Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication Measure (NQF 3313)

Technical Specifications and Resource Manual

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Center for Medicaid and CHIP Services

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ACKNOWLEDGMENTS

The Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication measure is maintained by the Lewin Group under the Home and Community-Based Services (HCBS) Measures Development, Endorsement, Maintenance, and Alignment project for the Centers for Medicare & Medicaid Services (CMS), contract HHSM-500-2014-00033I, Task Order #75FCMC19F0004.

For Proprietary Codes:

Limited proprietary coding is contained in the measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. Lewin disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT) © or other codes contained in the specifications. Professional organizations frequently update their codes. In this manual, we describe the value sets we used to specify and test the measure with 2020 data. In the Excel attachment, we provide value sets used to calculate the measure's numerator and denominator. We recommend that states seek input from their clinical experts to identify current codes.

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NDCs were updated using Medispan and FirstDataBank files in April 2020. NDC codes are subject to frequent changes so measure users should update these codes.

Code vocabularies other than NDC were updated in May 2020.

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I. BACKGROUND

These technical specifications focus on a measure for adult Medicaid beneficiaries, age 18 and older, who are newly prescribed an antipsychotic medication during the measurement year. Specifically, this manual is for the following measure:

- NQF 3313: Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.

This measure was developed for the CMS Medicaid Innovation Accelerator Program (IAP) area to improve quality of care for beneficiaries with physical and mental health (PMH) integration needs. This measure can be used by states, providers, and other stakeholders for quality improvement purposes.

The measure steward is CMS and this measure is constructed from Medicaid administrative and claims data. The technical specifications in Chapter III of this manual provide additional details of the measure.

II. DATA COLLECTION

To support consistency in reporting NQF 3313, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapter III and provide detailed information on how to calculate the measure.

Data Collection and Preparation for Reporting

- **Version of specifications**. This manual includes the most applicable version of the measure specifications available as of March 2021.
- **Value sets**. This measure specification references value sets that must be used for calculating the measure. A value set is the complete set of codes used to identify a service or drug included in a measure. See the attached required value sets.
- **Data collection time frames for measure**. This measure requires a data collection period of 16 months in total, from September 1 of the year prior to the measurement year to December 31 of the measurement year (for example, September 1, 2018 to December 31, 2019). The measurement period is 11 months from January 1 to November 30 of the measurement year (for example, January 1 to November 30, 2019). The look-back period requires 4 months of data from the year prior to the measurement year to determine whether a given antipsychotic prescription is a "new" prescription (for example, September 1 to December 31, 2018). An additional 1 month of data after November 30 of the measurement year is required (for example, November 30, 2019 to December 31, 2019) to allow for the follow-up period.
- **Continuous enrollment**. This refers to the time frame during which a beneficiary must be eligible for benefits in order for the beneficiary to be included in the measure. This measure requires enrollment in Medicaid during the four months prior to and the four weeks following a new prescription of an antipsychotic medication.
- **Allowable gap**. Some measures specify an allowable gap that can occur during continuous enrollment. This measure does not have an allowable gap.
- **Retroactive eligibility.** This refers to the time between the actual date when Medicaid became financially responsible for a beneficiary and the date when it received notification of the new member's eligibility. This measure does not apply retroactive eligibility.
- **Anchor date**. Some measures include an anchor date, which is the date that an individual must be enrolled and have the required benefit to be eligible for the measure. This measure does not have an anchor date.
- **Date specificity**. A date must be specific enough to determine that an event occurred during the time frame in the measure. There are instances when documentation of the year alone is adequate; for example, most optional exclusions and measures look for events in the "measurement year or the year prior to the

measurement year.” Terms such as “recent,” “most recent,” or “at a prior visit” are not acceptable.

- **Reporting unit**. The reporting unit is the state.
- **Eligible population for measurement**. The measure includes Medicaid beneficiaries who satisfy measure-specific eligibility criteria (e.g., age, continuous enrollment, benefit, and event).
- **Members with partial benefits.** States should include only Medicaid beneficiaries who are eligible to receive the services assessed in the numerator. If a beneficiary is not eligible to receive the services assessed in the measure, the beneficiary should not be included in the measure. Each state should assess the specific benefit packages of the beneficiaries in their state.
- **Aggregating information for state-level reporting**. To obtain a state-level rate for a measure that is developed from the rates of multiple units of measurement (such as multiple managed care organizations [MCOs]), the state should calculate a weighted average of the individual rates. How much any one entity (for example, individual MCOs) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that reporting units with larger eligible populations will contribute more toward the rate than those with smaller eligible populations.
- **Age criteria.** This measure applies to Medicaid FFS and managed care beneficiaries who are 18 years or older as of the first date of the measurement period (January 1).
- **Exclusions.** Some measure specifications contain required exclusions. For this measure, prescriptions for Medicaid beneficiaries who meet exclusion criteria should be removed from the measure. This measure excludes Medicaid beneficiaries who died or had an inpatient hospital stay during the four-week follow-up period following prescription of a new antipsychotic medication. States may require other exclusions as appropriate for their Medicaid programs and recipients.
- **Representativeness of data**. States should use the most complete data available and ensure that the rates reported are representative of the entire eligible population for the measure.
- **Data collection methods**. The data for this measure are collected from Medicaid and Medicare administrative claims and eligibility files.
- **Sampling**. This measure includes all FFS and managed care Medicaid beneficiaries age 18 and older who meet the denominator criteria. The measure does not require a sampling methodology.
- **Small numbers.** If a measure has a denominator that is less than 11, the state may choose not report the measure due to small numbers.
- **Risk adjustment.** This measure does not require risk adjustment.

III. TECHNICAL SPECIFICATIONS

This chapter presents the technical specifications for the measure of follow-up care for adult Medicaid beneficiaries who are newly prescribed an antipsychotic medication. The specification includes a description of the measure and information about the eligible population, key definitions, data collection method(s), instructions for calculating the measure, and any other relevant measure information.

NQF 3313: FOLLOW-UP CARE FOR ADULT MEDICAID BENEFICIARIES WHO ARE NEWLY PRESCRIBED AN ANTIPSYCHOTIC MEDICATION

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have an associated follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to prescriptions for Medicaid beneficiaries ages 18 and older.
- This measure uses the following administrative data claims or encounter data and pharmacy claims:
  - State Medicaid Management Information System (MMIS), MSIS, or T-MSIS files: Personal Summary (PS) file, Prescription Drug (RX) file, Inpatient (IP) file, Other Therapy (OT) file
  - Medicare Beneficiary Summary File (MBSF) and MedPAR file
  - Medicare Parts A, B, and D data for dual-eligible beneficiaries

The following coding systems are used in this measure: Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and National Drug Codes (NDC). Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Term	Definition
Newly prescribed	A prescription is considered to be a “newly prescribed” antipsychotic medication if the beneficiary prescribed the medication had no antipsychotic medications of any type dispensed during a period of 120 days (four months) prior to the prescription fill date. Antipsychotic medications are identified using NDCs. The value sets for the measure are attached.
Follow-up period	The four-week (28 day) period following the prescription of a new antipsychotic medication. The day after the prescription is counted as day 1 of the follow-up period.
Measurement period	January 1 to November 30 (11 months) of the measurement year.

C. ELIGIBLE POPULATION

Term	Description
Age	18 years and older as of the first day of the measurement period (January 1).
Continuous enrollment	Beneficiaries must be enrolled in Medicaid during the four months prior to and the four weeks following a new prescription of an antipsychotic medication.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefits	Medical (including mental health) and pharmacy
Exclusions	(1) Medicaid beneficiaries who had an acute inpatient admission during the four-week follow-up period after prescription of an antipsychotic medication. (2) Medicaid beneficiaries who died within four weeks of the new prescription date.

Term	Description
Event/diagnosis	Step 1: Identify Eligible Population: • Step 1A: Identify Medicaid beneficiaries (both dual-eligible and Medicaid-only enrollees) age 18 years and older. • Step 1B: From this group, identify new prescriptions of one or more antipsychotic medications. Step 2: Apply Continuous Enrollment Requirement From the population identified in step 1: • Step 2A: Remove any prescriptions for beneficiaries who were not continuously enrolled for at least four months before or four weeks following the new prescription. Step 3: Apply Exclusions From the population identified in step 2: • Step 3A: Remove any prescriptions for beneficiaries who had an acute inpatient admission during the four weeks following the fill date of the new prescription. • Step 3B: Remove any prescriptions for beneficiaries who died during the four weeks following the fill date of the new prescription. Step 4: Numerator From the prescriptions within the denominator (after denominator exclusions have been applied) • Step 4A: Identify the number of prescriptions for beneficiaries who had a qualifying outpatient encounter within four weeks of the fill date of the antipsychotic medication. Step 5: To calculate the measure score: • Step 5A: Divide the total number of prescriptions in the numerator by the total number of prescriptions in the denominator, after denominator exclusions have been applied. • Step 5B: Multiply this number by 100 to determine the performance rate.
Care settings	Ambulatory Care: Clinician Office/Clinic Behavioral Health/Psychiatric: Outpatient

D. ADMINISTRATIVE SPECIFICATION

Denominator

Measure data will be reported annually (12 months). To account for the follow-up period following a new antipsychotic prescription, the denominator period will start January 1 and end November 30 of the measurement year. The measure includes a 120 day (four month) look-back period to establish "new" antipsychotic prescriptions.

Eligible population meets the following conditions:

- Medicaid beneficiaries aged 18 years and older with at least one new antipsychotic medication fill during the year January 1 through November 30.
- Medicaid beneficiaries who were enrolled in Medicaid during the four months prior to and the four weeks following the qualifying newly prescribed antipsychotic prescription.

The denominator is based on prescriptions, not individuals. A beneficiary may have more than one qualifying "newly prescribed" antipsychotic prescription in a measurement year.

Antipsychotic medications are identified using NDCs. The value sets for the measure are attached.

Numerator

The number of new antipsychotic medication prescriptions with a qualifying outpatient visits within 28 days (4 weeks) of the prescription fill date.

Qualifying follow-up visits are identified using CPT and HCPCS codes. A list of value sets for the measure is attached. States may need to adapt the list of codes to include state-specific codes.

E. ADDITIONAL NOTES

The measure uses CPT and HCPCS codes to identify whether a follow-up visit occurred within the four-week follow-up period following a new antipsychotic prescription. The measure is intended to encompass follow-up provided through integrated approaches to care and as such does not limit the type of provider who conducts the follow-up visit. Although specific elements included in a follow-up visit are not identifiable in administrative and claims data, the intent of measuring follow-up is to assess whether a comprehensive assessment of symptoms, effectiveness of treatment, physical and mental side effects associated with treatment, and barriers to treatment adherence has occurred. These elements of follow-up are consistent across care settings.

F. OPTIONAL STRATIFICATIONS

None.