



Partnership for
Quality Measurement
Powered by Battelle

Fall 2022 Cycle

Prevention and Population Health Final Technical Report

October 2023



Contents

	<i>Page</i>
Executive Summary	1
Introduction	3
Prevention and Population Health Measure Evaluation	4
Scientific Methods Panel Measure Evaluation	4
Comments Received Prior to Standing Committee Evaluation	4
Comments Received After Standing Committee Evaluation	4
Summary of Potential High-Priority Gaps	5
Summary of Major Concerns or Methodological Issues.....	5
References	6
Appendix A: Details of Measure Evaluation	7
A.1 Measures Endorsed	8
Appendix B: Prevention and Population Health Standing Committee and Battelle Staff.....	27

Tables

Table 1a. Measures Submitted for Endorsement Consideration.....	1
Table 1b. Maintenance Measures Retired at the Steward’s Request	2
Table 2a. Number of Fall 2022 Prevention and Population Health Measures Submitted and Reviewed	4
Table A.1-1.1. Importance to Measure and Report (MUST PASS).....	9
Table A.1-1.2. Scientific Acceptability of Measure Properties (MUST PASS)	10
Table A.1-1.3. Feasibility.....	12
Table A.1-1.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)...	12
Table A.1-1.5. Related and Competing Measures.....	13
Table A.1-1.6. Standing Committee Recommendation for Endorsement.....	13
Table A.1-1.7. Public and Member Comment.....	13
Table A.1-1.8. CSAC Endorsement Decision	14
Table A.1-1.9. Appeals.....	14
Table A.1-2.1. Importance to Measure and Report (MUST PASS).....	16
Table A.1-2.2. Scientific Acceptability of Measure Properties (MUST PASS)	17
Table A.1-2.3. Feasibility.....	19
Table A.1-2.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)...	19
Table A.1-2.5. Related and Competing Measures.....	20
Table A.1-2.6. Standing Committee Recommendation for Endorsement.....	20
Table A.1-2.7. Public and Member Comment.....	20
Table A.1-2.8. CSAC Endorsement Decision	21
Table A.1-2.9. Appeals.....	21
Table A.1-3.1. Importance to Measure and Report (MUST PASS).....	22
Table A.1-3.2. Scientific Acceptability of Measure Properties (MUST PASS)	23
Table A.1-3.3. Feasibility.....	24
Table A.1-3.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)...	25
Table A.1-3.5. Related and Competing Measures.....	25
Table A.1-3.6. Standing Committee Recommendation for Endorsement.....	25
Table A.1-3.7. Public and Member Comment.....	26
Table A.1-3.8. CSAC Endorsement Decision	26
Table A.1-3.9. Appeals.....	26

Executive Summary

Prevention and population health has a central role in the mitigation of disease and the improvement of the nation’s health. Prevention and population health services are often characterized by routine disease screening practices and various methods of risk assessment as well as early disease detection and treatment.¹ The prevention-based population health approach remains a relevant practice across all domains of disease control and provides a commonly shared roadmap for clinical health professions to optimally engage their patients.

Quality measures are necessary tools for assessing improvements in population health, as well as the extent to which health care stakeholders are using evidence-based strategies (e.g., prevention programs, health screenings, and community needs assessments) to advance the quality of care. To support this effort, Battelle endorses and maintains performance measures related to prevention and population health through a standardized, consensus-based process.

For this project’s measure review cycle, three measures were submitted for endorsement consideration (Table 1a). One measure, up for maintenance endorsement review, was not submitted, as the measure was retired by the measure steward (Table 1b). The Prevention and Population Health standing committee recommended all three measures for endorsement. The Consensus Standards Approval Committee (CSAC) upheld the committee’s endorsement recommendations.

Effective March 27, 2023, the National Quality Forum (NQF) is no longer the consensus-based entity (CBE) funded through the Centers for Medicare & Medicaid Services (CMS) National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract. Battelle has been selected to oversee the endorsement & maintenance (E&M) of clinical quality and cost/resource use measures. Since the Fall 2022 cycle launched at NQF, measures submitted for Fall 2022 E&M cycle continued along the prior E&M protocols that were in place at time of the Fall 2022 “Intent to Submit.” In addition, the Scientific Methods Panel review and the committee’s measure evaluation meeting for the Fall 2022 cycle were conducted under NQF. Battelle took over the E&M work beginning with the public comment period to close out the Fall 2022 cycle. This included launching the Fall 2022 post-comment period, convening the E&M committees for the post-comment meeting, convening the CSAC to render a final endorsement decision, and executing the Appeals period.

Table 1a. Measures Submitted for Endorsement Consideration

Measure Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Maintenance	National Committee for Quality Assurance	Endorsed

Measure Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
0038	Childhood Immunization Status (CIS)	Maintenance	National Committee for Quality Assurance	Endorsed
1407	Immunizations for Adolescents	Maintenance	National Committee for Quality Assurance	Endorsed

Table 1b. Maintenance Measures Retired at the Steward’s Request

Measure Number	Measure Title	Developer/Steward	Reason for Withdrawal *
1382	Percentage of low birthweight births	Centers for Disease Control and Prevention	Retired the measure

**Endorsement was removed for measures retired by the measure steward.*

Summaries of the measure evaluation meetings are linked within the body of the report. Detailed summaries of the committee’s discussion and ratings of the criteria for each measure are in [Appendix A](#).

Introduction

Population health focuses on disease and illness as well as prevention and health promotion for an identified group of people. The result of these activities should achieve positive health outcomes within the identified population. Population health activities also look to reduce health inequities and disparities across populations; however, nearly 50% of health outcomes are affected by social determinants of health (SDOH), which include housing, food and nutrition, transportation, social and economic mobility, education, and environmental conditions.² While SDOH are important to improving the population's health, less than 5% of national health expenditures have been attributed to prevention services.³

Quality measures are tools to measure or quantify processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care. Furthermore, quality measures can be a powerful tool in helping identify substantial performance gaps in population health and preventive care, affecting patient outcomes and overall cost.

Battelle, a CBE, convenes volunteer committees to evaluate and build consensus around quality measures for endorsement based on a standardized set of criteria. For the Fall 2022 cycle, the Primary Prevention and Population Health standing committee reviewed measures focused on immunizations for both children and adolescents and tobacco use screening and cessation.

Child and Adolescent Immunization

Vaccines are critical tools for avoiding preventable illnesses in both the child and general population. By encouraging vaccination of children and adolescents, the most vulnerable individuals are protected from avoidable morbidity and mortality while building important herd immunity and reducing medical costs.⁴

Tobacco Use Screening and Cessation

Tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) are successful in helping tobacco users quit. Tobacco users who stop smoking lower their risk for heart disease, lung disease, and stroke.⁵

Prevention and Population Health Measure Evaluation

For the Fall 2022 measure review cycle, the Prevention and Population Health standing committee evaluated three measures undergoing maintenance review using standard measure evaluation criteria.

Table 2a. Number of Fall 2022 Prevention and Population Health Measures Submitted and Reviewed

	Maintenance	New	Total
Number of measures submitted for endorsement review	3	0	3
Number of measures withdrawn from consideration*	0	0	0
Number of measures reviewed by the committee	3	0	3
Number of measures endorsed	3	0	3
Number of measures not endorsed	0	0	0

**Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the CSAC meeting.*

Scientific Methods Panel Measure Evaluation

For the Fall 2022 cycle, the Scientific Methods Panel did not review any of the Prevention and Population Health measures as the measures and/or testing methods were deemed to be non-complex by NQF.

Comments Received Prior to Standing Committee Evaluation

For this evaluation cycle, pre-evaluation public commenting was conducted under NQF. For this evaluation cycle, no pre-evaluation comments were submitted prior to the measure evaluation meeting on [February 28, 2023](#).

Comments Received After Standing Committee Evaluation

Following the standing committee’s measure evaluation meeting, Battelle posted the committee endorsement recommendations to the [PQM website](#) for public comment. The commenting period opened on March 28, 2023, and closed on May 5, 2023. The committee did not receive any comments pertaining to the measures under review, nor the committee endorsement recommendations. Since no comments were received, Battelle staff, along with the standing committee chair, decided to cancel the post-comment web meeting scheduled for [June 12, 2023](#).

Summary of Potential High-Priority Gaps

During the standing committee's evaluation of the measures, no potential high-priority measurement gap areas were identified.

Summary of Major Concerns or Methodological Issues

During the standing committee's evaluation of the measures, no major concerns or methodological issues emerged. Details of the standing committee's discussion and ratings of the criteria for each measure are included in [Appendix A](#).

References

1. Institute of Medicine. (2010). *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*. The National Academies Press.
<https://doi.org/doi:10.17226/12750>
2. Whitman A, De Lew N, Chappel A, & al., e. (2022). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts.
<https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDO-H-Evidence-Review.pdf>
3. Bipartisan Policy Center's Nutrition and Physical Activity Initiative (NPAI). (2012). Lots to Lose: How America's Health and Obesity Crisis Threatens our Economic Future.
https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/5023_BPC_NutritionReport_FNL_Web.pdf
4. Centers for Disease Control and Prevention. (2023, April 27, 2023). *Child and Adolescent Immunization Schedule by Age*. Retrieved August 24, 2023 from
<https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>
5. U.S. Preventative Services Task Force. (2021). Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons: US Preventive Services Task Force Recommendation Statement. *JAMA*, 325(3), 265-279.
<https://doi.org/10.1001/jama.2020.25019>

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

Under the NQF process, quorum is 66% of active standing committee members minus any recused standing committee members. There were no recused committee members for the Fall 2022 cycle. Therefore, quorum (12 out of 18 standing committee members) was reached and maintained throughout the full measure evaluation meeting on February 28, 2023. Vote totals may differ between measure criteria and between measures because standing committee members may have joined the meeting late, stepped away for a portion of the meeting, or had to leave the meeting before voting was complete. The vote totals listed below reflect the committee members present and eligible to vote at the time of the vote.

A measure is recommended for endorsement by the standing committee when greater than 60% of voting members select a passing vote option (i.e., Pass, High and Moderate, or Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40% of voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement.

A.1 Measures Endorsed

CBE #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

[Staff Assessment](#) | [Specifications](#)

Numerator Statement: Population 1: Patients who were screened for tobacco use at least once within the measurement period

Population 2: Patients who received tobacco cessation intervention

Population 3: Patients who were screened for tobacco use at least once within the measurement period AND who received tobacco cessation intervention if identified as a tobacco user

Denominator Statement: Population 1: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Population 2: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use and identified as a tobacco user

Population 3: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Exclusions: Denominator Exclusions: not applicable. These are identified as denominator exceptions. We have defined the current methodology for distinguishing between denominator exclusions and denominator exceptions in question sp. 18. We did not receive testing information related to these exceptions.

Denominator Exceptions:

Population 1:

Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

Population 2:

Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)

Population 3:

Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason)

Adjustment/Stratification: None

Level of Analysis: Clinician: Individual

Setting of Care: Other

Type of Measure: Process

Data Source: Claims; Registry Data

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE EVALUATION

Table A.1-1.1. Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	Total Votes- 16; H-8; M-8; L-0; I-0 (16/16 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee recognized that this maintenance measure has a logic model that depicts that cessation intervention for adults 18 and older who report tobacco use during screening is not only effective in helping users quit, but can also lower the risk for heart disease, stroke, and lung disease. The developer submitted new evidence from systematic reviews completed between 2013 and 2022, as well as randomized and non-randomized trials, showing a link between receiving a cessation intervention and quitting among patients who report tobacco use. The developer also cited the 2021 Final Recommendation Statement from the United States Preventive Services Task Force (USPSTF). The committee agreed that although the evidence was updated, it is directionally the same and more robust than the evidence from the previous review. Therefore, the standing committee did not raise any questions or concerns and passed the measure on evidence.
1b. Performance Gap	Total Votes-16; H-2; M-14; L-0; I-0 (16/16 – 100.0%, Pass)	<ul style="list-style-type: none"> The developer provided 2020 (January 1-December 31, 2020) opt-in data from the Merit-based Incentive Payment System, which included 19,427 physicians and other clinicians (e.g., nurse practitioners, Physician Assistants). The developer found a mean performance of 70.71% with a standard deviation of 29.93. The committee recognized that disparities data has not yet been made available for analysis and reporting. However, using the 2015 National Health Interview Survey, the developer noted several disparities by age, race, type of health insurance, and among persons with disabilities. One standing committee member asked the developer to clarify why there is a lack of information on disparities data for the measure rates. Additionally, one member noted that it would be helpful if the developer provided disparities data on tobacco usage. The developer replied that while disparities data are not available to use or include in the measure submission, they agreed that disparities data are important and will be taken into consideration going forward. The standing committee accepted the developer’s response and passed the measure on performance gap.

Table A.1-1.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
<p>2a. Reliability</p>	<p>Total Votes- 16; H-0; M-13; L-2; I-1 (13/16 – 81.3%, Pass)</p>	<ul style="list-style-type: none"> • The committee noted that that reliability testing was conducted at the Accountable Entity Level: <ul style="list-style-type: none"> ○ The developer performed a signal-to-noise reliability test for each population (1: those screened for tobacco use, 2: those who received an intervention, and 3: those screened and who received an intervention). The data is from 19,427 individual physicians and other clinicians who opted into the Merit-based Incentive Payment System (MIPS). ○ For population 1, scores ranged from 0.888 to 1 with a mean reliability of 0.994. The 25th and 75th percentiles were 0.995 and 0.999 respectively, with a standard deviation of 0.012. ○ For population 2, scores ranged from 0.887 to 1 with a mean reliability of 0.992. The 25th and 75th percentiles were 0.993 and 0.998 respectively, with a standard deviation of 0.014. ○ For population 3, scores ranged from 0.896 to 1 with a mean reliability of 0.994. The 25th and 75th percentiles were 0.963 and 0.994 respectively, with a standard deviation of 0.023. • The committee acknowledged that the developer’s signal-to-noise ratio method was appropriate. • In reviewing the specifications, the committee discussed the difference in wording between the USPSTF recommendation and what was used within the measure. Specifically, the USPSTF recommendation states that both behavioral interventions and the United States (U.S.) Food and Drug Administration (FDA)-approved pharmacotherapy are recommended, whereas the measure focuses on behavioral interventions or pharmacotherapy. • The developer explained that the difference in wording is intended to give providers the ability to determine what intervention is most appropriate for each patient. Additionally, the developer stated that it will review the recommendations to ensure that the measure adequately aligns with the USPSTF’s guidelines going forward. • Ultimately, the committee agreed that this wording difference would not make a significant difference in practice and passed the measure on reliability.

<p>2b. Validity</p>	<p>Total Votes- 17; H-0; M-15; L-0; I-2 (15/17 – 88.2%, Pass)</p>	<ul style="list-style-type: none"> • The committee noted that that validity testing was conducted at the Accountable Entity Level: <ul style="list-style-type: none"> ○ The developer performed a Pearson correlation test for construct validity to determine if the tobacco measure results correlate with another behavioral health screening measure, specifically CBE #2152 - <i>Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling</i>. ○ The developer notes a difference between the number of rates for alcohol and tobacco measures. The alcohol measure has one rate assessing whether patients who were screened and identified as an unhealthy alcohol user received brief counseling, and the tobacco measure has three rates (1: those screened for tobacco use, 2: those who received an intervention, 3: those screened and who received an intervention). Each tobacco rate was assessed separately against the alcohol measure rate. ○ For population 1, the developer reports that the rate is positively and moderately associated with the alcohol measure rate. The correlation coefficient was 0.461, and a p value <0.001. ○ For population 2, the developer reports that the rate is positively and moderately associated with the alcohol measure rate. The correlation coefficient was 0.371, with a p value <0.001. ○ For population 3, the developer reports that the rate is positively and moderately associated with the alcohol measure rate. The correlation coefficient was 0.434, with a p value <0.001. ○ The developer attests that the tobacco measure performance is moderately associated with the alcohol screening measure. Therefore, the developer suggests that clinicians who perform well on one of these preventive behavioral health measures will likely perform well on the other. • In its review of the potential threats to validity, the committee mainly focused on missing data as a threat to validity. Specifically, one member was concerned with how one can assume that records are accurate if the extent of the missing data is unknown. • Another committee member asked how missing data are treated, specifically, are missing data being excluded, or if the event is missing, does the developer assume that the event did not occur? • Other committee members were particularly concerned with the impact this measure has on assessing disparities. • The developer stated that if data are missing, performance rates would be reflective of the underreporting of the intervention. Essentially, if a provider is missing data, they would receive a lower score. The developer stated that information on missing data is not available from the publicly available data it uses for the measure analysis and will take the committee’s comments into consideration going forward. • The committee accepted the developer’s response and passed the measure on validity.
----------------------------	---	---

Table A.1-1.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	Total Votes- 17; H-3; M-14; L-0; I-0 (17/17 – 100.0%, Pass)	<ul style="list-style-type: none"> Regarding feasibility, the committee did not raise any concerns other than clarification on why the electronic clinical quality measure (eCQM) version of the measure was retired. The developer explained that the eCQM version of the measure is still in use in the Healthcare Effectiveness Data and Information Set (HEDIS); however, it was voluntarily withdrawn from CBE endorsement review due to its inability to meet the testing requirements. The committee did not have any additional questions and passed the measure on feasibility.

Table A.1-1.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	Total Votes- 17; Pass-17; No Pass-0 (17/17 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee acknowledged that the measure is publicly reported in the Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) and the Million Hearts Clinical Quality Measures set. The committee did not have any questions or concerns and passed the measure on use.
4b. Usability	Total Votes- 17; H-1; M-14; L-0; I-2 (15/17 – 88.2%, Pass)	<ul style="list-style-type: none"> The committee noted that the developer did not report any improvement results due to limited availability of QPP data. The Standing Committee questioned why the developer did not report any improvement results from the QPP. The developer explained that publicly reported data were limited and that it uses customer feedback to improve the measure for future use. The committee did not have any additional questions or concerns and passed the measure on usability.

Table A.1-1.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> No related or competing measures were noted.

Table A.1-1.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Recommended for Endorsement	Total Votes- 17; Yes- 17; No-0 (17/17 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee passed the measure on its overall suitability for endorsement.

Table A.1-1.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	<ul style="list-style-type: none"> None 	N/A
Non-supportive comments	<ul style="list-style-type: none"> None 	N/A

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.1-1.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Endorsed	<ul style="list-style-type: none"> Total Votes-13; Yes-13; No-0 	<ul style="list-style-type: none"> Unanimous approval to endorse the measure via a consent calendar.

APPEALS BOARD EVALUATION

Table A.1-1.9. Appeals

Appeal Received (Yes/No)	Appellant Organization	Summary of Appeal and Its Review
No	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> N/A

CBE #0038 Childhood Immunization Status (CIS)

[Staff Assessment](#) | [Specifications](#)

Numerator Statement: Children who received the recommended vaccines by their second birthday.

Denominator Statement: Children who turn 2 years of age during the measurement year.

Exclusions: Exclude children who were in hospice, had a contraindication for a specific vaccine, or have immunodeficiencies.

Adjustment/Stratification: None

Level of Analysis: Health plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims; Paper Medical Record

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE EVALUATION

Table A.1-2.1. Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
<p>1a. Evidence</p>	<p>Total Votes- 14; M-14; L-0; I-0 (14/14 – 100.0%, Pass)</p>	<ul style="list-style-type: none"> • The committee recognized that this maintenance measure has a logic model that depicts when children 2 years of age and younger receive their recommended vaccinations, they become protected from potentially life-threatening diseases. • The committee acknowledged that there were no changes in clinical recommendations; therefore, the measure continues to be aligned with the guideline. • The committee noted that the measure is based on Advisory Committee on Immunization Practices (ACIP) guidelines; however, it questioned why an overall grade of evidence had not been provided. • The developer noted that each of the vaccines was evaluated by ACIP over time and the way ACIP presents the evidence for each vaccine is different based on when the review occurred. • As a result, an overall grade was not provided for each vaccine. The developer noted that it summarized the evidence for each vaccine given by ACIP but did not conduct its own systematic review. Therefore, an overall grade for the evidence was not provided by the developer. • The committee also asked the developer whether the new ACIP recommendations for the COVID-19 vaccine have been considered for this measure. The developer replied that it has been monitoring what has been happening with the COVID-19 vaccine, particularly, and it has been waiting for the evidence on COVID-19 vaccination to mature. • The developer noted that because there are different vaccines and dosing requirements, it will look to add COVID-19 into the measure once those recommendations are finalized. • The committee did not raise any additional questions and passed the measure on evidence.

Criterion	Total Votes	Rationale
1b. Performance Gap	Total Votes- 14; H-2; M-11; L-0; I-1 (13/14 – 92.9%, Pass)	<ul style="list-style-type: none"> • The developer provided performance measure rates for each of the ten immunizations for the years 2019 to 2021 for both commercial and Medicaid plans using HEDIS data. For each vaccine type, there was one commercial and one Medicaid plan per year, resulting in three years of data for each plan type. • During the discussion on performance gap, the committee raised the same issue with the data as was raised with CBE #0028, namely that while disparities are present for vaccination coverage, the developer’s submission does not provide actual data from the measure results to support this fact. • Rather, the developer referenced literature from the National Immunization Survey that showed disparities in vaccination coverage. The developer noted that the National Committee for Quality Assurance is adding race and ethnicity stratification to measures in HEDIS. However, in the meantime, the literature shows that disparities exist. • The committee did not raise any additional questions and passed the measure on performance gap.

Table A.1-2.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	Total Votes- 14; H-0; M-14; L-0; I-0 (14/14 – 100.0%, Pass)	<ul style="list-style-type: none"> • The committee noted that that reliability testing was conducted at the Accountable Entity Level: <ul style="list-style-type: none"> ○ The developer performed a signal-to-noise reliability test. ○ Reliability ranged from a low of 0.81 (VZV/MMR) to a high of 0.94 (IPV) among the commercial plans and from a low of 0.83 (VZV/MMR) to a high of 0.95 (Influenza) among the Medicaid plans. ○ The average commercial plan reliability ranged from 0.81 (MMR/VZV) to 0.94 (IPV/Pneumococcal conjugate). The average Medicaid plan reliability ranged from 0.83 (MMR/VZV) to 0.95 (Influenza). • The committee noted that the reliability is high for the individual vaccinations within the measure. The committee asked the developer to clarify how all the data still have the same reliability if they are coming from different sources. • The developer noted that HEDIS measures are audited to ensure that reported data are legitimate, and because of this fact, the developer has confidence that the data are still reliable even though the data may be coming from different sources. • The committee did not have any additional questions and passed the measure on reliability.

Criterion	Total Votes	Rationale
2b. Validity	Total Votes- 14; H-0; M-12; L-0; I-2 (12/14 – 85.7%, Pass)	<ul style="list-style-type: none"> • The committee noted that that validity testing was conducted at the Accountable Entity Level: <ul style="list-style-type: none"> ○ Validity was tested using construct validity by correlating vaccine rate for children under 2 years old with adolescent vaccination rates. ○ These were done for four of the vaccine rates (Dtap, MMR, Rotavirus, and VZV). ○ The developer correlated these against adolescent vaccines: Tdap, HPV, and Meningococcal respectively. ○ The results were stratified by payer. All correlations were positive. ○ Commercial plan correlations ranged from 0.52 to 0.79 and Medicaid plan correlations ranged from 0.41 to 0.59. Statistical testing with a p-value was not provided. ○ Validity tests were not provided for Hepatitis A, Hepatitis B, HiB, Influenza, IPV, or Pneumococcal Conjugate. • In its review of the potential threats to validity, the committee noted that the developer did provide information on prevalence of the exclusions by payer. • For commercial plans, 0.57% of the population was excluded and for Medicaid plans, 0.22% of the population was excluded. • The committee noted that the validity testing analysis was strong and appropriate and questioned why NQF staff gave the validity testing a preliminary rating of insufficient. During the committee measure evaluation meeting, prior to the transition of the E&M work to Battelle, NQF staff clarified that the insufficient rating was given because testing was only presented for four out of the 10 vaccines included in the measure. • The developer verbally noted that they conducted testing on all vaccines and found similarly strong results for the vaccines that were not included in the submission. • The committee asked NQF staff how they would rate the validity testing if the results were similar to what was presented. NQF staff noted that this is challenging to know without reviewing the results. • However, the committee can consider the developer’s verbal attestation of the results for its consideration when voting. • The committee noted that it was comfortable with the verbal attestation the developer gave and passed the measure on validity.

Table A.1-2.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	Total Votes- 14; H-6; M-8; L-0; I-0 (14/14 – 100.0%, Pass)	<ul style="list-style-type: none"> Regarding feasibility, the committee recognized that the measure is collected through administrative data, electronic clinical data, paper records, and registry data to allow for widespread adoption across health plans and health care practices. The committee did not have any additional questions and passed the measure on feasibility.

Table A.1-2.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	Total Votes- 14; Pass-14; No Pass-0 (14/14 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee acknowledged that the measure is publicly reported nationally in the NCQA Health Plan Rating system and is included in the NCQA State of Health Care Annual Report. It is also used in the CMS Medicaid Child Core Set, CMS Health Insurance Marketplaces – Quality Rating System, CMS EHR Incentive Program, MIPS QPP, NCQA Health Plan Accreditation, and Quality Compass. The committee did not have any questions or concerns and passed the measure on use.
4b. Usability	Total Votes- 14; H-7; M-7; L-0; I-0 (14/14 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee acknowledged that the number of accountable entities included in the measure has increased since the last submission and that performance rates generally remained high with some fluctuations, which may be attributable to the coronavirus 2019 (COVID-19) pandemic. To demonstrate this potential attribution, the developer cited a study that found that 43.5% of patients within 2020 were not up to date on their childhood vaccines. The committee did not have any additional questions or concerns and passed the measure on usability.

Table A.1-2.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	<ul style="list-style-type: none"> CBE #0041 Preventive Care and Screening: Influenza Immunization CBE # #1659 Influenza Immunization 	<ul style="list-style-type: none"> The developer attested that the measures are harmonized to the extent possible.

Table A.1-2.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Recommended for Endorsement	Total Votes- 14; Yes- 14; No-0 (14/14 – 100%, Pass)	<ul style="list-style-type: none"> The committee passed the measure on its overall suitability for endorsement.

Table A.1-2.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	<ul style="list-style-type: none"> None 	N/A
Non-supportive comments	<ul style="list-style-type: none"> None 	N/A

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.1-2.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Endorsed	Total Votes-13; Yes-13; No-0	<ul style="list-style-type: none"> Unanimous approval to endorse the measure via a consent calendar.

APPEALS BOARD EVALUATION

Table A.1-2.9. Appeals

Appeal Received (Yes/No)	Appellant Organization	Summary of Appeal and Its Review
No	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> N/A

CBE #1407 Immunizations for Adolescents

[Staff Assessment](#) | [Specifications](#)

Numerator Statement: Adolescents who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday.

Denominator Statement: Adolescents who turn 13 years of age during the measurement year.

Exclusions: This measure excludes patients who have a contraindication for the vaccine and patients who use hospice services during the measurement year.

Adjustment/Stratification: None

Level of Analysis: Health plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims; Paper Medical Records; Electronic Health Records; Registry Data

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE EVALUATION

Table A.1-3.1. Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	Total Votes- 15; M-15; L-0; I-0 (15/15 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee recognized that developer attests that there have been no changes in the evidence since the measure was last evaluated. The measure is based on evidence from the Advisory Committee on Immunization Practices (ACIP) guidelines, which are endorsed by the Centers for Disease Control and Prevention (CDC). The committee did not raise any additional questions and passed the measure on evidence.

Criterion	Total Votes	Rationale
1b. Performance Gap	Total Votes- 15; H-1; M-14; L-0; I-0 (15/15 – 100.0%, Pass)	<ul style="list-style-type: none"> The developer provided performance measure rates for each of the immunizations for the years 2020 to 2022 from the Healthcare Effectiveness Data and Information Set (HEDIS) reflecting the most recent years of measurement for this measure. A high level of mean performance rates for each of the vaccines was found within the measure with minimal standard deviations. However, the committee agreed that substantial disparities are present in childhood vaccination rates and applauded the developer for developing this measure to address this issue. The committee acknowledged that the measure can be stratified by certain patient characteristics, such as race, ethnicity, and socioeconomic status (SES), to assess health care disparities if the data are captured by the health plan. Additionally, the committee noted that the developer cited evidence from the National Immunization Survey, which concluded that while national coverage for most routine childhood vaccinations remains stable, disparities do exist. The committee noted that the developer did not provide measure data to support this claim and expressed that the lack of these data should not preclude the committee from accepting the measure. Raising no additional discussions, the committee passed the measure on performance gap.

Table A.1-3.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	Total Votes- 15; H-8; M-7; L-0; I-0 (15/15 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee noted that that reliability testing was conducted at the Accountable Entity Level: <ul style="list-style-type: none"> The developer performed a signal-to-noise reliability test with 2018 to 2020 data. Reliability ranged from a low of 0.91 (HPV) to a high of 0.94 (Tdap/Meningococcal) among the commercial plans and from a low of 0.93 (Tdap) to a high of 0.95 (Meningococcal) among the Medicaid plans. The average commercial plan reliability ranged from 0.92 (HPV) to 0.94 (Meningococcal/Tdap). The average Medicaid plan reliability ranged from 0.93 (Tdap) to 0.95 (Meningococcal). The committee did not have any questions or concerns and passed the measure on reliability.

Criterion	Total Votes	Rationale
2b. Validity	Total Votes -14; H-1; M-13; L-0; I-0 (14/14 – 100.0%, Pass)	<ul style="list-style-type: none"> • The committee noted that that validity testing was conducted at the Accountable Entity Level: <ul style="list-style-type: none"> ○ Validity was tested using construct validity by correlating vaccine rate for adolescents with vaccine rates for children under 2 years old. ○ The developer examined the correlation of Tdap with DTap and MMR, HPV with Rotavirus, and Meningococcal with VZV. These vaccines have similar dosing requirements. ○ The results were stratified by payer. All correlations were positive. Commercial plan correlations ranged from 0.52 to 0.79 and Medicaid plan correlations ranged from 0.41 to 0.59. Statistical testing with a p-values was not provided. • In its review of the potential threats to validity, the committee noted that the developer did provide information on prevalence of the exclusions by payer. • For commercial plans, 91 of 391 plans reported any exclusions, and among those reporting exclusions 0.69% of their population was excluded on average. • Among Medicaid plans, 16 of 239 plans reported any exclusions, and among those reporting exclusions 0.02% of the population were excluded. • In its review of validity testing, the committee requested the p-values for validity testing from the developer. The developer stated that all p-values were less than 0.001 and statistically significant. Therefore, the committee passed the measure on validity.

Table A.1-3.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	Total Votes- 14; H-1; M-13; L-0; I-0 (14/14 – 100.0%, Pass)	<ul style="list-style-type: none"> • Regarding feasibility, the committee noted that the measure is not currently developed as an eCQM and asked the developer whether they had plans to add the measure as an eCQM. • The developer replied that they do have plans to add clinical quality language to the measure and expect to add electronic clinical data systems reporting to this measure soon. • The committee noted that the developer reported that the data elements needed to compute the measure are generated and collected by health care personnel and coded by someone other than the original person obtaining the information. • The committee did not have any additional questions and passed the measure on feasibility.

Table A.1-3.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	Total Votes- 14; Pass-14; No Pass-0 (14/14 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee acknowledged that the measure is publicly reported nationally in the NCQA Health Plan Rating system and is included in the NCQA State of Health Care Annual Report. It is also used in the CMS Medicaid Child Core Set, CMS Health Insurance Marketplaces – Quality Rating System, NCQA Health Plan Accreditation, and Quality Compass. The committee did not have any questions or concerns and passed the measure on use.
4b. Usability	Total Votes- 14; H-3; M-11; L-0; I-0 (14/14 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee acknowledged that the developer reported that performance rates for this measure remained high throughout the COVID-19 pandemic. Further, the developer noted no unexpected harm from the use of the measure. The committee did not have any questions or concerns and passed the measure on usability.

Table A.1-3.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> The developer did not identify any endorsed or non-endorsed related or competing measures.

Table A.1-3.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Recommended for Endorsement	Total Votes- 14; Yes- 14; No-0 (14/14 – 100.0%, Pass)	<ul style="list-style-type: none"> The committee passed the measure on its overall suitability for endorsement.

Table A.1-3.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	<ul style="list-style-type: none"> None 	N/A
Non-supportive comments	<ul style="list-style-type: none"> None 	N/A

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.1-3.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Endorsed	<ul style="list-style-type: none"> Total Votes-13; Yes-13; No-0 	<ul style="list-style-type: none"> Unanimous approval to endorse the measure via a consent calendar.

APPEALS BOARD EVALUATION

Table A.1-3.9. Appeals

Appeal Received (Yes/No)	Appellant Organization	Summary of Appeal and Its Review
No	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> N/A

Appendix B: Prevention and Population Health Standing Committee and Battelle Staff

STANDING COMMITTEE

Amir Qaseem, MD, PhD, MHA, MRCP (London), FACP (Chair)

Vice President, Clinical Policy, American College of Physicians

Jayaram Brindala, MD, MBA, MPH

Chief Medical Officer for Population Health, AdventHealth

Ron Bialek, MPP, CQIA

President, Public Health Foundation

Gigi Chawla, MD, MHA

Chief of General Pediatrics, Children's Minnesota

Favio Freyre, MD

Clinical Quality Care and Revenue Cycle Manager, EazyDoc

Barry-Lewis Harris, II, MD

Regional Medical Director, Corizon Health

Catherine Hill, DNP, APRN

Chief Nursing Officer/Director of Quality and Clinical Outcomes, Texas Health Resources

Amy Nguyen Howell, MD, MBA, FAAFP

Chief Medical Officer, America's Physician Groups

Julia Logan, MD, MPH

Associate Medical Director, California Department of Health Care Services

Lisa Nichols, MSW

Asst. Vice President, Community Health, Intermountain Healthcare

Patricia Quigley, PhD, APRN, CRRN, FAAN, FAANP, FARN

Associate Director, Nurse Consultant

Carol Siebert, OTD, OT/L, FAOTA

Principal/Solo Practitioner, The Home Remedy

Jason Spangler, MD, MPH, FACPM

Executive Director, Medical Policy, Amgen, Inc.

Matt Stiefel, MPA, MS

Senior Director, Center for Population Health, Care Management Institute, Kaiser Permanente

Michael Stoto, PhD

Professor of Health Systems Administration and Population Health, Georgetown University

Arjun Venkatesh, MD, MBA

RWJF Clinical Scholar, Yale University School of Medicine

Ruth Wetta, RN, PhD, MPH, MSN

Lead Clinical Researcher, Cerner Corporation

Whitney Bowman-Zatzkin, MPA, MSR

Executive Officer, Rare Dots Consulting

BATTELLE STAFF

Nicole Brennan, MPH, DrPH

Executive Director

Brenna Rabel, MPH

Deputy Director

Matthew Pickering, PharmD

Principal Quality Measure Scientist

Quintella Bester, PMP

Senior Program Manager

Lydia Stewart-Artz, PhD

Social Scientist III

Isaac Sakyi, MSGH

Social Scientist III

Jessica Ortiz, MA

Social Scientist II

Elena Hughes, MS
Social Scientist I

Rajbir Kaur, MPH
Social Scientist I

