



## 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 #:** 2856

**Corresponding Measures:**

**De.2. Measure Title:** Pharmacotherapy Management of COPD Exacerbation

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

**De.3. Brief Description of Measure:** This measure assesses the percentage of COPD exacerbations for patients 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

**1b.1. Developer Rationale:** This measure assesses whether patients who had a hospitalization or an emergency department (ED) visit for a COPD exacerbation were provided appropriate medication (systemic corticosteroids and bronchodilators) to treat symptoms and prevent future exacerbations. The improvement in quality envisioned by the use of this measure is to increase the use of systemic corticosteroids and bronchodilators following a COPD exacerbation in order to improve patient outcomes, such as shorten recovery time, improve lung function and reduce the risk of early relapse, treatment failure, and length of hospital stay.

**S.4. Numerator Statement:** Numerator #1 (Systemic corticosteroids): The number of patients dispensed a prescription for a systemic corticosteroid on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date.

Numerator #2 (Bronchodilators): The number of patients dispensed a prescription for a bronchodilator on or 30 days after the Episode Date. Count bronchodilators that are active on the relevant date.

\*The Episode Date is the date of service for any acute inpatient discharge or ED claim/encounter during the 11-month intake period with a principal diagnosis of COPD.

**S.6. Denominator Statement:** All patients age 40 years or older as of January 1 of the measurement year with a COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.

**S.8. Denominator Exclusions:** This measure excludes patients who use hospice services, and patients with nonacute inpatient stays.

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

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

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

**IF Endorsement Maintenance – Original Endorsement Date:** Aug 03, 2016 **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

[PCE\\_Evidence\\_Form.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.

Yes

## 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 whether patients who had a hospitalization or an emergency department (ED) visit for a COPD exacerbation were provided appropriate medication (systemic corticosteroids and bronchodilators) to treat symptoms and prevent future exacerbations. The improvement in quality envisioned by the use of this measure is to increase the use of systemic corticosteroids and bronchodilators following a COPD exacerbation in order to improve patient outcomes, such as shorten recovery time, improve lung function and reduce the risk of early relapse, treatment failure, and length of hospital stay.

**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, Medicare, Medicaid).

### Systemic Corticosteroids – Commercial Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2016	69.7%	9.5%	33.3%	57.5%	64.5%	70.5%	76.7%	81.4%	88.2%	12.2%
2017	75.5%	7.6%	40.7%	66.7%	71.7%	75.7%	80.0%	84.0%	100%	8.3%
2018	74.2%	8.0%	46.9%	64.2%	70.2%	75.7%	79.7%	84.9%	91.5%	9.5%

### Systemic Corticosteroids – Medicaid Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2016	66.0%	11.6%	27.1%	49.8%	61.9%	67.9%	73.1%	77.7%	88.8%	11.2%
2017	68.3%	11.3%	24.5%	53.6%	63.0%	70.2%	76.3%	80.4%	92.5%	13.3%
2018	68.4%	11.7%	34.6%	50.3%	63.9%	71.1%	75.5%	81.3%	91.2%	11.6%

### Systemic Corticosteroids – Medicare Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2016	67.7%	10.6%	13.3%	54.9%	62.4%	69.7%	74.7%	78.9%	87.8%	12.3%
2017	70.4%	7.8%	27.8%	62.5%	67.5%	71.6%	74.7%	78.4%	87.5%	7.2%
2018	71.4%	9.1%	18.5%	60.6%	68.0%	73.0%	76.9%	80.5%	90.9%	8.9%

### Bronchodilators – Commercial Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2016	75.8%	8.7%	36.0%	65.8%	70.3%	75.9%	81.8%	86.4%	95.8%	11.5%
2017	80.1%	7.0%	45.2%	71.9%	76.3%	80.4%	84.3%	88.3%	96.8%	8.0%

2018 | 79.6% | 7.4% | 50.0% | 70.8% | 75.3% | 79.2% | 84.7% | 89.0% | 100% | 9.4%

#### Bronchodilators – Medicaid Rate

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

2016 | 80.7% | 9.7% | 39.5% | 71.8% | 78.3% | 83.5% | 86.4% | 88.4% | 96.0% | 8.1%

2017 | 81.4% | 10.1% | 32.7% | 70.6% | 78.8% | 83.8% | 87.6% | 89.7% | 96.6% | 8.8%

2018 | 81.4% | 10.8% | 40.5% | 68.8% | 79.4% | 84.7% | 87.9% | 89.8% | 95.0% | 8.5%

#### Bronchodilators – Medicare Rate

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

2016 | 77.9% | 9.1% | 37.7% | 67.8% | 72.8% | 78.6% | 84.5% | 88.3% | 97.2% | 11.7%

2017 | 79.6% | 8.2% | 33.3% | 71.2% | 75.7% | 79.9% | 84.9% | 89.5% | 97.2% | 9.2%

2018 | 79.8% | 8.5% | 42.2% | 70.4% | 76.1% | 80.4% | 85.4% | 89.5% | 98.1% | 9.3%

The data references are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2018, HEDIS measures covered more than 190 million people. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the mean eligible population for the measure across health plans.

#### Commercial

YEAR | N Plans | Mean Denominator Size per plan

2016 | 263 | 179

2017 | 254 | 178

2018 | 255 | 165

#### Medicaid

YEAR | N Plans | Mean Denominator Size per plan

2016 | 200 | 863

2017 | 201 | 885

2018 | 189 | 937

#### Medicare

YEAR | N Plans | Mean Denominator Size per plan

2016 | 385 | 681

2017 | 390 | 750

2018 | 388 | 707

**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.”

In the 2019 CMS report, Asian/Pacific Islander patients with a COPD exacerbation were significantly more likely than White patients to receive a systemic corticosteroid with 14 days, while Hispanic patients were significantly less likely than White patients to receive the same. There was no significant difference between White and Black patients. Regarding the receipt of a bronchodilator with

30 days of a COPD exacerbation, Asian/Pacific Islander patients and Black patients were more likely to receive than White patients, while Hispanic patients were less likely.

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**

Disparities are present in the quality of care of COPD, as well as in disease burden. In a study that examined the quality of care for patients who were hospitalized for acute exacerbations of COPD, several patient characteristics were shown to be associated with a decreased likelihood of receiving guidelines-based care, which included the receipt of inhaled anticholinergic bronchodilators, inhaled short-acting 2-agonists, and systemic corticosteroids. Patients who were 75 years and older, or African American, were less likely to receive comprehensive care, compared to younger patients, or white patients, respectively (Lindenauer, et al, 2006). African Americans have been shown to be more likely than whites to report having a COPD exacerbation that required hospitalization in the previous year (Han, et al, 2011). Lower education and lower income, often used as proxies for lower socioeconomic status, have been shown to be correlated with a greater risk of COPD exacerbations (Eisner, et al 2009).

#### References

Eisner, M. D., Blanc, P. D., Omachi, T. A., Yelin, E. H., Sidney, S., Katz, P. P., ... Iribarren, C. (2009). Socioeconomic status, race and COPD health outcomes. *Journal of Epidemiology & Community Health*, 65(1), 26-34. doi:10.1136/jech.2009.089722

Han, M. K., Curran-Everett, D., Dransfield, M. T., Criner, G. J., Zhang, L., Murphy, J. R., ... Foreman, M. G. (2011). Racial Differences in Quality of Life in Patients With COPD. *Chest*, 140(5), 1169-1176. doi:10.1378/chest.10-2869

Lindenauer, P. K., Pekow, P., Gao, S., Crawford, A. S., Gutierrez, B., & Benjamin, E. (2006). Quality of Care for Patients Hospitalized for acute exacerbations of chronic obstructive pulmonary disease. *Annals of Internal Medicine*, 144(12), 894-903.

## 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):

Respiratory, Respiratory : Chronic Obstructive Pulmonary Disease (COPD)

**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):

Elderly, 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: 2856\_PCE\_Value\_Sets\_Fall\_2019.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.

N/A

**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).

Numerator #1 (Systemic corticosteroids): The number of patients dispensed a prescription for a systemic corticosteroid on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date.

Numerator #2 (Bronchodilators): The number of patients dispensed a prescription for a bronchodilator on or 30 days after the Episode Date. Count bronchodilators that are active on the relevant date.

\*The Episode Date is the date of service for any acute inpatient discharge or ED claim/encounter during the 11-month intake period with a principal diagnosis of COPD.

**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).

**Numerator 1 (Systemic Corticosteroid):** Identify the number of patients dispensed a prescription for a systemic corticosteroid on or 14 days after the Episode Date.

-The Episode Date is the date of service for any acute inpatient discharge or ED visit during the 11-month intake period with a principal diagnosis of COPD.

-Count systemic corticosteroids that are active on the relevant date. A prescription is considered active if the “days supply” indicated on the date the patient filled the prescription is the number of days or more between that date and the relevant date. For an acute inpatient encounter, the relevant date is the date of admission. For an ED visit, the relevant date is the date of service.

**Systemic Corticosteroid Medications List:**

Glucocorticoids: cortisone-acetate, dexamethasone, hydrocortisone, methylprednisolone, prednisolone, and prednisone. See attached Value Set Excel document.

**Numerator 2 (Bronchodilator):** Identify the number of patients dispensed a prescription for a bronchodilator on or 30 days after the Episode Date.

-The Episode Date is the date of service for any acute inpatient discharge or ED visit during the 11-month intake period with a principal diagnosis of COPD.

-Count bronchodilators that are active on the relevant date. A prescription is considered active if the “days supply” indicated on the date the patient filled the prescription is the number of days or more between that date and the relevant date. For an acute inpatient encounter, the relevant date is the date of admission. For an ED visit, the relevant date is the date of service.

**Bronchodilator Medications List:**

-Anticholinergic agents: albuterol-ipratropium, acclidinium-bromide, ipratropium, tiotropium, umeclidinium

-Beta 2-agonists: albuterol, arformoterol, budesonide-formoterol, fluticasone-salmeterol, fluticasone-vilanterol, formoterol, formoterol-glycopyrrolate, indacaterol, indacaterol-glycopyrrolate, levalbuterol, formoterol-mometasone, metaproterenol, olodaterol hydrochloride, olodaterol-tiotropium, salmeterol, umeclidinium-vilanterol

-Anti-asthmatic combinations: dyphylline-guaifenesin

See attached Value Set Excel document.

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

All patients age 40 years or older as of January 1 of the measurement year with a COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.

**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).

The eligible population for this measure is based on acute inpatient discharges and ED visits, not on patients. It is possible for the denominator to include multiple events for the same individual. The eligible population for the denominator is defined by following the series of steps below:

Step 1: Identify all patients who had either of the following during the Intake Period (an 11-month period that begins on January 1 of the measurement year and ends on November 30 of the measurement year):

1) An ED visit (ED Value Set) with a principal diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). Do not include ED visits that result in an inpatient stay.

2) An acute inpatient discharge with a principal diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set) on the discharge claim. To identify acute inpatient discharges:

a. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set)

b. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set)

c. Identify the discharge date for the stay

**Step 2: Identify all COPD Episodes.** For each patient identified in Step 1, identify all acute inpatient discharges and ED Visits. An acute inpatient discharge and ED visit on the same date are counted as one COPD episode (ED visits that result in an inpatient stay are excluded in Step 1). Multiple ED visits on the same date are counted as one COPD episode.

**Step 3: Test for direct transfers.** For episodes with a direct transfer to an acute or nonacute setting for any diagnosis, the Episode Date is the discharge data from the last admission.

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.

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

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

See corresponding Excel file for value sets referenced above.

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

This measure excludes patients who use hospice services, and patients with nonacute inpatient stays.

**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 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, claims/encounter data (Hospice Encounter Value Set, Hospice Intervention Value Set).

Exclude patients with nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

See attached Hospice Encounter Value Set, Hospice Intervention Value Set, and Nonacute Inpatient Stay Value Set.

**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.)*

N/A

**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.)*

Note: The denominator for this measure is based on acute inpatient discharges and ED visits, not patients.

**Step 1: Determine the eligible population:** identify patients who meet the age criteria, with an ED visit or inpatient visit with a principal diagnosis of COPD, emphysema or chronic bronchitis



Step 2: Identify all COPD Episodes: for each patient identified in Step 1, identify all acute inpatient discharges and ED Visits. Multiple ED visits on the same date are counted as one COPD episode.

Step 3: Test for direct transfers.

Step 4: Determine the numerator:

Numerator 1 (Systemic Corticosteroid): identify the number of patients dispensed a prescription for a systemic corticosteroid on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date.

Numerator 2 (Bronchodilator): identify the number of patients dispensed a prescription for a bronchodilator on or 30 days after the Episode Date. Count bronchodilators that are active on the relevant date.

Step 5: Calculate two rates.

A. Numerator 1/Denominator

B. Numerator 2/Denominator

**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**

PCE\_nqf\_testing\_attachment\_7.1.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 managed care organization's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable 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 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 Health Plan Rating <a href="https://www.ncqa.org/hedis/reports-and-research/ratings-2019/">https://www.ncqa.org/hedis/reports-and-research/ratings-2019/</a>

	<p>Health Plan Rating  <a href="https://www.ncqa.org/hedis/reports-and-research/ratings-2019/">https://www.ncqa.org/hedis/reports-and-research/ratings-2019/</a></p> <p>Payment Program          Medicare Advantage Plan Rating  <a href="https://www.medicare.gov/find-a-plan/questions/home.aspx">https://www.medicare.gov/find-a-plan/questions/home.aspx</a>          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>Regulatory and Accreditation Programs          NCQA Health Plan 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></p> <p>Quality Improvement (external benchmarking to organizations)          NCQA Quality Compass  <a href="https://www.ncqa.org/programs/data-and-information-technology/data-purchase-and-licensing/quality-compass/">https://www.ncqa.org/programs/data-and-information-technology/data-purchase-and-licensing/quality-compass/</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

NCQA HEALTH PLAN RATINGS/REPORT CARDS: This measure is used in the calculation of health plan ratings, which are reported on the NCQA website annually. These ratings 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.

NCQA 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 scored for accreditation 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 national benchmarks.

NCQA QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting health plans, 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.

**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, 30-day 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 whether certain notation in medical record documentation is sufficient to meet measure criteria. Many of the questions ask about various scenarios concerning emergency department or inpatient visits, and whether the patient should be included in the denominator in that scenario. Other questions have sought clarification about different systemic corticosteroid and/bronchodilator prescribing or dispensing scenarios, and whether they satisfy the measure numerator.

**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.**

Feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure to clarify how to identify which inpatient and ED visits should be included in the denominator.

#### **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.**

The performance rates, for both numerators, were higher in 2017 than in 2016, across all product lines. From 2017 to 2018, some of the same rates showed modest increases, while others showed modest decreases, making it difficult to identify a trend for the last 3 years. For the systemic corticosteroid rate, commercial and Medicare plans consistently report higher rates than Medicaid. For the bronchodilator rate, Medicaid plans consistently report higher rates than commercial and Medicare plans.

#### **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 unexpected 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)

0102 : COPD: inhaled bronchodilator therapy

0577 : Use of Spirometry Testing in the Assessment and Diagnosis of COPD

1825 : COPD - Management of Poorly Controlled COPD

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

N/A

### 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.

For all three related measures, there is no impact on interpretability or added burden of data collection because the focus of this measure is different. For the measures that report use of pharmacotherapy for COPD, the denominator focuses on all adults, whereas this measure focuses on older adults (40 years and over). 0102 (similar numerator, different denominator) 0102's numerator is prescription of an inhaled corticosteroid. The denominator includes certain COPD patients 18 years or older. Unlike this measure, the level of analysis for 0102 is the clinician. 0577 (different numerator, similar denominator) 0577's numerator is presence of a spirometry test to confirm a new or newly active COPD diagnosis. The denominator is persons 40 years or older with a new or newly active diagnosis of COPD. 1825 (somewhat similar numerator, different denominator) 1825's numerator is patients 18 years or older who are taking a long-acting bronchodilator. The denominator includes all patients 18 years or older with poorly controlled COPD who are taking a short-acting bronchodilator.

### 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:** Bob, Rehm, [nqf@ncqa.org](mailto:nqf@ncqa.org), 202-955--

## 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.**

**RESPIRATORY MEASUREMENT ADVISORY PANEL (RMAP) MEMBERS:**

David Au, MD, MS, (CHAIR) Associate Prof. of Medicine, VA Puget Sound Health Care System

Kurt Elward, MD, MPH, Senior Medical Director, Innovation Health

Laura Feemster, MD, MS, Investigator/Staff Physician, University of Washington Medical Center

Anne Fuhlbrigge, MD, MS, Senior Associate Dean for Clinical Affairs, University of Colorado School of Medicine

Min Joo, MD, MPH, FCCP, Assistant Professor of Medicine, University of Illinois at Chicago/ Jesse Brown VA Medical Center

Christine Joseph, PhD, MPH, BSc, Associate Director of Research, Epidemiologist, Henry Ford Health System

Todd Lee, PharmD, PhD, Primary: Senior Investigator, Secondary: Associate Professor, University of Illinois at Chicago

Allan Luskin, MD, President, Healthy Airways

Richard O'Connor, MD, Director, Dept. of Quality Management, Allergist/Immunologist, Sharp Rees-Stealy Medical Group

**COMMITTEE ON PERFORMANCE MEASUREMENT (CPM) MEMBERS:**

Andrew Baskin, MD, National Medical Director, Aetna

Elizabeth Drye, MD, SM, Senior Director, Yale/CORE; Research Scientist, Pediatrics, Yale University

Andrea Gelzer, MD, MS, FACP, Senior VP, Medical Affairs, AmeriHealth Caritas

Kate Goodrich, MD, MHS, Chief Medical Officer and Director, CCSQ, CMS

David Grossman, MD, MPH, Senior Associate Medical Director, Washington Permanente Medical Group

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

David K. Kelley, MD, MPA, Chief Medical Officer, Office of Medical Assistance Programs, Pennsylvania Department of Human Services

Jeffery Kelman, MMSc, MD, Chief Medical Officer, United States Department of Health and Human Services

Nancy Lane, PhD, Independent Consultant

Bernadette Loftus, MD, Freelancer

Adrienne Mims, MD, MPH, AGSF, FFAFP, VP, Chief Medical Officer, Alliant Health Solutions

Amanda Parsons, MD, MBA, Deputy Chief Medical Officer, Metroplus

Wayne Rawlins, MD, MBA, Chief Medical Officer, ConnectiCare

Misty Roberts, MSN, RN, CPHQ, PMP, Associate Vice President, Clinical Quality Officer, Humana

Rudy Saenz, MD, MMM, FACOG, Physician, Medical Director of Quality, Riverside Medical Clinic

Marcus Thygeson, MD, MPH (Co-Chair), Chief Health Officer, Bind On-Demand  
JoAnn Volk, MA, Research Professor, Georgetown University

**HEDIS EXPERT CODING PANEL MEMBERS:**

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  
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

**HEDIS EXPERT PHARMACY PANEL MEMBERS:**

Gerry Hobson, RPh, Cerner Multum  
Chronis Manolis, RPh, UPMC Health Plan  
Cathrine Misquitta, PharmD, MBA, BCPS, BCGP, FCSHP, Envolve Pharmacy Solutions  
Kevin Park, MD, Care Wisconsin

**TECHNICAL MEASUREMENT ADVISORY PANEL MEMBERS:**

Andy Amster, MSPH, Senior Director, Kaiser Permanente  
Jennifer Brudnicki, MBA, Product Services Manager, Inovalon  
Lindsay Cogan, PhD, MS, Director, Division of Quality Measurement, New York State Department of Health  
Kathryn Coltin, MPH, Independent Consultant  
Michael Farina, R.Ph, MBA, Director, Health Care Quality, Capital District Physicians' Health Plan  
Marissa Finn, MBA, CIGNA  
Scott Fox, MS, MEd, Principal, Payment Reform, The MITRE Corporation  
Carlos Hernandez, Director, Quality Management, CenCalHealth  
Harmon Jordan, ScD, Senior Study Director, Westat  
Gigi Raney, LCSW, Center for Medicaid and CHIP Services  
Lynne Rothney-Kozlak, MPH, President, Rothney-Kozlak Consulting, LLC  
Laurie Spoll, Director, Aetna

The NCQA Respiratory Measurement Advisory Panel advised NCQA during measure development. They evaluated the way staff specified the measure, reviewed field test results, and assessed NCQA's overall desirable attributes of Relevance, Scientific Soundness, and Feasibility. The advisory panel consisted of a balanced group of experts. In addition to this advisory panel, we vetted the measure with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders.

**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, 2019

**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:** The HEDIS® measures and specifications were developed by and are owned by the National Committee for Quality Assurance (NCQA). The HEDIS measures and specifications 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 or specifications. NCQA holds a copyright in these materials and can rescind or alter these materials at any time. These materials may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the materials without modification for a non-commercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA.



©2019 NCQA, all rights reserved.

Calculated measure results, based on unadjusted HEDIS specifications, may not be termed “Health Plan HEDIS rates” until they are audited and designated reportable by an NCQA-Certified Auditor. Such unaudited results should be referred to as “Unaudited Health Plan HEDIS Rates.” Accordingly, “Health Plan HEDIS rate” refers to and assumes a result from an unadjusted HEDIS specification that has been audited by an NCQA-Certified HEDIS Auditor.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

Content reproduced with permission from HEDIS, Volume 2: Technical Specifications for Health Plans. To purchase copies of this publication, including the full measures and specifications, contact NCQA Customer Support at 888-275-7585 or visit [www.ncqa.org/publications](http://www.ncqa.org/publications).

**Ad.7 Disclaimers:** This HEDIS® performance measure is not a clinical guideline and does not establish a standard of medical care and has 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, without modification, are encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Modifications to, and/or commercial use of, a measure requires the prior written consent of NCQA and is subject to a license at the discretion 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.