



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 #: 0018

Corresponding Measures:

De.2. Measure Title: Controlling High Blood Pressure

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

De.3. Brief Description of Measure: The percentage of adults 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

1b.1. Developer Rationale: One out of every three Americans have hypertension, or high blood pressure. Even with the availability of effective treatment options, only about half (54%) of these people have their high blood pressure under control (Merai et al, 2016). Improvements in quality or better control of blood pressure as related to this measure would help significantly reduce the probability of serious and costly complications, including coronary artery disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease and retinopathy.

Merai R, Siegel C, Rakotz M, Basch P, Wright J, Wong B; DHSc., Thorpe P. CDC Grand Rounds: A Public Health Approach to Detect and Control Hypertension. MMWR Morb Mortal Wkly Rep. 2016 Nov 18;65(45):1261-1264.

S.4. Numerator Statement: Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.

S.6. Denominator Statement: Patients 18-85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.

S.8. Denominator Exclusions: 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.

Additionally, this measure excludes patients with evidence of end-stage renal disease, dialysis, nephrectomy, or kidney transplant on or prior to the December 31 of the measurement year. It also excludes female patients with a diagnosis of pregnancy during the measurement year, and patients who had a nonacute inpatient admission during the measurement year.

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

S.17. Data Source: Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records

S.20. Level of Analysis: Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Nov 20, 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**

CBP_Evidence_Form_-18-.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.

One out of every three Americans have hypertension, or high blood pressure. Even with the availability of effective treatment options, only about half (54%) of these people have their high blood pressure under control (Merai et al, 2016). Improvements in quality or better control of blood pressure as related to this measure would help significantly reduce the probability of serious and costly complications, including coronary artery disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease and retinopathy.

Merai R, Siegel C, Rakotz M, Basch P, Wright J, Wong B; DHSc., Thorpe P. CDC Grand Rounds: A Public Health Approach to Detect and Control Hypertension. MMWR Morb Mortal Wkly Rep. 2016 Nov 18;65(45):1261-1264.

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.

Controlling High Blood Pressure

N = Number of Health Plans

YEAR = Measurement Year

Commercial

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

2016|352|59%|12%|22%|44%|50%|57%|68%|75%|90%|18%

2017|350|58%|12%|26%|44%|51%|58%|66%|75%|92%|15%

2018|403|55%|21%|0%|9%|52%|60%|67%|74%|84%|15%

Medicaid

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

2016|259|56%|12%|25%|40%|48%|57%|65%|72%|90%|17%

2017|264|57%|13%|2%|42%|49%|59%|66%|71%|85%|17%

2018|248|59%|13%|0%|46%|53%|61%|67%|72%|85%|14%

Medicare

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

2016|466|70%|13%|24%|51%|61%|71%|81%|84%|97%|19%

2017|460|71%|14%|8%|54%|63%|74%|80%|86%|96%|18%

2018|483|69%|11%|0%|57%|64%|71%|76%|81%|100%|12%

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 with a diagnosis of hypertension who had their blood pressure under control. Approximately 69% of White and Asian or Pacific Islander beneficiaries who had a diagnosis of hypertension had their blood pressure under control while 59% of Blacks had their blood pressure under control. Hispanics underperformed compared to Whites and Asian or Pacific Islanders, but by less than 3%. About 67% of Hispanics had their blood pressure under control.

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

Although HEDIS measures are not stratified by race and ethnicity, there is an abundance of disparities data related to hypertension.

The prevalence of hypertension rises with increasing age and varies by race. Data from the Framingham Heart Study found that among adults with a baseline SBP/DBP of 130 to 139/85 to 89 mm Hg, 49.5 percent of adults 65 to 94 years of age developed hypertension compared to 37.3 percent of adults 35 to 64 years of age (Vasan, 2001). Among various races, blacks have the highest prevalence of hypertension across the world (Benjamin et al, 2019). Between 2013-2016 the prevalence of hypertension for adults ≥20, among non-Hispanic black males and females was 58.6 percent and 56.0 percent, among non-Hispanic white males and females was 48.2 percent and 41.3 percent, among non-Hispanic Asian males and females was 46.4 percent and 36.4 percent, and among Hispanic males and females was 47.4 and 40.8 percent, respectively (Benjamin et al, 2019).

There are disparities in awareness, treatment, and control of hypertension. Data between 2013-2016 from NHANES showed that

those with hypertension who were ≥20 years of age, 64.7 percent were aware of their condition, 53.4 percent were under current treatment, and 24.7 percent had their hypertension under control (Benjamin et al, 2019). When comparing races, non-Hispanic whites and blacks are more aware of their hypertension than Hispanic and non-Hispanic Asian adults (Benjamin et al, 2019). Based on Medicare Advantage data in 2017, the percent of adequately controlled blood pressure for hypertensive adults 18-85, among Asian or Pacific Islander beneficiaries was 69.4 percent, among non-Hispanic white beneficiaries was 68.6 percent, among Hispanic beneficiaries was 66.7 percent, among non-Hispanic black beneficiaries was 58.9 percent (CMS, 2019). Older adults are more likely to be aware and receive treatment for their hypertension. An average of 54.4 percent of adults 40 and older had their hypertension in control compared to 10.2 percent of adults between 20-39 years of age (Benjamin et al, 2019).

Benjamin EJ et al., Heart Disease and Stroke Statistics—2019 Update: A Report From the American Heart Association. *Circulation*. 2019;139:e56–e528. DOI: 10.1161/CIR.0000000000000659

Vasan RS, Larson MG, Leip EP, Kannel WB, Levy D. Assessment of frequency of progression to hypertension in non-hypertensive participants in the Framingham Heart Study: a cohort study. *Lancet*. 2001;358:1682–1686. doi: 10.1016/S0140-6736(01)06710-1.

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 : Hypertension, Endocrine : Diabetes

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

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

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: 0018_CBP_Value_Sets_Fall_2019-637002741932672877.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.

This measure has undergone several changes since its last maintenance review. The measure now uses a purely administrative approach to identify patients for the denominator, assesses a blood pressure threshold of <140/90 mm Hg for all patients and incorporates the use of blood pressure readings from certain remote monitoring devices. In addition to that, there have been minor changes to the value sets and medication lists to reflect current practice.

NCQA added a hospice exclusion to most 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 less than six months to live. 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 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 our HEDIS quality measures 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 focus of 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). This measure has undergone several changes since its last maintenance review. The measure now uses a purely administrative approach to identify patients for the denominator, assesses a blood pressure threshold of <140/90 mm Hg for all patients and incorporates the use of blood pressure readings from certain remote monitoring devices. In addition to that, there have been minor changes to the value sets and medication lists to reflect current practice.

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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 whose most recent blood pressure level was <140/90 mm Hg during the measurement year.

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

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

There are two data sources and approaches used for collecting data reporting the numerator for this measure: Administrative Claims and Medical Record Review

ADMINISTRATIVE CLAIMS

Use codes (See code value sets located in question S.2b.) to identify the most recent BP reading taken during an outpatient visit, a nonacute inpatient encounter, or remote monitoring event during the measurement year.

The blood pressure reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria).

The patient is numerator compliant if the blood pressure is <140/90 mm Hg. The patient is not compliant if the blood pressure is $\geq$ 140/90 mm Hg, if there is no blood pressure reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple blood pressure readings on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the presentative blood pressure.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

VALUE SET / NUMERATOR COMPLIANCE

Systolic Less Than 140 Value Set / Systolic compliant

Systolic Greater Than or Equal to 140 Value Set / Systolic not compliant

Diastolic Less Than 80 Value Set / Diastolic compliant

Diastolic 80-89 Value Set / Diastolic compliant

Diastolic Greater Than or Equal to 90 Value Set / Diastolic not compliant

See attached code value sets.

MEDICAL RECORD REVIEW

The number of patients in the denominator whose most recent blood pressure (both systolic and diastolic) is adequately controlled during the measurement year. For a patient's blood pressure to be controlled the systolic and diastolic blood pressure must be <140/90 mm hg (adequate control). To determine if a member's blood pressure is adequately controlled, the representative blood pressure must be identified.

All eligible blood pressure measurements recorded in the record must be considered. If an organization cannot find the medical record, the patient remains in the measure denominator and is considered noncompliant for the numerator.

Use the following guidance to find the appropriate medical record to review.

- Identify the patient's PCP.
- If the patient had more than one PCP for the time-period, identify the PCP who most recently provided care to the patient.
- If the patient did not visit a PCP for the time-period or does not have a PCP, identify the practitioner who most recently provided care to the patient.
- If a practitioner other than the patient's PCP manages the hypertension, the organization may use the medical record of that practitioner.

Identify the most recent blood pressure reading noted during the measurement year.

The blood pressure reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in

medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.

- Reported by or taken by the patient.

BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider and interpreted by the provider.

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The patient is not compliant if the BP reading is $\geq 140/90$ mm Hg or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

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

Patients 18-85 years of age who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.

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 in the measurement year. No more than one gap in continuous enrollment of up to 45 days during the measurement year. If the patient has Medicaid, then no more than a 1-month gap in coverage.

Patients are identified for the denominator using claim/encounter data.

Patients who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year. Visit type need not be the same for the two visits.

Any of the following combinations meet criteria:

- Outpatient visit with any diagnosis of hypertension
- A telephone visit with any diagnosis of hypertension
- An online assessment with any diagnosis of hypertension

Only one of the two visits may be a telephone visit, an online assessment or an outpatient telehealth visit. Identify outpatient telehealth visits by the presence of a telehealth modifier or the presence of a telehealth POS code associated with the outpatient visit.

See attached code value sets.

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

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.

Additionally, this measure excludes patients with evidence of end-stage renal disease, dialysis, nephrectomy, or kidney transplant on or prior to the December 31 of the measurement year. It also excludes female patients with a diagnosis of pregnancy during the measurement year, and patients who had a nonacute inpatient admission during the measurement year.

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

ADMINISTRATIVE CLAIMS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of

when the service 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 during the measurement year.
 - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run data of the file to determine if a patient had an LTI flag during 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. Patients must meet BOTH of the following frailty and advanced illness criteria to be excluded:
 1. At least one claim/encounter for frailty during 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 during the measurement year.

Exclude patients with evidence of end-stage renal disease, dialysis, nephrectomy, or kidney transplant on or prior to December 31 of the measurement year, female patients with a diagnosis of pregnancy during the measurement year, and patients who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:

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 admission date for the stay.

See attached code value sets.

MEDICAL RECORD REVIEW

Exclusionary evidence in the medical record must include a note indicating diagnosis of pregnancy or evidence of a nonacute inpatient admission during the measurement year, or evidence of ESRD, dialysis, nephrectomy or kidney transplant any time during the patient's history through December 31 of the measurement year.

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

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.)

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

- AGES: 18-75 years as of December 31 of the measurement year.

- EVENT/DIAGNOSIS: Identify patients with hypertension in two ways: by claim/encounter data and by medical record data. SEE responses in S.6 and S.7 for eligible population and denominator criteria and details.

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

STEP 3: Determine the number of patients in the eligible population who had a blood pressure reading during the measurement year through the search of administrative data systems or medical record data.

STEP 4: Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure notation in the medical record.

STEP 5: Determine whether the result was <140/90 mm Hg.

STEP 6: Calculate the rate by dividing the numerator (STEP 5) 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.

Plans may report this measure using a systematic sample of 411 members. Plans are instructed to list and sort all eligible members for a measure. NCQA then provides plans with a Random Number Table that is released towards the end of the measurement year. The Random Number table lists a value that is used to determine which members from the eligible populations (i.e., every nth member) for whom numerator compliance will be determined.

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, Electronic Health Data, Electronic Health Records, Paper Medical Records

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 and medical record documentation collected in the course of providing care to health plan patients. NCQA collects 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

[CBP_Testing_Form_-18-.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**.

Some data elements are in defined fields in electronic sources

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).

To allow for widespread reporting across health plans and health care practices, this measure is collected through multiple data sources (administrative data, electronic clinical data, and paper records). We anticipate as electronic health records become more widespread, the reliance on paper record review will decrease.

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 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 Ratings https://www.ncqa.org/hedis/reports-and-research/ratings-2019/ Health Plan Report Card https://reportcards.ncqa.org/#/health-plans/list Payment Program CMS Medicare Star Rating Program https://www.medicare.gov/find-a-plan/questions/home.aspx CMS Medicaid Adult Core Set https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html CMS Quality Payment Program: https://qpp.cms.gov/ California's Value Based Pay for Performance Program http://www.iha.org/our-work/accountability/value-based-p4p Regulatory and Accreditation Programs 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

CALIFORNIA VALUE BASED PAY FOR PERFORMANCE PROGRAM: This measure is used in the California P4P program, which is the largest non-governmental physician incentive program in the United States. Founded in 2001, it is managed by the Integrated

Healthcare Association (IHA) on behalf of ten health plans representing 9 million insured persons. IHA reports results on approximately 35,000 physicians in 200 physician organizations.

CMS MEDICARE ADVANTAGE STAR RATING PROGRAM: This measure is included in the composite Medicare Advantage Star Rating. CMS calculates a Star Rating (1-5) for all Medicare Advantage health plans based on 53 performance measures. Medicare beneficiaries can view the star rating and individual measure scores on the CMS Plan Compare website. The Star Rating is also used to calculate bonus payments to health plans with excellent performance. The Medicare Advantage Plan Rating program covers 11.5 million Medicare beneficiaries in 455 health plans across all 50 states.

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

CMS QUALITY PAYMENT PROGRAM: This measure is used in the Quality Payment Program (QPP) which is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

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.

HEALTH PLAN RATING/REPORT CARDS: This measure is used to calculate health plan rankings which are reported on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2019, a total of 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.

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.

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 clarification on the use of blood pressure readings obtained during potentially stressful procedures or specific visit types, suggestions for exclusions, and the use of patient-reported readings.

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.

During the measure's last major update, feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure, including re-working the denominator approach to minimize burden, adding an administrative approach for the numerator, allowing readings from remote monitoring devices, and updating the numerator threshold to focus on a target of <140/90 mm Hg.

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.

Performance across all plan types has generally improved over the past several years, with Medicare, Medicaid, and commercial plan performance increasing each year by about 1%. This trend broke in measurement year 2018 when the measure underwent a number of changes, including changing the denominator to use a purely administrative method for identification of patients with hypertension, the addition of an administrative approach for the numerator, allowing readings from remote monitoring devices to count for the numerator, and changing the numerator threshold to focus on a target of <140/90 mm Hg. As plans adjust to these changes, we expect performance will continue to improve. Current average performance (MY 2018) is highest in Medicare plans

(69%), followed by Medicaid plans (59%), and then commercial plans (55%).

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)

0061 : Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)

2602 : Controlling High Blood Pressure for People with Serious Mental Illness

2606 : Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)

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

#0729: Optimal Diabetes Care (NQF Endorsed) - this was not listed in 5.1a.

#0076: Optimal Vascular Care (NQF Endorsed) - this was not listed in 5.1a.

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.

There are several related measures that assess blood pressure control but are either focused on different population, use different data sources or are specified at different levels of accountability than NQF 0018. Measure 0061 is NQF endorsed as a single measure that uses health plan reported data to assess the percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level is <140/90 mm Hg. Measure 2602 is NQF endorsed as a single measure that uses health plan reported data to assess the percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. Measure 2606 is NQF endorsed as a single measure that uses health plan reported data to assess the percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent blood pressure reading during the measurement year is <140/90 mm Hg. Measure 0076 is NQF endorsed as a composite measure (all or nothing) that uses physician reported data to assess the

percentage of adult ischemic vascular disease patients, 18-75 years of age, who have optimally managed modifiable risk factors including blood pressure and three other indicators. Measure 0729 is NQF endorsed as a composite measure (all or nothing) that uses physician reported data to assess the percentage of adult diabetes patients, 18-75 years of age, who have optimally managed modifiable risk factors including blood pressure and four other indicators. HARMONIZED MEASURE ELEMENTS: All measures described above focus on a blood pressure target of <140/90 mm Hg. UNHARMONIZED MEASURE ELEMENTS: - Data Source and Level of Accountability: Measures 0018, 0061, 2602, and 2606 are collected through administrative claims and/or medical record review using health plan reported data. Measures 0076 and 0729 are collected through medical record abstraction and reported at the physician level of accountability. - Population Focus: Measure 0018 is focused on the general population of people with hypertension while the other measures focus on either diabetes, serious mental illness with diabetes, or serious mental illness with hypertension. - Age Range: Measures 0018 and 2602 focus on adults 18-85 while the other measures focus on adults 18-75. IMPACT ON INTERPRETABILITY?AND DATA COLLECTION BURDEN:? The differences between measures 0018, 0061, 2602, and 2606 do not have an impact on interpretability of publicly reported rates or an impact on data collection burden as the measures are focused on different populations. The differences between 0018, 0076, and 0729 also do not have an impact on interpretability of publicly reported rates or an impact on data collection burden because the data for each measure is collected from different data sources by different entities.

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.)

NA

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.

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, 202-955-1728-

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

Co.4 Point of Contact: Brittany, Wade, Wade@ncqa.org

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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JoAnn Volk, MA, Georgetown University

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 1999

Ad.3 Month and Year of most recent revision: 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

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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, “Heath Plan HEDIS rate” refers to and assumes a result from an unadjusted HEDIS specification that has been audited by an NCQA-Certified HEDIS Auditor.

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