



## 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 #:** 0071

**Corresponding Measures:**

**De.2. Measure Title:** Persistence of Beta-Blocker Treatment After a Heart Attack

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

**De.3. Brief Description of Measure:** The percentage of patient's 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

**1b.1. Developer Rationale:** This measure addresses the appropriate clinical management of a person who has experienced an AMI. Persistent beta-blocker treatment after a heart attack reduces the risk of mortality, reduces the risk of severity of reinfarction, and improves the preservation of the left ventricular function.

**S.4. Numerator Statement:** Patients who received at least 135 days of treatment with beta-blockers during the 180-day measurement interval.

**S.6. Denominator Statement:** An acute inpatient discharge from July 1 of the year prior to the measurement year through June 30 of the measurement year with any diagnosis of acute myocardial infarction (AMI) on the discharge claim.

**S.8. Denominator Exclusions:** Any of the following any time during the patient's history through the end of the continuous enrollment period meet criteria:

- Asthma
- COPD
- Obstructive chronic bronchitis
- Chronic respiratory conditions due to fumes and vapors
- Hypotension, heart block >1 degree or sinus bradycardia
- A medication dispensing event indicative of a history of asthma
- Intolerance or allergy to beta-blocker therapy

Additionally, this measure excludes adults in hospice. It also excludes adults with advanced illness and frailty, as well as Medicare adults 65 years of age and older enrolled in an I-SNP or living long-term in institutional settings.

**De.1. Measure Type:** Outcome: Intermediate Clinical Outcome

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

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

**IF Endorsement Maintenance – Original Endorsement Date:** Aug 10, 2009 **Most Recent Endorsement Date:** Jul 31, 2020

**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

[PBH\\_Evidence\\_Form\\_-71-.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 addresses the appropriate clinical management of a person who has experienced an AMI. Persistent beta-blocker treatment after a heart attack reduces the risk of mortality, reduces the risk of severity of reinfarction, and improves the preservation of the left ventricular function.

**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 and reflect the most recent years of measurement for this measure. Performance data is summarized at the health plan level and summarized by the mean, standard deviation, minimum health plan performance, maximum health plan performance, performance percentiles (10th, 25th, 50th, 75th, and 90th percentile) and the interquartile range. Data is stratified by year and product line (i.e. commercial, Medicare, Medicaid) at the health plan level.

Persistence of Beta-Blocker Treatment After a Heart Attack

N = Number of Health Plans

YEAR = Measurement Year

#### Commercial

YEAR|N|MEAN|ST DEV|MIN|10th|25th|50th|75th|90th|MAX|Interquartile Range

2015|245|83%|6%|62%|76%|79%|83%|88%|91%|99%|9%

2016|251|84%|7%|57%|76%|80%|85%|89%|92%|98%|9%

2017|243|85%|6%|57%|77%|81%|85%|89%|92%|100%|8%

#### Medicaid

YEAR|N|MEAN|ST DEV|MIN|10th|25th|50th|75th|90th|MAX|Interquartile Range

2015|115|80%|11%|43%|64%|75%|83%|88%|92%|97%|13%

2016|136|80%|9%|50%|67%|77%|81%|86%|90%|95%|9%

2017|145|78%|9%|39%|66%|74%|80%|84%|89%|97%|10%

#### Medicare

YEAR|N|MEAN|ST DEV|MIN|10th|25th|50th|75th|90th|MAX|Interquartile Range

2015|258|91%|5%|68%|85%|88%|91%|94%|97%|100%|6%

2016|256|90%|5%|61%|83%|88%|91%|94%|96%|100%|6%

2017|272|90%|5%|71%|84%|88%|91%|93%|95%|100%|6%

**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.**

The CMS Office of Minority Health in collaboration with the RAND Corporation produces an annual report: CMS Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage. We provide below summary data for this measure from that report. The authors note that “for reporting HEDIS data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from CMS administrative data, surname, and residential location.”

The report described racial and ethnic disparities among beneficiaries 18 and older who received persistent beta blocker treatment for 6-months following a hospital discharge for a heart attack. Overall, Whites were more likely to receive treatment. Whites received treatment over 3% more than Blacks, at a rate of 92.2% while Blacks received treatment at 86.8%, respectively. Hispanic beneficiaries received treatment at a slightly higher rate than Blacks, at 87.6%, but still remain under treated compared to Whites. White beneficiaries were also more likely to receive treatment than Asian or Pacific Islanders, but well within 3 percentage points of each other. Pacific Islanders or Asians were treated at a rate of 90.0%.

2019 CMS Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage report. <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/2019-National-Level-Results-by-Race-Ethnicity-and-Gender.pdf>

HEDIS data are stratified by type of insurance (e.g. commercial, Medicaid, Medicare). NCQA does not currently collect performance data stratified by race, ethnicity, or language. Escarce et al. have described in detail the difficulty of collecting valid data on race, ethnicity, and language at the health plan level (Escarce, 2011). 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. The HEDIS Health Plan Measure Set contains two measures that can assist with stratification to assess health care disparities. The Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines 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.

Escarce, J.J., Carreon, R., Veselovskiy, G., Lawson, E.G. Collection of Race and Ethnicity Data by Health Plans has Grown Substantially, but Opportunities Remain to Expand Efforts. *Health Affairs (Millwood)* 2011; 30(10):1984-91.  
<http://www.ncbi.nlm.nih.gov/pubmed/21976343>

**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**

Heart disease is the leading cause of death for people of most ethnicities in the United States, including African Americans, Hispanics, and whites. For American Indians or Alaska Natives and Asians or Pacific Islanders, heart disease is the second leading cause of death (CDC, 2017). Non-Hispanic black adults are at least 50% more likely to die of heart disease or stroke prematurely (i.e., before age 75 years) than their non-Hispanic white counterparts (CDC, 2013). Black women and men are more likely to die before age 75 as a result of coronary heart disease (CHD) than white women and men (rates of death are 37.9%, 61.5%, 19.4%, and 41.5%, respectively) (CDC, 2011). Racial and age-related disparities also exist in rates of recurrent MI or fatal CHD within 5 years of a first MI. Of those who have a first MI, the percentage with a recurrent event is as follows: at 45 to 64 years of age, 14% of white men, 18% of white women, 22% of black men, and 28% of black women; at ≥65 years of age, 21% of white men and women, 33% of black men, and 26% of black women (Mozaffarian et al., 2015).

A 2012 study by Zhang et al. compared medication adherence among MI survivors by disability, status, race/ethnicity, and income for all Medicare fee-for-service beneficiaries discharged post-MI in 2008. Among the disabled who were taking beta-blockers, the

percentage of beneficiaries with good adherence for 6-month adherence was highest for Whites at 67% and lowest for Blacks at 52% with Asians, Hispanics, and Native Americans ranging in between (Zhang et al., 2012).

The CDC analyzed data from 2008-2012 to identify if employment status had an impact on rates of CHD/stroke. The results of this analysis showed that 1.9% of employed adults aged <55 years reported a history of CHD/stroke, compared with 2.5% of unemployed adults looking for work, and 6.3% of adults not in the labor force. Workers employed in service and blue-collar occupations were more likely than those in white collar occupations to report a history of CHD/stroke (Luckhaupt, 2014).

Center for Disease Control and Prevention (CDC). 2017. Heart Disease Facts. Last modified November 28, 2017.  
<http://www.cdc.gov/heartdisease/facts.htm>

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2013. "CDC Health Disparities and Inequalities Report-United States, 2013." Morbidity and Mortality Weekly Report (MMWR) 62(03); 1-2.  
<http://www.cdc.gov/heartdisease/facts.htm>

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2011. "Fact Sheet: Health Disparities in Coronary Heart Disease and Stroke." <http://www.cdc.gov/minorityhealth/CHDIR/2011/FactSheets/CHDStroke.pdf>

Luckhaupt, S.E., Calvert, G.M. August 2014. "Prevalence of Coronary Heart Disease or Stroke Among Workers Aged <55 years-United States 2008-2012." Morbidity and Mortality Weekly Report (MMWR). 63(30); 645-649.  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6630a1.htm>

Mozaffarian, D., Benjamin, E.J., Go, A.S., et al. 2015. "Heart Disease and Stroke Statistics-2015 Update: A Report from the American Heart Association." Circulation. 131:e29-e322. doi: 10.1161/CIR.000000000000152

Zhang, Y., Baik, S.H., Chang, C-C.H., Kaplan, C.M., Lave, J.R. 2012. "Disability, Race/ethnicity, and Medication Adherence Among Medicare Myocardial Infarction Survivors." American Heart Journal. 164(3): 425-433.e4. doi: 10.1016/j.ahj.2012.05.021.

## 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):  
 Cardiovascular, Cardiovascular : Coronary Artery Disease (AMI)

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

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

**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.)  
 N/A

**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: 0071\_PBH\_Value\_Sets\_Fall\_2019-637091548789757231.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.

Yes

**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.

There have been minor changes to the value sets and medication lists to reflect current practice.

NCQA added a hospice exclusion to HEDIS measures in 2016. The focus of hospice care is not to cure illnesses of patients, but rather to improve comfort and quality of life for those with limited life expectancy. Most HEDIS quality measures are focused on health screenings or treatments that are not clinically appropriate or beneficial for those who are at end of life. Many of these screenings and treatments would also be uncomfortable or pose risks for hospice patients, add undue burden and have no impact on improving length or quality of life. Therefore, including individuals who are receiving hospice in this measure is inappropriate.

In addition, NCQA added exclusion criteria for adults with advanced illness and frailty, as well as Medicare adults 65 years of age and older enrolled in an I-SNP or living long-term in institutional settings. We recognize that for individuals with limited life expectancy, advanced illness or more complex clinical situations, the treatment identified in this measure may not be relevant or in line with the patient's goals of care. By implementing this set of exclusions, those providing care to the frail and advanced illness population can focus on care that's more appropriate for their conditions and health status. Attention can be more focused on quality measures that capture services and care processes that are most relevant for this population (e.g., improving care transitions, getting follow-up after acute care episodes, or avoiding preventable hospitalizations).

**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).

Patients who received at least 135 days of treatment with beta-blockers during the 180-day measurement interval.

**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).

At least 135 days of treatment with beta-blockers during the 180-day measurement interval.

180-day measurement interval – The 180-day period that includes the discharge date and the 179 days after discharge.

To determine continuity of treatment during the 180-day period, identify all prescriptions filled within the 180-day measurement interval, and add the number of allowed gap days (up to a total of 45 days) to the number of treatment days for a maximum of 180 days (i.e., 135 treatment days + 45 gap days = 180 days).

Treatment days (days covered) – The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval (i.e., a prescription of a 90-day supply dispensed on the 100th day will have 80 days counted in the 180-day interval).

Assess for active prescriptions and include days supply that fall within the 180-day measurement interval. For patients who were on beta-blockers prior to admission and those who were dispensed an ambulatory prescription during their inpatient stay, factor those prescriptions into adherence rates if the actual treatment days fall within the 180-day measurement interval.

#### PBH-B BETA-BLOCKER MEDICATIONS

##### DESCRIPTION / PRESCRIPTION

Noncardioselective beta-blockers / Carvedilol; Labetalol; Nadolo; Penbutolol; Pindolol; Propranolol; Timolol; Sotalol

Cardioselective beta-blockers / Acebutolol; Atenolol; Betaxolol; Bisoprolol; Metoprolol; Nebivolol

Antihypertensive combinations / Atenolol-chlorthalidone; Bendroflumethiazide-nadolol; Bisoprolol-hydrochlorothiazide;

Hydrochlorothiazide-metoprolol; Hydrochlorothiazide-propranolol

See attached code value sets.

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

An acute inpatient discharge from July 1 of the year prior to the measurement year through June 30 of the measurement year with any diagnosis of acute myocardial infarction (AMI) on the discharge claim.

**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).*

Patients who had continuous enrollment from discharge date through 179 days after discharge. No more than one gap in continuous enrollment of up to 45 days within the 180 days of the event. If the patient has Medicaid, then no more than a 1-month gap in coverage.

An acute inpatient discharge from July 1 of the year prior to the measurement year through June 30 of the measurement year with any diagnosis of acute myocardial infarction (AMI) on the discharge claim.

To identify an acute inpatient discharge:

1. Identify all acute and nonacute inpatient stays.
2. Exclude nonacute inpatient stays.
3. Identify the discharge date for the stay.

If a patient has more than one episode of AMI that meets the event/diagnosis criteria, from July 1 of the year prior to the measurement year through June 30 of the measurement year, include only the first discharge.

Direct transfers to an acute inpatient care setting: If a patient had a direct transfer to an acute inpatient setting (for any diagnosis), use the discharge date from the transfer setting, not the initial discharge. Exclude both the initial discharge and the direct transfer discharge if the transfer discharge occurs after June 30 of the measurement year. Use the instructions below to identify direct transfers and exclude nonacute inpatient stays.

Direct transfers to a nonacute inpatient care setting: Exclude from the denominator, hospitalizations in which the patient had a direct transfer to a nonacute inpatient care setting for any diagnosis. Use the instructions below to identify direct transfers and confirm the stay was for nonacute inpatient care based on the presence of a nonacute code on the claim.

A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.

- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.

1. Identify all acute and nonacute inpatient stays.
2. If needed, identify nonacute inpatient stays.
3. Identify the admission and discharge dates for the stay.

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

Any of the following any time during the patient's history through the end of the continuous enrollment period meet criteria:

- Asthma
- COPD
- Obstructive chronic bronchitis
- Chronic respiratory conditions due to fumes and vapors
- Hypotension, heart block >1 degree or sinus bradycardia
- A medication dispensing event indicative of a history of asthma
- Intolerance or allergy to beta-blocker therapy

Additionally, this measure excludes adults in hospice. It also excludes adults with advanced illness and frailty, as well as Medicare adults 65 years of age and older enrolled in an I-SNP or living long-term in institutional settings.

**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.)*

Patients identified as having an intolerance or allergy to beta-blocker therapy. Any of the following any time during the patient's history through the end of the continuous enrollment period meet criteria:

- Asthma
- COPD
- Obstructive chronic bronchitis
- Chronic respiratory conditions due to fumes and vapors
- Hypotension, heart block >1 degree or sinus bradycardia
- A medication dispensing event indicative of a history of asthma

**MEDICATIONS TO IDENTIFY HISTORY OF ASTHMA**

**DESCRIPTION / PRESCRIPTION**

Bronchodilator combinations / Budesonide-formoterol; Fluticasone-vilantero; Fluticasone-salmeterol; Formoterol-mometasone  
Inhaled corticosteroids / Beclomethasone; Budesonide; Ciclesonide; Flunisolide; Fluticasone; Mometasone

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data.

Exclude adults who meet any of the following criteria:

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time on or between July 1 of the year prior to the measurement year and the end of the measurement year.
  - Living long-term in an institution any time on or between July 1 of the year prior to the measurement year and the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if an adult had an LTI flag any time on or between July 1 of the year prior to the measurement year and the end of the measurement year.
- Members 66-80 years of age as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Adults must meet BOTH of the following frailty and advanced illness criteria to be excluded:



1. At least one claim/encounter for frailty any time on or between July 1 of the year prior to the measurement year and the end of the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
  - At least two outpatient visits, observation visits, ED visits, nonacute inpatient encounters or nonacute inpatient discharges (instructions below) on different dates of service, with an advanced illness diagnosis. Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays.
    2. Confirm the stay was for nonacute care based on the presence of a nonacute code on the claim.
    3. Identify the discharge date for the stay.
  - At least one acute inpatient encounter with an advanced illness diagnosis.
  - At least one acute inpatient discharge with an advanced illness diagnosis. To identify an acute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays.
    2. Exclude nonacute inpatient stays.
    3. Identify the discharge date for the stay.
  - A dispensed dementia medication.

#### DEMENTIA MEDICATIONS

#### DESCRIPTION / PRESCRIPTION

Cholinesterase inhibitors / Donepezil; Galantamine; Rivastigmine

Miscellaneous central nervous system agents / Memantine

- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty any time on or between July 1 of the year prior to the measurement year and the end of the measurement year.

See attached code value sets.

**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.)

No stratification

**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.)

STEP 1: Determine the eligible population. To do so, identify patients who meet all specified criteria.

- AGES: 18 years and older as of December 31 of the measurement year.

- EVENT/DIAGNOSIS: Identify patients who were discharged from an acute setting with an AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year. SEE S.6 and S.7 for eligible population and denominator criteria and details.

STEP 2: Exclude patients who meet the exclusions criteria. SEE S.8 and S.9 for denominator exclusion criteria and details.

STEP 3: Determine the number of patients in the eligible population who were given a 180-day course of treatment with beta blockers post discharge.



**STEP 4:** Identify patients whose dispensed days' supply is  $\geq 135$  days in the 180-day measurement interval. SEE S.4 and S.5 for numerator criteria and details.

**STEP 5:** Calculate the rate by dividing the numerator (STEP 4) by the denominator (after exclusions) (STEP 2).

**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

**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

PBH\_Testing\_Form\_11.20.2019-637099345185494109.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), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

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 measure. This system informs both annual updates to the measures as well as routine re-evaluation of measures. These processes include updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence.

**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 this measure is encouraged. NCQA has agreed with NQF that noncommercial users do not require the consent of the measure developer. Use by health care providers in connections with their own practices is not commercial use. Commercial use of a measure requires the period 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 Health Plan Ratings Report Cards <a href="https://www.ncqa.org/hedis/reports-and-research/ratings-2019/">https://www.ncqa.org/hedis/reports-and-research/ratings-2019/</a> <a href="https://reportcards.ncqa.org/#/health-plans/list">https://reportcards.ncqa.org/#/health-plans/list</a> Health Plan Ratings Report Cards <a href="https://www.ncqa.org/hedis/reports-and-research/ratings-2019/">https://www.ncqa.org/hedis/reports-and-research/ratings-2019/</a> <a href="https://reportcards.ncqa.org/#/health-plans/list">https://reportcards.ncqa.org/#/health-plans/list</a>  Regulatory and Accreditation Programs NCQA Accreditation <a href="https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/">https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/</a> NCQA Accreditation

<https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/>  
 Quality Improvement (external benchmarking to organizations)  
 Quality Compass  
<http://www.ncqa.org/hedis-quality-measurement/quality-measurement-products/quality-compass>  
 Annual State of Health Care Quality  
<https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/>

**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

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 2018, the report included results from calendar year 2017 for health plans covering a record 136 million people, or 43 percent of the U.S. population.

HEALTH PLAN RATING/REPORT CARDS: This measure is used to calculate health plan rankings which are reported in Consumer Reports and on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2019, a total of 255 Medicare health plans, 515 commercial health plans and 188 Medicaid health plans across 50 states were included in the rankings.

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.

HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of Medicare Advantage Health Plans. As of Fall 2017, a total of 184 Medicare Advantage health plans were accredited using this measure among others covering 9.2 million Medicare beneficiaries; 451 commercial health plans covering 113 million lives; and 125 Medicaid health plans covering 35 million lives. Health plans are scored based on performance compared to benchmarks.

**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 Update and Best Practices Conference (now the Health Care Quality Congress), NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly and insight into new measure development projects. 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 clarifications in the specification language, suggestions for potential exclusions, and clarifications on the recently added exclusion for advanced illness and frailty.

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

This measure has been deemed a priority measure by NCQA, as illustrated by its use in programs such as Health Plan Rating, NCQA Accreditation and Quality Compass. States, employers and regional health quality organizations value this measure (and other HEDIS measures) for shining a light on quality.

**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.**

We have provided minor clarifications about the measure during the annual update process in order to address questions received through the Policy Clarification Support System.

#### **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, Commercial plan performance has increased each year by about 1%; Medicare plan performance has remained relatively stable; a slight decrease in Medicaid plan performance was observed (2%). Current average performance (MY 2017) is highest in Medicare plans (90%), followed by commercial plans (85%), and then Medicaid plans (78%). We are encouraged by the sustained high performance across health plans but there is still room for improvement.

#### **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 unexpected findings during testing or since implementation of this measure.

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

There were no identified unexpected findings during testing or since implementation of this measure.

## 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)

0070 : Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)

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?

No

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

DUE TO THE TEXT LIMIT IN THIS SECTION – WE ARE PROVIDING OUR ANSWER FOR 5a.2 IN SECTION 5b.1

### 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.)

ANSWER FOR SECTION 5a.2

NCQA's current Persistence of Beta Blocker Treatment After a Heart Attack measure (NQF measure 0071) uses health plan-reported data to assess the percentage of patients 18 years of age and older during the measurement year who were discharged with a diagnosis of AMI during the 6 months prior to the beginning of the measurement year through the 6 months after the beginning of the measurement year and who received persistent beta-blocker treatment for six months after discharge.

RELATED NQF MEASURE 0070 (Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)):

This measure assesses the percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current left ventricular ejection fraction (LVEF) <40% who were prescribed beta-blocker therapy.

HARMONIZED MEASURE ELEMENTS:

Measure 0071 and 0070 focus on patients 18 years and older who are prescribed beta-blocker treatment post-discharge after having a MI or history of MI. The National Quality Strategy Priorities classification for both measures is Prevention and Treatment of Cardiovascular Disease. Both measures exclude patients who are allergic or have an intolerance to beta blockers.

#### DIFFERENCES:

Below are the unharmonized measure elements between measure 0071 and measure 0070:

Measure 0071 focuses on beta-blocker treatment post a MI and Measure 0070 focuses on patients who have a prior MI or a current or prior LVEF <40%.

- Data Source: Data for measure 0071 is collected through administrative claims, electronic clinical data, and pharmacy data, while data for measure 0070 is collected through medical record, electronic health record data, electronic clinical data, and paper records

- Level of Accountability: Measure 0071 is a health plan level measure while measure 0070 is a clinician-level measure.

- Population: Measure 0071 focuses on patients who were diagnosed with a MI and discharged and prescribed a beta-blocker therapy treatment. Measure 0070 focuses on patients in a measurement year with a diagnosis of coronary artery diseases who also have a prior MI or current or prior LVEF.

- Exclusions: The difference in exclusions is that measure 0071 specifies asthma, COPD, obstructive chronic bronchitis, chronic respiratory conditions due to fumes and vapors, hypotension, heart block >1 degree, sinus bradycardia, and medication dispensing events indicative of a history of asthma as exclusions. Additionally, measure 0071 excludes hospitalizations in which the patient was transferred directly to a nonacute care facility for any diagnosis, patients enrolled in an I-SNP, patients living long-term in an institution, patients 66-80 years of age with frailty and advanced illness, and patients 81 years of age and older with frailty. Measure 0070 exclusions include: documentation of patient reason(s) for not prescribing beta-blocker therapy (e.g., patient declined, other patient reasons) and documentation of system reason(s) for not prescribing beta-blocker therapy (e.g., other reasons attributable to the health care system).

#### IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN:

The differences between measures 0071 and 0070 do not have an impact on interpretability of publicly reported rates, or the burden of data collection, because all data for both measures are collected from different data sources by different entities.

#### ANSWER FOR SECTION 5b.1

Our current measure has a long-standing history of use by health plans and has been implemented for nearly 15 years.

## 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

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

**Co.4 Point of Contact:** Kristen, Swift, [nqf@ncqa.org](mailto:nqf@ncqa.org), 202-955-1728-

## 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.**

NCQA follows a standard process of vetting members of the measurement advisory panel for conflicts of interest.



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

**Ad.2 Year the measure was first released:** 2005

**Ad.3 Month and Year of most recent revision:** 07, 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, 2020

**Ad.6 Copyright statement:** © 1999 by the National Committee for Quality Assurance

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**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:** Publication of each Measure is to be accompanied by the following notice:

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