MATHEMATICA
Policy Research

FROM: Mathematica Policy Research **DATE:** 9/5/2016

SUBJECT: Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees:
Questions for Public Comment on Measure for Medicaid Beneficiaries with Physical-Mental Health Integration Needs (PMH)

Project Overview:
The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following groups of Medicaid beneficiaries: (1) those eligible for both Medicare and Medicaid, or "dual enrollees"; (2) those receiving long-term services and supports (LTSS) through managed care organizations or through fee-for-service delivery arrangements; and, (3) people with complex needs and high costs (BCN), substance use disorders (SUD), physical and mental health integration needs (PMH). The contract number is HHSM-500-2013-13011I, Task Order #HHSM-500-T0004.

Documents and Measures for Comment:
As part of its measure development process, CMS requests interested parties to submit comments on the candidate or concept measures that may be suitable for this project.

This call for public comment concerns the measure specifications, and justification, for the following measure:

- PMH-1 – Follow-up care for adult Medicaid beneficiaries who are prescribed an antipsychotic medication

The Measure Information Form (MIF) and Measure Justification Form (MJF) for this measure are available in separate files here: < BCN SUD PMH measures MIFs and MJFs.zip>

The project team seeks public comment on the following questions:

General Questions

1. Is the candidate measure useful for measuring important domains of quality for the specified Medicaid population?
2. Are you aware of any new or additional measures (beyond those listed in the MJF) that address this quality domains and have already been validated and widely used, are now under development, or will be submitted for consensus-based entity (NQF) endorsement?
3. Are the measure specifications in the MIFs clear, for example, the numerator, denominator, and any potential exclusions? What should be more clearly defined?
4. Are any revisions to the specifications needed either to make measure reporting more feasible, or to include or exclude certain individuals or events?

5. Are the proposed reporting levels, such as state or region, or specific Medicaid programs (e.g. Medicaid Health Homes) for the measure appropriate?
6. Are you aware of any new or additional studies that should be included in the MJF that support (or weaken) the justification for developing the measure? If so, please describe the findings and provide a full citation.

Questions specific to PMH-1 (*Follow-up care for adults prescribed a new antipsychotic medication)*

1. Which groups of beneficiaries should be included, or excluded, in the denominator for this measure? For example:
   a. The definition of the denominator currently proposes to exclude beneficiaries with a gap in Medicaid enrollment, those with an acute inpatient admission, or those who die during the four week follow-up period. Are there any additional groups of beneficiaries who should be excluded from the measure denominator?
   b. The definition of the denominator is currently restricted to beneficiaries with a *new* antipsychotic prescription. Should those who change antipsychotic medications (e.g., from one antipsychotic to another drug in the same class, change in dosage of a particular antipsychotic drug, change from a generic to a brand name of same drug) or those who receive prescription refills also be included in the measure?
   c. The denominator currently defines "new prescription" as those beneficiaries with no prescriptions for antipsychotic medications within the previous four months. Is this four month look-back period an appropriate timeframe?
   d. The denominator currently specifies that Medicaid beneficiaries be continuously enrolled from four months prior to prescription of an antipsychotic through four weeks following prescription of an antipsychotic. Is this an appropriate timeframe for accountability purposes, taking into account the need to ensure sufficient sample sizes to construct a reliable measure?
2. The numerator definition needs to specify the types of encounters and providers that should be included as appropriate follow-up care within four (4) weeks of antipsychotic prescription. What types of visits and providers should be counted as follow-up care to count towards the numerator? For example:
   a. Is the list of follow-up encounter types as currently defined in the measure appropriate? Should any encounter types be added to or removed from the list?
   b. Is the proposed list of providers who can provide follow-up care appropriate? Should any provider types be added to, or removed from the list?
   c. Is it appropriate to allow the first follow-up visit after a new prescription of antipsychotic to be done by phone, video conference, or written communication, rather than in-person?

Public Comment Instructions:

- If you are providing comments on behalf of an organization, include the organization's name and contact information.
- If you are commenting as an individual, submit identifying or contact information.
- Please do not include personal health information in your comments.
- In the subject line of your message, put **Public Comments PMH-BCN-SUD**
- Send your comments **by close of business September 29, 2016** to MedicaidQualMeasures@mathematica-mpr.com

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on September 2, 2016.

Measure Name

Descriptive Information

Measure Name (Measure Title De.2.) Follow-Up Care for Adult Medicaid Beneficiaries Who are Prescribed an Antipsychotic Medication

Measure Type De.1. Process

Brief Description of Measure De.3. Percentage of Medicaid beneficiaries age 18 years and older who were newly prescribed an antipsychotic medication and have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.

Although specific elements included in a follow-up visit are not identifiable in claims, 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.

If Paired or Grouped De.4. Not Applicable

Subject/Topic Areas De.5.

- Behavioral Health: Behavioral Health
- Behavioral Health: Serious Mental Illness
- Mental Health: Mental Health
- Mental Health: Serious Mental Illness

Crosscutting Areas De 6.

- Care Coordination: Care Coordination
- Safety: Safety
- Safety: Medication Safety

Measure Specifications

Measure-specific Web Page S.1. Not applicable. This measure is still under development.

If This Is an eMeasure S.2a. Not applicable. This is not an eMeasure.

Data Dictionary, Code Table, or Value Sets S.2b. Not applicable. This measure is still under development.

For Endorsement Maintenance S.3. Not applicable. This measure is still under development.

Numerator Statement S.4. Medicaid beneficiaries from the denominator who completed a follow-up visit with a provider with prescribing authority within four weeks of prescription of an antipsychotic medication. During testing we will assess robustness to different treatments of the measurement period. Numerator statement may change as this measure is still under development.

Time Period for Data S.5. The intended measurement period is eleven months, to allow for the four week follow-up period (e.g., January 1 through November 30, 2014). In addition, the measure requires a four month look-back into the prior year to ensure continuous enrollment (e.g., September 1 through December 2013). The proposed period will be refined during testing, taking into account the final timeframe for follow-up.

Numerator Details S.6. The proposed numerator uses a four-week follow-up period based on clinical guidelines for appropriate follow-up after prescription of new antipsychotic medications. The optimal follow-up time period will be determined through testing and consultation with the clinical advisory work group. The day after the prescription is counted as day 1 of the follow-up period. The date of the follow-up visit with a provider is determined using the service date on the medical claim. The specific qualifying provider types (e.g., advanced practice nurses, physician assistants, physicians) as well as qualifying types of follow-up encounters (e.g., telemedicine encounters) will also be determined with clinical advisory work group input.

Encounters (CPT) during which follow-up with a provider with prescribing ability may occur include:

- Office Visit (99201-99205, 99212-99215)
- Outpatient Consultation (99241-99245)
- Domiciliary, Rest Home, or Custodial Care Services (99324-99328, 99334-99337, 99339, 99340)
- Home Health Care (99341-99345, 99347-99350)
- Prolonged Service with Direct Patient Contact (99354, 99355)
- Preventive Care Services-Initial Office Visit, 18 and Up (99385-99387)
- Preventive Care Services – Established Office Visit, 18 and Up (99395-99397)
- Behavioral Health (90832, 90834, 90837, 90839, 90845, 90846, 90847, 90849, 90853, 96150, 96151, 96152, 96153, 96154, 96155)
- Medication Management (90863 – add on code)

Numerator details may change as this measure is still under development.

Denominator Statement S.7. Medicaid beneficiaries age 18 years or older with a newly filled prescription for an antipsychotic medication

Target Population Category S.8. Populations at Risk: Individuals with multiple chronic conditions, Senior Care

Denominator Details S.9. Target population meets the following conditions:

1. Medicaid beneficiary age 18 years and older (including dual and Medicaid-only enrollees)
2. Newly prescribed an antipsychotic medication

Beneficiaries with "newly filled prescription" will have had no antipsychotic medications dispensed for either new or refill prescriptions during a period of 120 days (four months) prior to the prescription fill date.

Based on initial feedback from the IAP TEP, clinical advisory work group, and CMS, we expect to focus the measure on new prescriptions of antipsychotic medications; however, we may include medications for treatment of bipolar disorder based on additional input and public comment.

The preliminary list of antipsychotic medications identified for this measure include:

- aripiprazole (Abilify)
- asenapine maleate (Saphris)
- chlorpromazine hydrochloride
- clozapine (Clozaril, FazaClo, Versacloz)
- Compazine
- droperidol (Inapsine)
- fluoxetine hydrochloride-olanzapine (Symbyax)
- fluoxetine-olanzapine
- fluphenazine
- haloperidol (Haldol)
- iloperidone (Fanapt)
- loxapine succinate (Loxitane)
- lurasidone hydrochloride (Latuda)
- molindone hydrochloride (Moban)
- olanzapine (Zyprexa)

- paliperidone (Invega)
- Permitil
- perphenazine
- pimozide (Orap)
- prochlorperazine maleate
- quetiapine fumarate (Seroquel)
- risperidone (Risperdal)
- thioridazine hydrochloride
- thiothixene (Navane)
- trifluoperazine hydrochloride
- trilafon
- ziprasidone (Geodon)

A preliminary list of National Drug Codes (NDCs) has been developed for the medications listed above for the purposes of initial testing efforts. Specific medications and NDC codes to be included in this measure will continue to be refined based on additional feedback.

Denominator details may change as this measure is still under development.

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10. The following beneficiaries are excluded from the denominator:

- Medicaid beneficiaries with a gap in enrollment during the four months prior to or during the four-week follow-up period after prescription of an antipsychotic medication
- Medicaid beneficiaries with an acute inpatient admission during the four-week follow-up period after prescription of an antipsychotic medication
- Patients who expired within four weeks of new prescription date

Qualifying exclusions and/or exceptions will be determined based on expert input.

Denominator exclusions may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11.
Gap in enrollment: Enrollment requirements will need to be further refined. Similar measures have a continuous enrollment requirement that looks as follows:

Continuous eligibility: Four months prior and four weeks following the new prescription

Acute inpatient admission during the four-week follow-up period will be identified if the beneficiary has an inpatient discharge during the time period.

Patients with a date of death during the four week follow-up period will be excluded from the measure.

Denominator exclusions may change as this measure is still under development.

Stratification Details/Variables S.12.

Performance scores may be stratified based on:

- Age (18-64 and 65+)
- Race
- Ethnicity
- Sex
- Enrollment status (dual-enrollee vs Medicaid only)
- Disability status

Stratification details/variables may change as this measure is still under development.

Risk Adjustment Type S.13. Not applicable

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. Higher score = better quality

Calculation Algorithm/Measure Logic S.18. To calculate the denominator:

<u>Eligible Population:</u>

1. Identify Medicaid beneficiaries (both dual and Medicaid-only enrollees) age 18 years and older.
2. From this group, identify those who were newly prescribed one or more antipsychotic medications.

<u>Exclusions:</u>

From the population identified in step 2

3. Remove any Medicaid-only or dual beneficiaries who were not continuously enrolled for at least 4 months prior or four weeks following the new prescription.
4. Remove any Medicaid-only or dual beneficiaries who had an acute inpatient admission during the four weeks following the new prescription

5. Remove any Medicaid beneficiaries who expired during the four weeks following the new prescription

Numerator

From the Medicaid beneficiaries within the denominator (after denominator exclusions have been applied)

6. Identify the number of patients who had a qualifying outpatient encounter within four weeks of the prescription date of the antipsychotic medication

To calculate the measure score:

7. Divide the total number of beneficiaries in the numerator by the total number of beneficiaries in the denominator, after denominator exclusions have been applied.
8. Multiply this number by 100 to determine the performance rate.

Calculation algorithm/measure logic may change as this measure is still under development.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19. Not applicable, no calculation algorithm diagram available at this time.

Sampling S.20. Not applicable

Survey/Patient-Reported Data S.21. Not applicable

Missing Data S.22. The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23. Administrative claims data

Data Source or Collection Instrument S.24. Medicaid and Medicare administrative claims or encounter data and pharmacy claims

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

This is a claims based measure. Data sources include:

- State: State Medicaid Management Information System (MMIS), MSIS, or T-MSIS or Medicaid Analytic eXtract (MAX) file: MAX PS, MAX RX, MAX IP, MAX OT
- Additional Data Sources for dual Enrollees: Medicare Parts A, B, and D data

Level of Analysis S.26. Population: State, Hospital Referral Region (HRR)

Care Setting S.27. Ambulatory Care: Clinician Office/Clinic, Behavioral Health/Psychiatric: Outpatient

Composite Performance Measure S.28. Not applicable

Measure Justification Form

Project Title:

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Date:

- Information included is current on September 2, 2016.

Measure Name

Follow-Up Care for Adult Medicaid Beneficiaries Who are Prescribed an Antipsychotic Medication

Type of Measure

Process

Importance

1a—Opportunity for Improvement

1a.1. This is a Measure of

Process: Completion of an outpatient follow-up visit following the prescription of an antipsychotic medication.

Note: Additional medications commonly used for the treatment of bipolar disorder are under consideration for addition to this measure.

1a.2.—Linkage

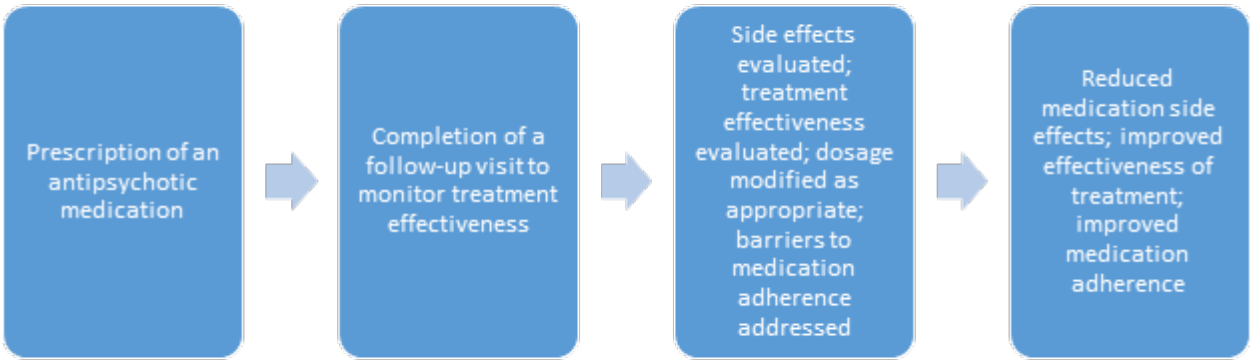
Not applicable: Not an outcome measure

1a.2.1 Rationale

Not applicable: Not an outcome measure (per guidance in blueprint)

1a.3.—Linkage

Among individuals with serious mental illness, physical health problems such as cardiovascular disease, metabolic disorders, and infectious disease are more prevalent compared to the general population. Antipsychotic medications can exacerbate existing physical problems as well as increase a patient's risk for developing new health concerns such as metabolic complications. Timely follow-up with a provider following the prescription of antipsychotic medications is an essential first step to ensure that physical impacts of antipsychotic medications are identified and addressed early. Early follow up is also critical to monitor for treatment effectiveness and modify dosage as necessary, as well as to identify and address any barriers to treatment adherence. By proactively following up with patients who are prescribed antipsychotic medications, providers can identify problems early in the course of treatment and minimize potential harms associated with use of those medications. Regardless of the care setting in which a patient is being treated, comprehensive assessment of both physical and mental health factors is an essential aspect of treatment with antipsychotic medications.



1a.3.1. Source of Systematic Review

- ✓ Clinical Practice Guideline recommendation – ***complete sections 1a.4, and 1a.7***
- US Preventive Services Task Force Recommendation – ***complete sections 1a.5 and 1a.7***
- ✓ Other systematic review and grading of the body of evidence (e.g., Cochrane Collaboration, AHRQ Evidence Practice Center) – **complete sections 1a.6 and 1a.7**
- ✓ **Other – complete section 1a.8**

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation

Guideline 1:

American Diabetes Association (ADA), American Psychiatric Association (APA), American Association of Clinical Endocrinologists (AACE), North American Association for the Study of Obesity (NAASO). Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care.* 2004;27(2): 596-601.

Guideline 2:

Lehman AF, Lieberman JA, Dixon LB, et al; American Psychiatric Association; Work Group on Schizophrenia. Practice guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry.* 2004;161(2 Suppl):1-56.

Guideline 3:

2015 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults (December 2015). The University of South Florida, Florida Medicaid Drug Therapy Management Program sponsored by the Florida Agency for Health Care Administration. Available at: http://www.medicaidmentalhealth.org/_assets/file/Guidelines/Web_2015-Psychotherapeutic%20Medication%20Guidelines%20for%20Adults_Final_Approved1.pdf

Guideline 4:

A Summary for Monitoring Physical Health and Side-Effects of Psychiatric Medications in the Severely Mentally Ill Population (March 2014). The University of South Florida, Florida Medicaid Drug Therapy Management Program for Behavioral Health sponsored by the Florida Agency for Health Care Administration. Available at: http://medicaidmentalhealth.org/_assets/file/Summaries/2014_Monitoring%20Physical%20Health%20and%20Side-Effects%20of%20Psychiatric%20Medicati....pdf

1a.4.2. Specific Guideline

Taken together, all four guidelines provide recommendations that emphasize the importance of ongoing, comprehensive assessment of both physical and mental health factors for patients taking psychotropic medications, with Guidelines 1 and 2 focusing specifically on antipsychotic medications. Each guideline provides an overview of key factors that need to be assessed as part of the course of treatment. A comprehensive assessment of physical and mental health factors is an essential part of treatment for patients who are prescribed psychotropic medications, regardless of the care setting in which their treatment

is provided. Cited below are the specific guideline recommendations around comprehensive assessment for patients taking antipsychotic medications and/or psychotropic medications.

Guideline 1 (Page 599-600)

Follow-up monitoring:

"The patient's weight should be reassessed at 4, 8, and 12 weeks after initiating or changing second generation antipsychotic (SGA) therapy and quarterly thereafter at the time of routine visits."

"Fasting plasma glucose, lipid levels, and blood pressure should also be assessed 3 months after initiation of antipsychotic medications. Thereafter, blood pressure and plasma glucose values should be obtained annually or more frequently in those who have a higher baseline risk for the development of diabetes or hypertension. In those with a normal lipid profile, repeat testing should be performed at 5-year intervals or more frequently if clinically indicated"

"Blood pressure, lipid, and glycemic goals of therapy for people with diabetes apply equally to those who also have psychiatric disorders. However, all goals need to be individualized. The benefits and risks of different therapeutic agents used in the treatment of diabetes and its comorbidities should be considered in the context of the patient's psychiatric condition and treatment.

In summary, the panel recommends the following:

- Consideration of metabolic risks when starting SGAs
- Patient, family, and care giver education
- Baseline screening
- Regular monitoring
- Referral to specialized services, when appropriate"

Guideline 2 (Page 11).

The recommended dose is that which is both effective and not likely to cause side effects that are subjectively difficult to tolerate, since the experience of unpleasant side effects may affect long-term adherence [I]. The dose may be titrated as quickly as tolerated to the target therapeutic dose of the antipsychotic medication, and unless there is evidence that the patient is having uncomfortable side effects, monitoring of the patient's clinical status for 2–4 weeks is warranted to evaluate the patient's response to the treatment [II].

Guideline 3 (Pages 4-5):

Principles of Practice

Comprehensive Assessment

- Careful, differential diagnostic evaluation
- Risk for suicide and violence
- Co-occurring mental and medical disorders
- Substance abuse disorders, including tobacco use
- Potential bipolar disorder must be assessed in patients presenting with depression
- Serious mental health conditions are chronic in nature; therefore, a long-term
- management plan is essential
    - Use measurement-based care to measure symptoms, side effects, and adherence
    - Select maintenance medications that have a low relative risk of weight gain and metabolic syndrome
    - Monitoring of physical health parameters and medication side effects (See
    - Program publication A Summary for Monitoring Physical Health and Side-Effects of Psychiatric Medications in the Severely Mentally Ill Population available at www.medicaidmentalhealth.org)
    - Integrate care of psychiatrists and primary care providers
    - Incorporate collaborative/shared treatment decision-making with patients and family/caregivers
    - Perform a psychosocial assessment
    - Assess social support system (housing, family, other caregivers)
    - Evaluate threats to continuity of care (access to medication, adherence, etc.)
    - Give patients tools/support for recovery and self-management

Adjunctive Psychosocial Treatments (As Indicated)

- Individual and family psychoeducation
- Cognitive-behavioral therapy (CBT)
- Interpersonal psychotherapy (IPT)
- Interpersonal and social rhythm therapy (IPSRT)
- Family-focused therapy
- Group psychoeducation (especially for bipolar disorder)
- Social skills training (especially in schizophrenia)

- Cognitive remediation/rehabilitation (to improve attention, memory, and/or executive function)

**Note on pharmacogenomic testing - Limited data exists examining whether patient care that integrates pharmacogenomic test information results in better or safer treatment.*

Measurement-Based Care

Questionnaires and rating scales are useful tools for diagnostic assessment and evaluation of treatment outcomes, and such instruments can be helpful in providing supplemental information to clinical judgment. The integration of measurement scales into routine clinical practice is suggested for each of the conditions covered in this document. Clinicians should use rating scales to assess symptom severity during the initial evaluation/treatment, when medication changes are implemented, and/or when the patient reports a change in symptoms.

- Treatment targets need to be precisely defined.
- Effectiveness and safety/tolerability of the medication treatment must be systematically assessed by methodical use of appropriate rating scales and side-effect assessment protocols.
- Internet links to the following scales are available on the program website - www.medicaidmentalhealth.org
    - Beck Depression Inventory (BDI)
    - Brief Psychiatric Rating Scale (BPRS)
    - Clinical Global Impression (CGI) Scale
    - Clinician-Rated Dimensions of Psychosis Symptom Severity (CRDPSS)
    - Hamilton Rating Scale for Depression (HAM-D)
    - Montgomery-Asberg Depression Rating Scale (MADRS)
    - Patient Health Questionnaire (PHQ-9)
    - Positive and Negative Syndrome Scale (PANSS)
    - Quick Inventory of Depression Symptomatology (QIDS)
    - Young Mania Rating Scale (YMRS)

Guideline 4 (pages 20-21):

General Recommendations: Monitoring Physical Health in Patients with Severe Mental Illness

Table 12: Monitoring Patients with Severe Mental Illnesses: Recommended Frequency of Assessment[1,2]

Assessment	Base-line	During titration/ At target dose	Each Visit	At 6 weeks	At 3 months	Every 3 months	At 12 months	Annually after first 12 months
Personal and family history	√	—	—	—	—	—	√	√
Lifestyle behaviors (smoking, exercise, dietary habits)	√	—	√	√	√	—	√	√
Weight	√	—	√	√	√	—	√	√
Waist circumference*	√	—	—	√	√	—	√	√
BP and pulse	√	√ (during titration with clozapine and quetiapine)	√	√	√	—	√	√
Sedation/ somnolence	√	—	√	√	√	—	√	√
Sexual/ reproductive dysfunction	√	√	—	√	√	√	—	—
Prolactin	√[a]	—	—	—	√[b]	—	√[b]	√[b]
Fasting blood glucose	√	—	—	√	√	—	√	√
Fasting lipid profile	√	—	—	—	√	—	√	√
Parkinsonism (SAS or ESRS), Akathisia (AIMS or ESRS)†	√	√	—	—	√	—	—	√
Electrolytes, full blood count, renal function	√	—	—	—	—	—	√ (more frequent blood counts if on clozapine)	√ (more frequent blood counts if on clozapine)
FTardive dyskinesia	√	—	—	—	—	—	√	√
Liver function tests	√	—	—	—	—	—	√	√
Dental health	√	—	—	—	—	—	√	√
ECG‡ parameters	√[‡]	—	—	—	—	—	—	—

*Studies have shown that waist circumference is a better predictor of cardiovascular risk compared to Body Mass Index (BMI)

[a]recommended to obtain baseline values; if too expensive, obtain only in cases where sexual or reproductive system abnormalities are reported

[b]obtain in cases where sexual dysfunction coincides with antipsychotic treatment or dose change

‡ECG = electrocardiogram; perform EKG at baseline then only if symptomatic

1Adapted from Hert, et al, 2011. “Physical Illness in patients with severe mental disorders, II, Barriers to care, monitoring, and treatment guidelines, plus recommendations at the system and individual level. World Psychiatry. 10: 138-151.

2Adapted from Florida Medicaid Drug Therapy Management Program for Behavioral Health: Florida Best Practice Medication Child/

Adolescent Guidelines

†Abbreviations: SAS = Simpson-Angus Scale; ESRS = Extrapyramidal Symptom Rating Scale; AIMS = Abnormal Involuntary Movement Scale.

1a.4.3. Grade

The APA schizophrenia guideline (guideline 2) assigned a grade II to its follow-up recommendation. None of the remaining guidelines provided a grade for the cited recommendations.

1a.4.4. Grades and Associated Definitions

The APA grading scale is defined as follows:

[I] Recommended with substantial clinical confidence.

[II] Recommended with moderate clinical confidence.

[III] May be recommended on the basis of individual circumstances.

None of the remaining guidelines provided a grade for the cited recommendations.

1a.4.5. Methodology Citation

Not applicable. Neither guideline has a separate citation for the methodology associated with their development.

1a.4.6. Quantity, Quality, and Consistency

The APA guideline (Guideline 2) was developed based on a comprehensive literature review. However, the details of the quality, quantity, and consistency of the evidence related to follow-up care after prescription of an antipsychotic medication were not made available within the guideline.

The remaining three guidelines cited above were developed using a consensus-based approach involving a group of stakeholders and experts in the field. While the consensus-based approach was supplemented with a review of the evidence as part of the development of each guideline, the details of the quality, quantity, and consistency of the reviewed evidence were not provided.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation. Not applicable.

1a.5.2. Specific Recommendation. Not applicable.

1a.5.3. Grade. Not applicable.

1a.5.4. Grades and Associated Definitions. Not applicable.

1a.5.5. Methodology Citation. Not applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation. Not applicable.

1a.6.2. Methodology Citation. Not applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review

Guideline 1 was developed as a result of a consensus development conference of key experts and stakeholders. The key goal of the conference was to establish consensus on the following questions:

1. What is the current use of antipsychotic drugs?
2. What is the prevalence of obesity, pre-diabetes, and type 2 diabetes in the populations in which second-generation antipsychotics (SGAs) are used?
3. What is the relationship between the use of SGAs and the incidence of obesity or diabetes?
4. Given the above risks, how should patients be monitored for the development of significant weight gain, dyslipidemia, and diabetes, and how should they be treated if diabetes develops?
5. What research is needed to better understand the relationship between these drugs and significant weight gain, dyslipidemia, and diabetes?

The evidence reviewed to support Guideline 2 included clinical trials and meta-analyses related to schizophrenia and schizoaffective disorder to reflect a synthesis of the current literature and clinical practice on the treatment of patients with schizophrenia.

Guidelines 3 and 4 were developed using a consensus-based approach. While evidence was reviewed as part of the development process for these guidelines, the details of the evidence review were not provided.

1a.7.2. Grade

None of the cited guidelines assigned a grade to the quality of the quoted evidence.

1a.7.3. Grades and Associated Definitions

None of the cited guidelines assigned a grade to the quality of the quoted evidence.

1a.7.4. Time Period

Guideline 1: Evidence cited in support of the consensus document ranges from 1997-2003.

Guideline 2: Evidence reviewed in the development of this guideline spanned from 1994-2002.

Guideline 3: Evidence cited in support of this guideline ranges from 1988-2015.

Guideline 4: The details of the evidence reviewed for this guideline are not available.

1a.7.5. Number and Type of Study Designs

Guideline 1:

While this is a consensus-based guideline, the authors cited 4 clinical practice guidelines, 5 systematic evidence reviews, 11 retrospective analyses, 3 randomized trials, and 1 cross-sectional analysis in support of the document.

Guideline 2:

Evidence cited in support of this guideline includes 181 double-blind randomized clinical trials, 116 randomized clinical trials, 152 clinical trials, 133 cohort or longitudinal studies, 122 case-control studies, 71 reviews with secondary data analysis, 167 literature reviews, and 497 other types of studies.

Guidelines 3 and 4 were developed using a consensus-based approach. While evidence was reviewed as part of the development process for these guidelines, the details of the evidence review were not provided.

1a.7.6. Overall Quality of Evidence

None of the cited guidelines include a formal estimate of the overall quality of the evidence. However, the APA guideline recommended close monitoring of patient status following the prescription of antipsychotic medications with moderate clinical confidence.

1a.7.7. Estimates of Benefit

None of the cited guidelines provide a quantitative estimate of benefit for follow-up care for patients prescribed antipsychotic medications. However, there is consensus among the guidelines that close follow-up monitoring is an essential standard of care for patients

prescribed antipsychotic medications to ensure effectiveness of treatment and to mitigate any adverse consequences or reactions to the drugs.

1a.7.8. Benefits Over Harms

While the guidelines do not give a quantitative estimate of the balance of benefits versus harms, we anticipate the expected benefits of follow-up care to far outweigh any potential harms because ongoing monitoring and follow-up is a basic standard of care for patients taking antipsychotic medications. We anticipate that any potential harms associated with improved follow-up would be minimal.1a.7.9. Provide for Each New Study

1a.8.—Other Source of Evidence

1a.8.1. Process Used

The project team conducted an environmental scan, which included a targeted literature review, an evaluation of existing performance measures related to physical and mental health care integration to identify critical measurement gaps, and interviews with key stakeholders and subject matter experts. Stakeholders interviewed by the project team emphasized the importance of ongoing follow-up after the prescription of psychotropic medications to evaluate treatment effectiveness and modify the treatment regimen as appropriate. Timely follow-up is also essential to address medication side effects and potential barriers to treatment adherence. The importance of ongoing follow-up for patients on psychotropic medications is also emphasized in recent government efforts to promote best prescribing practices for psychotropics (MACPAC 2015). In a 2015 study, Mert and colleagues identified irregular follow-up as an important risk factor for medication non-adherence among patients with mental illness (Mert et al. 2015).

Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress on Medicaid and CHIP. June 2015. available at: https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf. Accessed February 4, 2016.

Mert DG, Turgut NH, Lelleci M, Semiz M. Perspectives on reasons of medication nonadherence in psychiatric patients. Patient Prefer Adherence. 2015;9:87–93. doi: 10.2147/PPA.S75013.

1a.8.2. Citation

Quality Measures for Medicaid Beneficiaries Needing Physical-Mental Health Integration: Environmental Scan. December 2015.

1b.—Evidence to Support Measure Focus (the data in the following section will be updated to reflect a more targeted focus once target medications are selected for the measure)

1b.1. Rationale

Use of antipsychotic medications has been associated with increased risk of of health problems such as obesity, metabolic syndrome, diabetes, diabetic ketoacidosis, cardiovascular disease, sudden cardiac death, and sexual dysfunction (De Hert et al. 2011). Timely follow-up with a provider following the prescription of antipsychotic medications is an essential first step to ensure that physical impacts of these medications are identified and addressed early. Early follow-up is also critical to monitor for treatment effectiveness and modify dosage as necessary, as well as to identify and address any barriers to treatment adherence. By proactively following up with patients who are prescribed antipsychotics, providers can identify problems early in the course of treatment and minimize potential harms associated with use of these medications.

De Hert M, Correll CU, Bobes J, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry.*2011;10:52-77.

1b.2. Performance Scores

Not applicable. This measure is still under development and performance scores are not yet available.

1b.3. Summary of Data Indicating Opportunity

Follow-up is a minimal clinical standard of care for patients with mental illness who are prescribed psychotropic medications and is a critical component of disease management. A follow-up visit with a provider is essential to monitor treatment effectiveness, evaluate health concerns, and adjust treatment as needed to minimize potential harms associated with the use of psychotropic medications. One 2014 cross-sectional analysis of nationally-representative data estimates that 35 percent to 50 percent of mental health care episodes consist of psychotropic drug fills without an outpatient visit to monitor treatment and up to 35 percent of episodes consisted of only a single visit (Le Cook et al. 2014). Despite the importance of follow-up for patients taking antipsychotics, there is evidence that these patients are not receiving adequate follow-up care. For example, there is a growing body of evidence that shows persistent gaps in monitoring for metabolic effects of antipsychotic medications despite available guidelines and recommendations. While follow-up care should encompass more than just metabolic monitoring, metabolic testing rates can be useful to gain a general idea of the adequacy of follow-up care. In a 2016 analysis of data from the Missouri Medicaid program, Morrato and colleagues reported annual testing rates of 79.6

percent for glucose and 41.2 percent for lipids among beneficiaries taking antipsychotics (Morrato et al. 2016). This shows improvement over an earlier 2010 analysis data from three state Medicaid programs, which found testing rates as low as 27 percent for glucose testing and 10 percent for lipid testing (Morrato et al. 2010). This improvement is consistent with a 2011 analysis of Kansas Medicaid data that found improvement in annual testing between 2002 and 2007 from 23 percent to 75.3 percent for glucose monitoring and from 10.1 percent to 52.5 percent for lipid monitoring (Moeller, Rigler, Mayorga, Nazir, & Shireman 2011). While progress on testing at a state level is encouraging, there is still considerable room for improvement at a local level. In a 2011 analysis of Medicaid data, rates of metabolic testing were found to vary significantly based on geographic location and patient characteristics such as age and comorbidity (Morrato et al. 2011). Inadequte follow-up care is often reflected by poor treatment adherence. A 2015 study found irregular attendance at follow-up appointments to be significantly associated with medication nonadherence (OR: 5.7; 95 percent confidence interval 2.92-11.31) among patients with psychiatric illness (Mert et al. 2015). A 2013 study found an antipsychotic non-adherence rate of nearly 38 percent among Medicaid patients with schizophrenia, with new prescription of antipsychotics and baseline non-adherence increasing the likelihood of non-adherence twelvefold (Lang et al. 2013). Appropriate follow-up care is essential for patients taking antipsychotic medications to receive the full benefit of treatment and to minimize potential harms associated with use of antipsychotics.

Lang K, Federico V, Muser E, Menzin J, Menzin J. Rates and predictors of antipsychotic non-adherence and hospitalization in Medicaid and commercially-insured patients with schizophrenia. J Med Econ. 2013;16(8):997-1006. doi: 10.3111/13696998.2013.816310.

Le Cook B, Zuvekas SH, Carson N, et al. Assessing racial/ethnic disparities in treatment across episodes of mental health care. *Health Serv Res.*2014;49(1):206-29. doi: 10.1111/1475-6773.12095.

Mert DG, Turgut NH, Lelleci M, Semiz M. Perspectives on reasons of medication nonadherence in psychiatric patients. Patient Prefer Adherence. 2015;9:87-93. doi: 10.2147/PPA.S75013.

Moeller KE, Rigler SK, Mayorga A, Nazir N, and Shireman TI. Quality of monitoring for metabolic effects associated with second generation antipsychotics in patients with schizophrenia on public insurance. *Schizophr Res.* 2011;126(1-3):117-23. doi: 10.1016/j.schres.2010.11.015

Morrato EH, Campagna EJ, Brewer SE, et al. Metabolic testing for adults in a state Medicaid program receiving antipsychotics: remaining barriers to achieving population health

prevention goals. *JAMA Psychiatry.*2016;73(7):721-30. doi:10.1001/jamapsychiatry.2016.0538

Morrato EH, Druss B, Hartung DM, et al. Metabolic testing rates in 3 state Medicaid programs after FDA warnings and ADA/APA recommendations for second-generation antipsychotic drugs. *Arch Gen Psychiatry.* 2010;67(1):17-24. doi:10.1001/archgenpsychiatry.2009.179

Morrato EH, Druss BG, Hartung DM, et al. Small area variation and geographic and patient-specific determinants of metabolic testing in antipsychotic users. *Pharmacoepidemiol Drug Saf.* 2011;20(1):66-75. doi:10.1002/pds.2062.

1b.4. and 1b.5. Disparities

The literature demonstrates racial and ethnic differences in the way patients seek treatment for mental illness as well as the way mental illness is managed. A 2014 cross-sectional analysis of nationally-representative data found that black and Latino patients were less likely than white patients to initiate treatment and receive adequate treatment for mental illness. Black patients were also more likely to have an episode of care that included a psychiatric emergency department or inpatient visit. However, white patients were more likely than Latino or black patients to experience an episode of care with that included continuous psychotropic drug fills without an outpatient visit to monitor treatment (Le Cook et al. 2014). A 2014 analysis of Medicaid claims data from California, Florida, New York, and North Carolina found that that black and Latino beneficiaries experienced poorer quality schizophrenia care than white beneficiaries, as measured by a composite measure of quality derived from 14 evidence-based quality indicators. In particular, black and Latino patients had lower scores on metrics such as antipsychotic adherence, psychosocial visits, routine psychotherapy, routine psychiatric care, and follow-up after discharge, with Latino patients generally experiencing better care than blacks but worse care than whites (Horvitz-Lennon et al. 2014).

Horvitz-Lennon M, Volya R, Donohue JM, Lave JR, Stein BD, Normand SLT. Disparities in quality of care among publicly insured adults with schizophrenia in four large U.S. states, 2002-2008. *Health Serv Res.* 2014;49(4):1121-44. doi: 10.1111/1475-6773.12162.

Le Cook B, Zuvekas SH, Carson N, et al. Assessing racial/ethnic disparities in treatment across episodes of mental health care. *Health Serv Res.*2014;49(1):206-29. doi: 10.1111/1475-6773.12095.

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

Affects large numbers

High resource use

Patient/societal consequences of poor quality

1c.3. Epidemiologic or Resource Use Data

A 2011 report by the Robert Wood Johnson Foundation found that more than half of disabled Medicaid enrollees with psychiatric conditions had a comorbid physical health condition. Patients with schizophrenia or bipolar disorder, two conditions that are commonly treated with antipsychotics, were found to be as much as three times as likely to have three or more chronic conditions compared to patients without mental illness. The report additionally found that comorbid physical and mental illness was associated with elevated symptom burden, functional impairment, reduced life expectancy, diminished quality of life, and increased healthcare costs (Druss and Walker 2011). Antipsychotic medications in particular have been associated with increased risk of cardiometabolic complications. In 2011, approximately one fifth of Medicaid enrollees, approximately 9.86 million individuals, had a behavioral health diagnosis, with 3.3 percent of enrollees using antipsychotic medications. Antipsychotic medications accounted for17.7 percent of the program's psychotropic claims and 55.9 percent of the program's fee-for service psychotropic spending. (MACPAC 2015). In many cases, treatment with antipsychoticmedications can cause or exacerbate comorbid medical conditions, as they are associated with physical effects such as obesity, metabolic syndrome, diabetes, diabetic ketoacidosis, cardiovascular disease, sudden cardiac death, and sexual dysfunction (De Hert et al. 2011).. In addition to direct health system costs, mental illness is also associated with increased homelessness and involvement in the criminal justice system. A 2013 analysis of claims data from the Florida Medicaid program found that monthly medication possession combined with receipt of outpatient services reduced the likelihood of arrest for Medicaid enrollees with schizophrenia or bipolar disorder (Van Dorn et al. 2013). This is consistent with an earlier 2011 analysis of Florida Medicaid claims data that found a significant interaction between outpatient services and use of second generation antipsychotics (SGAs), such that patients taking SGAs who received frequent outpatient visits were less likely to be arrested compared to patients taking SGAs with fewer outpatient services (Van Dorn et al. 2011).

1c.4. Citations

De Hert M, Correll CU, Bobes J, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry.*2011;10:52-77.

Druss BG, Walker ER; Robert Wood Johnson Foundation. Mental disorders and medical comorbidity. Research synthesis report No. 21. Available at: http://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf. Published February 2011. Accessed February 15, 2016.

Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress on Medicaid and CHIP. June 2015. available at: https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf. Accessed February 4, 2016.

Van Dorn RA, Andel R, Boaz TL, et al. Risk of arrest in persons with schizophrenia and bipolar disorder in a Florida Medicaid program: the role of atypical antipsychotics, conventional neuroleptics, and routine outpatient behavioral health services. *J Clin Psychiatry*. 2011;72(4):502-8 doi: 10.4088/JCP.10m06618.

Van Dorn RA, Desmarais SL, Petrila J, Haynes D, Singh JP. Effects of outpatient treatment on risk of arrest of adults with serious mental illness and associated costs. *Psychiatr Serv.* 2013;64(9):856-62. doi: 10.1176/appi.ps.201200406.

1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

Not applicable. This measure is not a PRO-PM.

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.2. Rationale why Risk Adjustment is not Needed

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.4. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R2)

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.9. Results of Risk stratification Analysis

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.10. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method for determining

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Not applicable. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

Not applicable. Feasibility will be determined during the measure testing phase.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. Feasibility will be determined during the measure testing phase.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Feasibility will be determined during the measure testing phase.

3c.2. Describe any fees, licensing, or other requirements

Not applicable. Feasibility will be determined during the measure testing phase.

Usability and Use

4.1—Current and Planned Use

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

Not applicable. Usability will be determined during the measure testing phase.

4a.2. If not publicly reported or used for accountability, reasons

Not applicable. Usability will be determined during the measure testing phase.

4a.3. If not, provide a credible plan for implementation

Not applicable. Usability will be determined during the measure testing phase.

4b.1. Progress on improvement

Not applicable. Usability will be determined during the measure testing phase.

4b.2. If no improvement was demonstrated, what are the reasons

Not applicable. Usability will be determined during the measure testing phase.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. The measure titles and NQF numbers are listed here

NQF 0108	Follow-Up Care for Children Prescribed ADHD Medication
NQF 1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
NQF 1927	Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
NQF 1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
NQF 2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics

5.1b. If the measures are not NQF-endorsed, indicate the measure title

The following measures are available via the Center for Quality Assessment and Improvement in Mental Health:

- Follow-up contact in antidepressant treatment
- Follow-up visits in antidepressant treatment
- Scheduled follow-up for antidepressant therapy
- Scheduled follow-up for minor tranquilizer therapy

5a—Harmonization

5a.1. Are the measure specifications completely harmonized

This measure concept addresses a different target population than NQF 0108 by focusing on adults rather than children and a different target quality action than NQF 1879, NQF 1927, NQF 1932, and NQF 2800. In addition, this measure concept captures a broader patient population than existing NQF-endorsed measures because it is not limited to patients with a specific diagnosis. Where possible definitions and specifications within this measure were harmonized to align with existing measures.

5a.2. If not completely harmonized, identify the differences rationale, and impact

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

Because this measure is not limited to patients with a specific diagnosis, it captures a broader patient population than existing measures related to antipsychotic medications.

Additional Information

Co.1.—Measure Steward Point of Contact

Co.1.1. Centers for Medicare & Medicaid Services (CMS)

Co.1.2. Roxanne

Co.1.3. Dupert-Frank

Co.1.4. Roxanne.Dupert-Frank@cms.hhs.gov

Co.1.5. (410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Co.2.1. Mathematica Policy Research

Co.2.2. Debra

Co.2.3. Lipson

Co.2.4. DLipson@Mathematica-Mpr.com

Co.2.5. (202) 238-3325

Ad.1. Workgroup/Expert Panel Involved in Measure Development. Not applicable.

Ad.2. Year the Measure Was First Released. Not applicable.

Ad.3. Month and Year of Most Recent Revision. Not applicable.

Ad.4. What is your frequency for review/update of this measure? Not applicable.

Ad.5. When is your next scheduled review/update for this measure? Not applicable.

Ad.6. Copyright Statement. Not applicable.

Ad.7. Disclaimers. Not applicable.

Ad.8. Additional Information/Comments