individuals identified in Step 3, keep those who had:
   At least two encounters with a principal or secondary diagnosis of diabetes with different dates of service in an outpatient setting or non-acute inpatient setting during the measurement period;
   OR
   At least one encounter with a principal or secondary diagnosis of diabetes in an acute inpatient setting or emergency department setting during the measurement period;
   OR
   At least one prescription drug claim for insulin or other oral diabetes medication dispensed during the measurement period.
5. Of the individuals identified in Step 4, exclude those with a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes who do not have at least one visit with a diagnosis of diabetes in any setting during the measurement period.
6. For the remaining individuals, extract Part D claims for any ACEIs and ARBs. Attach generic name and drug ID to

the dataset.

7. Of the individuals identified in Step 6, exclude those who did not have at least two Part D claims for any ACEI/ARB on different dates of service during the measurement period.

Numerator: Individuals with diabetes mellitus who had at least two prescription drug claims for ACEIs/ARBs and have a PDC of at least 0.8 for ACEIs/ARBs

Create Numerator:

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

1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an ACEI/ARB medication in the measurement period.
2. Within the medication therapy period, count the days the individual was covered by at least one drug in the ACEI/ARB class based on the prescription drug claim service date and days of supply.
    a. Sort and de-duplicate Part D ACEI/ARB 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 ACEI/ARB therapy per individual.
        i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.
        ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.
        iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.
3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

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

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

Physician Group Attribution:

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

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPI) combinations from all 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, cardiac surgery, endocrinology or nephrology (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 (PDPs)

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 1.0
January 1, 2013 – December 31, 2013

Measure Steward

Centers for Medicare & Medicaid Services (CMS)
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