



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

### Brief Measure Information

**NQF #:** 0033

**Corresponding Measures:**

**De.2. Measure Title:** Chlamydia Screening in Women (CHL)

**Co.1.1. Measure Steward:** National Committee for Quality Assurance

**De.3. Brief Description of Measure:** The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

**1b.1. Developer Rationale:** This measure assesses the percentage of women 16-24 years of age who were identified as sexually active and who received a test for chlamydia. The improvement in quality envisioned by the use of this measure is increased identification of untreated chlamydia infections in women that can lead to serious and irreversible complications and can be unknowingly transmitted to sexual partners. Despite the availability of effective treatments, a large proportion of sexually active individuals continue to go undiagnosed due to the disease's asymptomatic nature. Early detection, screening, and treatment have proven to be effective in managing and preventing chlamydia.

Centers for Disease Control and Prevention (CDC). 2021. "Sexually Transmitted Diseases: Chlamydia—CDC Fact Sheet." <http://www.cdc.gov/std/chlamydia/STDFact-chlamydia-detailed.htm>

**S.4. Numerator Statement:** Women who were tested for chlamydia during the measurement year.

**S.6. Denominator Statement:** Women 16-24 years of age who had a claim or encounter indicating sexual activity.

**S.8. Denominator Exclusions:** Women who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray.

Women who were in hospice or using hospice services during the measurement year.

**De.1. Measure Type:** Process

**S.17. Data Source:** Claims, Enrollment Data

**S.20. Level of Analysis:** Health Plan

**IF Endorsement Maintenance – Original Endorsement Date:** Aug 10, 2009 **Most Recent Endorsement Date:** Oct 25, 2016

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** N/A

### 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

**1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form**

[nqf\\_evidence\\_attachment\\_7.1\\_508Compliant.docx](#)

**1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?**

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

**1b. Performance Gap**

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

**1b.1. Briefly explain the rationale for this measure** (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

*If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.*

This measure assesses the percentage of women 16-24 years of age who were identified as sexually active and who received a test for chlamydia. The improvement in quality envisioned by the use of this measure is increased identification of untreated chlamydia infections in women that can lead to serious and irreversible complications and can be unknowingly transmitted to sexual partners. Despite the availability of effective treatments, a large proportion of sexually active individuals continue to go undiagnosed due to the disease's asymptomatic nature. Early detection, screening, and treatment have proven to be effective in managing and preventing chlamydia.

Centers for Disease Control and Prevention (CDC). 2021. "Sexually Transmitted Diseases: Chlamydia—CDC Fact Sheet." <http://www.cdc.gov/std/chlamydia/STDFact-chlamydia-detailed.htm>

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data is summarized at the health plan level and summarized by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at 10th, 25th, 50th, 75th, and 90th percentile. Data is stratified by year and product line (i.e. commercial, Medicaid).

The following data demonstrate the variation in the rate of chlamydia screening for women across health plans. These gaps in performance underscore the opportunity for improvement.

**Chlamydia Screening in Women**

**Commercial Rate – 16 to 20 years of age**

YEAR	N	MEAN	ST DEV	Min	10TH	25TH	50TH	75TH	90TH	Max
2019	393	44%	13%	21%	30%	35%	42%	51%	63%	82%
2018	382	43%	12%	21%	30%	35%	41%	50%	62%	81%
2017	386	43%	12%	18%	30%	35%	40%	79%	60%	75%

**Commercial Rate – 21 to 24 years of age**

YEAR	N	MEAN	ST DEV	Min	10TH	25TH	50TH	75TH	90TH	Max
2019	396	55%	10%	26%	43%	48%	54%	61%	70%	83%
2018	384	54%	10%	29%	42%	47%	53%	59%	69%	80%
2017	385	53%	10%	0%	41%	46%	51%	59%	67%	80%

**Commercial Rate - Total**

YEAR	N	MEAN	ST DEV	Min	10TH	25TH	50TH	75TH	90TH	Max
2019	402	50%	11%	23%	36%	42%	48%	56%	66%	82%
2018	391	49%	11%	25%	37%	42%	47%	55%	65%	80%
2017	390	48%	11%	0%	36%	41%	46%	54%	64%	77%

## Medicaid Rate – 16 to 20 years of age

YEAR | N | MEAN | ST DEV | Min | 10TH | 25TH | 50TH | 75TH | 90TH | Max

2019 | 247 | 55% | 13% | 12% | 38% | 47% | 54% | 63% | 70% | 88%

2018 | 213 | 55% | 12% | 28% | 40% | 47% | 54% | 63% | 71% | 88%

2017 | 217 | 54% | 12% | 12% | 40% | 47% | 53% | 63% | 70% | 91%

## Medicaid Rate – 21 to 24 years of age

YEAR | N | MEAN | ST DEV | Min | 10TH | 25TH | 50TH | 75TH | 90TH | Max

2019 | 236 | 64% | 10% | 16% | 55% | 60% | 65% | 70% | 74% | 87%

2018 | 216 | 64% | 10% | 31% | 50% | 58% | 65% | 70% | 75% | 84%

2017 | 222 | 63% | 10% | 14% | 51% | 57% | 64% | 70% | 74% | 82%

## Medicaid Rate - Total

YEAR | N | MEAN | ST DEV | Min | 10TH | 25TH | 50TH | 75TH | 90TH | Max

2019 | 251 | 58% | 12% | 14% | 43% | 51% | 58% | 66% | 71% | 86%

2018 | 218 | 58% | 11% | 31% | 44% | 50% | 58% | 66% | 72% | 84%

2017 | 224 | 58% | 11% | 13% | 45% | 51% | 56% | 65% | 71% | 87%

The data references are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. It includes the number of health plans included in HEDIS data collection and the median denominator for the measure across health plans.

## Commercial – 16 to 20 years of age

YEAR | N Plans | Median Denominator Size per plan

2019 | 393 | 1,385

2018 | 382 | 1,469

2017 | 386 | 1,374

## Commercial – 21 to 24 years of age

YEAR | N Plans | Median Denominator Size per plan

2019 | 396 | 1,665

2018 | 384 | 1,713

2017 | 385 | 1,652

## Commercial – Total

YEAR | N Plans | Median Denominator Size per plan

2019 | 395 | 3,011

2018 | 391 | 3,062

2017 | 390 | 2,925

## Medicaid – 16 to 20 years of age

YEAR | N Plans | Median Denominator Size per plan

2019 | 247 | 2,261

2018 | 213 | 2,697

2017 | 217 | 2,667

## Medicaid – 21 to 24 years of age

YEAR | N Plans | Median Denominator Size per plan

2019 | 236 | 1,482

2018 | 216 | 1,663  
2017 | 222 | 1,859

Medicaid – Total

YEAR | N Plans | Median Denominator Size per plan  
2019 | 251 | 3,796  
2018 | 218 | 4,531  
2017 | 224 | 4,582

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

N/A

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

HEDIS data are stratified by type of insurance (e.g., Commercial, Medicaid). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities, if the data are available to a plan. NCQA is actively engaged with partners including the CMS Office of Minority Health in identifying feasible methods to further integrate social risk factors into health plan quality measures, with a focus on stratification. Our work is aligned with recent recommendations from MedPAC and ASPE on optimal methods for addressing social risk in quality measurement and programs.<sup>1,2</sup> This is an NCQA wide initiative. Our intent is to implement methods to bridge data concerns in the future.

HEDIS includes two measures that can be used as tools for assessing race/ethnicity and language needs of a plan’s population: Race/Ethnicity Diversity of Membership and the Language Diversity of Membership. These measures promote standardized methods for collecting these data and follow Office of Management and Budget and National Academy of Medicine guidance for collecting and categorizing race/ethnicity and language data. In addition, NCQA’s Multicultural Health Care Distinction Program outlines standards for collecting, storing, and using race/ethnicity and language data to assess health care disparities.

1. Medicare Payment Advisory Commission. (2020). The Medicare Advantage program: Status report. In Report to the Congress: Medicare Payment Policy (p. 397). [http://medpac.gov/docs/default-source/reports/mar20\\_medpac\\_ch13\\_sec.pdf](http://medpac.gov/docs/default-source/reports/mar20_medpac_ch13_sec.pdf)
2. Office of the Assistant Secretary for Planning and Evaluation, & U.S. Department of Health & Human Services. (2020). Second Report to Congress on Social Risk and Medicare’s Value-Based Purchasing Programs. <https://aspe.hhs.gov/social-risk-factors-and-medicare-value-based-purchasing-programs>

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4**

Studies show that racial/ethnic disparities continue to exist in chlamydia infection rates, particularly in Black, American Indian/Alaska Native (AI/AN) and Native Hawaiian/Other Pacific Islander (NHOPI) populations. In 2018, the rate of reported chlamydia infections for Black females was 5 times that of white females (1,411.1 and 281.7 cases per 100,000 population, respectively). The rate among AI/ANs and NHOPIs were 3.7 times and 3.3 times the rate among Whites, respectively (784.8 cases per 100,000 population and 700.8 cases per 100,000 population) (Centers for Disease Control and Prevention, 2019). Rates of screening also differ by race/ethnicity showing disparities. One study found that chlamydia screening rates for women aged 15-25 were 45.6% for white women and 57.5% for black women (Patel, 2016).

Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2018. Atlanta: U.S. Department of Health and Human Services; 2019. DOI: 10.15620/cdc.79370.

Patel CG, Chesson HW, Tao G. Racial Differences in Receipt of Chlamydia Testing Among Medicaid-Insured Women in 2013. Sex Transm Dis. 2016;43(3):147-151. doi:10.1097/OLQ.0000000000000405

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

Infectious Diseases (ID) : Sexually Transmitted

**De.6. Non-Condition Specific**(check all the areas that apply):

Screening

**De.7. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Children, Women

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

NA

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: 033\_CHL\_Spring\_2021\_Value\_Sets-637553860316459511.xlsx

**S.2c.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

**S.2d.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

**S.3.1. For maintenance of endorsement:** Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

No

**S.3.2. For maintenance of endorsement**, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

As part of NCQA's annual measure maintenance, we routinely make coding and other specification tweaks to ensure the measure remains up-to-date with current practice and based on feedback received from measure users. There have been no changes to the measure specifications since the last measure update.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population,

i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Women who were tested for chlamydia during the measurement year.

**S.5. Numerator Details** (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Women who had at least one test for chlamydia (Chlamydia Tests Value Set) during the measurement year.

**S.6. Denominator Statement** (Brief, narrative description of the target population being measured)

Women 16-24 years of age who had a claim or encounter indicating sexual activity.

**S.7. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Women 16-24 years of age as of December 31 of the measurement year who were identified as sexually active during the measurement year. Two methods are used to identify sexually active women: claim/encounter data and pharmacy data. Both methods are used to identify the eligible population; however, women only need to be identified in one method to be eligible for the measure.

Claim/encounter data: women who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meet criteria: Pregnancy Value Set, Sexual Activity Value Set, Pregnancy Tests Value Set.

Pharmacy data: women who were dispensed prescription contraceptives during the measurement year.

Contraceptives Medications List

--Contraceptives: Desogestrel-ethinyl estradiol; Dienogest-estradiol (multiphasic); Drospirenone-ethinyl estradiol; Drospirenone-ethinyl estradiol-levomefolate (biphasic); Ethinyl estradiol-ethynodiol; Ethinyl estradiol-etonogestrel; Ethinyl estradiol-levonorgestrel; Ethinyl estradiol-norelgestromin; Ethinyl estradiol-norethindrone; Ethinyl estradiol-norgestimate; Ethinyl estradiol-norgestrel; Etonogestrel; Levonorgestrel; Medroxyprogesterone; Mestranol-norethindrone; Norethindrone

--Diaphragm

--Spermicide: Nonoxonyl 9

**S.8. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

Women who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray.

Women who were in hospice or using hospice services during the measurement year.

**S.9. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Exclude women who were identified as sexually active based on a pregnancy test alone (Pregnancy Tests Value Set) AND who met either of the following:

1) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND a prescription for isotretinoin on the date of the pregnancy test or the 6 days after the pregnancy test.

2) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the 6 days after the pregnancy test.

Retinoid Medications: Isotretinoin

Exclude women who were in hospice or using hospice services during the measurement year.

**S.10. Stratification Information** (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

The measure includes two age stratifications and a total rate:

- 1) 16-20 years.
- 2) 21-24 years.
- 3) Total

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Rate/proportion

If other:

**S.13. Interpretation of Score** (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

**S.14. Calculation Algorithm/Measure Logic** (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Refer to items S.7 (Denominator details) and S.2b (Data Dictionary) for tables.

Step 1. Determine the eligible population. Identify all women 16-24 years of age as of December 31 of the measurement year who were identified as sexually active during the measurement year. Two methods are used to identify sexually active women: pharmacy data (see Contraceptives Medications List) and claim/encounter data (Pregnancy Value Set, Sexual Activity Value Set, and Pregnancy Tests Value Set). Both methods are used to identify the eligible population; however, women only need to be identified in one method to be eligible for the measure.

Step 2. Exclude women who qualified for the eligible population based on a pregnancy test (Pregnancy Tests Value Set) alone AND who meet either of the following: (1) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND a prescription for isotretinoin on the date of the pregnancy test or the 6 days after the pregnancy test; or (2) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the 6 days after the pregnancy test. Exclude women who used hospice services or elected to use a hospice benefit any time during the measurement year, regardless of when the services began.

Step 3. Determine the denominator: eligible population minus exclusions.

Step 4. Determine the numerator. Determine the number of women in the denominator who had at least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

Step 5. Report two age stratifications (16-20 years and 21-24 years), and a total rate. The total is the sum of the age stratifications.

**S.15. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A



**S.16. Survey/Patient-reported data** (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

**S.17. Data Source** (Check *ONLY* the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims, Enrollment Data

**S.18. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

If instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

**S.19. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

**S.20. Level of Analysis** (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

Health Plan

**S.21. Care Setting** (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

**S.22. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

## **2. Validity – See attached Measure Testing Submission Form**

[nqf\\_testing\\_attachment\\_7.1\\_508Compliant.docx](#)

### **2.1 For maintenance of endorsement**

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

### **2.2 For maintenance of endorsement**

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

### **2.3 For maintenance of endorsement**

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted



### 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

#### 3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

##### 3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

#### 3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields** (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*) Update this field for **maintenance of endorsement**.

ALL data elements are in defined fields in electronic claims

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.** For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

N/A

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.**

Attachment:

#### 3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Required for maintenance of endorsement.** Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

**IF instrument-based**, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable apples-to-apples comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) Information practices and control procedures
- 2) Sampling methods and procedures
- 3) Data integrity
- 4) Compliance with HEDIS specifications
- 5) Analytic file production
- 6) Reporting and documentation

In addition to the HEDIS audit, NCQA provides a system to allow “real-time” feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system, NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measures. This system is vital to the regular re-evaluation of the NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).**

Broad public use and dissemination of these measures are encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, “commercial use” refers to any sale, license, or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed, or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

## 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

Specific Plan for Use	Current Use (for current use provide URL)
	Public Reporting CMS Medicaid Adult Core Set <a href="https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html">https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html</a> CMS Qualified Health Plan (QHP) Quality Rating System (QRS) <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2017_QRS_and_QHP_Enrollee_Survey_Technical_Guidance.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2017_QRS_and_QHP_Enrollee_Survey_Technical_Guidance.pdf</a> NCQA Health Plan Rating/Report Card <a href="http://reportcard.ncqa.org/plan/external/plansearch.aspx">http://reportcard.ncqa.org/plan/external/plansearch.aspx</a> CMS Medicaid Adult Core Set <a href="https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html">https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html</a> CMS Qualified Health Plan (QHP) Quality Rating System (QRS) <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2017_QRS_and_QHP_Enrollee_Survey_Technical_Guidance.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2017_QRS_and_QHP_Enrollee_Survey_Technical_Guidance.pdf</a> NCQA Health Plan Rating/Report Card <a href="http://reportcard.ncqa.org/plan/external/plansearch.aspx">http://reportcard.ncqa.org/plan/external/plansearch.aspx</a>

	<p>Payment Program</p> <p>California Align. Measure. Perform. (AMP) Commercial HMO Program  <a href="https://www.iha.org/performance-measurement/amp-program/amp-program-descriptions/">https://www.iha.org/performance-measurement/amp-program/amp-program-descriptions/</a></p> <p>California Align. Measure. Perform. (AMP) Medi-Cal Managed Care Program  <a href="https://www.iha.org/performance-measurement/amp-program/amp-program-descriptions/">https://www.iha.org/performance-measurement/amp-program/amp-program-descriptions/</a></p> <p>California Align. Measure. Perform. (AMP) Commercial HMO Program  <a href="https://www.iha.org/performance-measurement/amp-program/amp-program-descriptions/">https://www.iha.org/performance-measurement/amp-program/amp-program-descriptions/</a></p> <p>California Align. Measure. Perform. (AMP) Medi-Cal Managed Care Program  <a href="https://www.iha.org/performance-measurement/amp-program/amp-program-descriptions/">https://www.iha.org/performance-measurement/amp-program/amp-program-descriptions/</a></p> <p>Regulatory and Accreditation Programs</p> <p>NCQA Health Plan Accreditation  <a href="http://www.ncqa.org/tabid/123/Default.aspx">http://www.ncqa.org/tabid/123/Default.aspx</a></p> <p>NCQA Accountable Care Organization Accreditation  <a href="http://www.ncqa.org/Programs/OtherPrograms/comeasuresPilotProject.aspx">http://www.ncqa.org/Programs/OtherPrograms/comeasuresPilotProject.aspx</a></p> <p>NCQA Health Plan Accreditation  <a href="http://www.ncqa.org/tabid/123/Default.aspx">http://www.ncqa.org/tabid/123/Default.aspx</a></p> <p>NCQA Accountable Care Organization Accreditation  <a href="http://www.ncqa.org/Programs/OtherPrograms/comeasuresPilotProject.aspx">http://www.ncqa.org/Programs/OtherPrograms/comeasuresPilotProject.aspx</a></p> <p>Quality Improvement (external benchmarking to organizations)</p> <p>NCQA Quality Compass  <a href="http://www.ncqa.org/tabid/177/Default.aspx">http://www.ncqa.org/tabid/177/Default.aspx</a></p> <p>NCQA Annual State of Health Care Quality  <a href="http://www.ncqa.org/tabid/836/Default.aspx">http://www.ncqa.org/tabid/836/Default.aspx</a></p>
--	---

**4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:**

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

**CALIFORNIA ALIGN. MEASURE. PERFORM. (AMP) COMMERCIAL HMO PROGRAM:** This measure is used in California's (AMP) Commercial HMO program. California's AMP programs focus on creating comprehensive benchmarks and a reliable assessment of performance for medical groups, independent practice association (IPAs), and accountable care organizations (ACOs) across health plans. The AMP Commercial HMO program (formerly known as Value Based Pay for Performance) is the cornerstone upon which all of IHA's performance measurement programs were built. Initiated in 2001, the program now includes participation from eleven health plans and about 200 California physician organizations caring for over 9 million Californians enrolled in commercial HMO and point of service products—representing 95% of commercial HMO enrollment in the state. AMP Commercial HMO has four key components: a common set of measures and benchmarks that spans clinical quality, patient experience, utilization, and cost of care measures; value-based health plan incentive payments to physician organizations; public reporting of Triple Aim performance results for physician organizations; and public recognition awards.

**CALIFORNIA ALIGN. MEASURE. PERFORM. (AMP) MEDI-CAL MANAGED CARE PROGRAM:** This measure is used in California's (AMP) Medi-Cal Managed Care program. California's AMP programs focus on creating comprehensive benchmarks and a reliable assessment of performance for medical groups, independent practice association (IPAs), and accountable care organizations (ACOs) across health plans. The AMP Medi-Cal Managed Care program is based on a common set of measures and benchmarks that spans clinical quality, patient experience, utilization, and cost of care measures. The program collects data and calculates performance results for medical groups, IPAs and FQHCs that provide care to Medi-Cal Managed Care enrollees. Health plans can use the results to make value-based incentive payments to their contracted providers.

**MEDICAID ADULT CORE SET:** There are a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers of Medicare & Medicaid (CMS) in partnership with the Agency for Healthcare Research and Quality (AHRQ). The data collected from these measures will help CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, as of 2014, state data on the adult quality measures is part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid.

**NCQA HEALTH PLAN RATING/REPORT CARDS:** This measure is used to calculate health plan rankings which are reported on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2019, a total of 515 commercial health plans and 188 Medicaid health plans across 50 states were included in the rankings.

**NCQA STATE OF HEALTH CARE ANNUAL REPORT:** This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2019, the report included results from calendar year 2018 for health plans covering a record 136 million people, or 43 percent of the U.S. population.

**NCQA HEALTH PLAN ACCREDITATION:** This measure is used in scoring for accreditation of commercial and Medicaid health plans. In 2019, 336 commercial health plans covering 87 million lives and 77 Medicaid health plans covering 9.1 million lives were accredited. Health plans are scored based on performance compared to benchmarks.

**NCQA ACCOUNTABLE CARE ORGANIZATION ACCREDITATION:** This measure is used in NCQA's ACO Accreditation program, that helps health care organizations demonstrate their ability to improve quality, reduce costs and coordinate patient care. ACO standards and guidelines incorporate whole-person care coordination throughout the health care system.

**NCQA QUALITY COMPASS:** This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

**QUALIFIED HEALTH PLAN (QHP) QUALITY RATING SYSTEM (QRS):** This measure is used in the Qualified Health Plan (QHP) Quality Rating System, which provides comparable information to consumers about the quality of health care services and QHP enrollee experience offered in the Marketplaces.

**4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

N/A

**4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

N/A

**4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

**How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.**

Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans.

Public reporting and benchmarking are effective quality improvement methods.

**4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Quality Congress, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System, as described in Section 3c.1.

**4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

**Describe how feedback was obtained.**

NCQA measures are evaluated regularly using a consensus-based process to consider input from multiple stakeholders, including but not limited to entities being measured. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

**4a2.2.2. Summarize the feedback obtained from those being measured.**

Questions received through the Policy Clarification Support system have generally centered around clarification on the definition of "sexually active." Other questions have sought clarification about whether direct optical observation would count as screening.

**4a2.2.3. Summarize the feedback obtained from other users**

This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as NCQA's Health Plan Accreditation and CMS's Medicaid Adult Core Set program.

**4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

During the measure's regular maintenance cycle, feedback obtained through the mechanisms described in 4a2.2.1 informed how we implemented minor updates to the measure.

**Improvement**

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

**4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**

**If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

Over the past three years, this measure has shown slight improvement (approximately 1% improvement over the past three years) across commercial health plans (see section 1b.2 for summary of data from health plans) and consistent average performance of 58% across Medicaid plans. The greatest improvement in performance has been seen for commercial plans (avg. 24% improvement for plans at the minimum performance rate). There is also variation in performance rates when comparing across low- and high-performance plans. For example, in 2019, the percentage point difference between commercial and Medicaid plans in the 10th and 90th percentile was 30 and 28 percentage points, respectively. These gaps indicate a continued opportunity for improvement. These data are nationally representative.

**4b2. Unintended Consequences**

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

**4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.**

There were no identified unintended findings for this measure during testing or since implementation.

**4b2.2. Please explain any unexpected benefits from implementation of this measure.**

There were no identified unintended benefits for this measure during testing or since implementation.

## 5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

### 5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.  
Yes

#### 5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0409 : HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

#### 5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

### 5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

#### 5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

Yes

#### 5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

NQF #0409 assesses the percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, who have received chlamydia, gonorrhea, and syphilis screenings at least once since the diagnosis of HIV infection. The measures differ in level of accountability and population of focus. Measure #0409 is a physician level measure and therefore, only includes patients who had an office visit with an eligible provider while NQF #0033 is reported by health plans and includes the entire health plan population. NQF #0409 focuses specifically on patients (both male and female) aged 13 and older that have been diagnosed with HIV/AIDS. Measure 0033 focuses on sexually active female adolescents and young adults, which is aligned to the U.S. Preventive Services Task Force recommendation. In addition, measure 0409 measures screenings at least once since the diagnosis of HIV, while 0033 assesses yearly screening of chlamydia. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN: The measure performance rates should not be compared, as they focus on different populations of interest.

### 5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

#### 5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

N/A

## Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or

methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**No appendix Attachment:**

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance

**Co.2 Point of Contact:** Bob, Rehm, [nqf@ncqa.org](mailto:nqf@ncqa.org), 202-955-1728-

**Co.3 Measure Developer if different from Measure Steward:** National Committee for Quality Assurance

**Co.4 Point of Contact:** Brittany, Wade, [wade@ncqa.org](mailto:wade@ncqa.org), 202-530-0463-

## Additional Information

### Ad.1 Workgroup/Expert Panel involved in measure development

**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

#### COMMITTEE ON PERFORMANCE MEASUREMENT

Andrew Baskin, MD CVS Health/Aetna

Elizabeth Drye, MD, SM Yale School of Medicine

Andrea Gelzer, MD, MS, FACP AmeriHealth Caritas

Kate Goodrich, MD, MHS Centers for Medicare & Medicaid Services

David Grossman, MD, MPH Washington Permanente Medical Group

Christine S. Hunter, MD (Co-Chair) Independent Board Director

David K. Kelley, MD, MPA Pennsylvania Department of Human Services

Jeff Kelman, MD, MMSc Department of Health and Human Services

Nancy Lane, PhD Independent Consultant

Bernadette Loftus, MD Independent Consultant

Adrienne Mims, MD, MPH, AGSF, FAAFP Alliant Health Solutions

Amanda Parsons, MD, MBA MetroPlus

Wayne Rawlins, MD, MBA ConnectiCare

Misty Roberts, MSN, RN, CPHQ, PMP Humana

Rodolfo Saenz, MD, MMM, FACOG Riverside Medical Clinic

Marcus Thygeson, MD, MPH (Co-Chair) Bind Benefits

JoAnn Volk, MA Georgetown University Liaisons

Rose Baez, RN, MSN, MBA, CPHQ Blue Cross Blue Shield Association

Jeff Brady, MD, MPH Agency for Healthcare Research and Quality

Ron Kline, MD Office of Personnel Management

Elisa Munthali, MPH National Quality Forum

Chinwe Nwosu, MS America's Health Insurance Plans

Chesley Richards, MD, MPH, FACP Centers for Disease Control and Prevention

Anecia Suneja, CNS-BC Veteran's Health Administration

#### HEDIS Expert Coding Panel

Glen Braden, MBA, CHCA, Attest Health Care Advisors, LLC

Denene Harper, RHIA, American Hospital Association

DeHandro Hayden, BS, American Medical Association

Patience Hoag, RHIT, CPHQ, CHCA, CCS, CCS-P, Health Services Advisory Group

Nelly Leon-Chisen, RHIA, American Hospital Association

Tammy Marshall, LVN, Aetna

Alec McLure, RHIA, CCS-P, Verisk Health

Michele Mouradian, RN, BSN, McKesson Health Solutions

Craig Thacker, RN, CIGNA HealthCare

Mary Jane F. Toomey, RN CPC, Aetna Better Health

#### NCINQ Measurement Advisory Panel



Mary Applegate, MD, Ohio Department of Job and Family Services  
Katie Brookler, Colorado Department of Health Care Policy and Financing  
Cathy Caldwell, MPH, Alabama Department of Public Health  
Ted Ganiats, MD, University of California, San Diego  
Darcy Gruttadaro, JD, National Allegiance on Mental Illness  
Jennifer Havens, MD, NYU School of Medicine  
Virginia Moyer, MD, MPH, FAAP, Baylor College of Medicine, USPSTF  
Edward Schor, MD, Lucile Packard Foundation for Children's Health  
Xavier Sevilla, MD, FAAP, Whole Child Pediatrics  
Gwen Smith, Illinois Department of Healthcare and Family Services/Health Management Associates  
Janet (Jessie) Sullivan, MD, Hudson Health Plan  
Kalahn Taylor-Clark, PhD, MPH, George Mason University  
Craig Thiele, MD, CareSource  
Jeb Weisman, PhD, Children's Health Fund  
Charles Wibbelsman, MD, Kaiser Permanente Medical Group, Inc.

NCINQ Clinician Advisory Panel  
Elizabeth Alderman, MD, FAAP, Albert Einstein College of Medicine  
Sarah Brewington, MD, Sandhills Pediatrics Inc  
Gale Burstein, MD, MPH, FAAP, FSAHM, Women and Children's Hospital of Buffalo, NY  
Barry Bzostek, MD, FAAP, Women and Children's Hospital of Buffalo, NY  
Danielle Casher, MD, FAAP, St. Christopher's Hospital for Children  
Edward Curry, MD, FAAP, Emergency Department, St. Christopher's Hospital for Children, PA  
Eve Kimball, MD, FAAP, Southern California Permanente Medical Group  
Paul Melinkovich, MD, FAAP, Kaiser Permanente  
Jackie Nelson, MD, FAAP, Lander Regional H  
Ellen Squire, MD, FAAP, HaysMed Pediatric Center

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 1999

**Ad.3 Month and Year of most recent revision:** 12, 2018

**Ad.4 What is your frequency for review/update of this measure?** Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

**Ad.5 When is the next scheduled review/update for this measure?** 12, 2021

**Ad.6 Copyright statement:** ©2021 by the National Committee for Quality Assurance

1100 13th Street, NW, Suite 1000

Washington, DC 20005

**Ad.7 Disclaimers:** These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

**Ad.8 Additional Information/Comments:** NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

These performance measures were developed and are owned by NCQA. They are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or physician that uses or reports performance measures, and NCQA has no liability to anyone who relies on such measures. NCQA holds a copyright in these measures and can rescind or alter these measures at any time. Users of the measures shall not have the right to alter, enhance or otherwise modify the measures, and shall not disassemble, recompile or reverse engineer the source code or object code relating to the measures. Anyone desiring to use or reproduce the measures without modification for a noncommercial

purpose may do so without obtaining approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. © 2012 by the National Committee for Quality Assurance