NATIONAL
QUALITY FORUM

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 #: 1934
Corresponding Measures:
De.2. Measure Title: Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
Co.1.1. Measure Steward: National Committee for Quality Assurance
De.3. Brief Description of Measure: The percentage of patients 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
1b.1. Developer Rationale: The evidence suggests a higher prevalence of diabetes and non-treatment rates for individuals with schizophrenia. Monitoring may lead to proper management for diabetes in this population and may reduce morbidity and mortality

S.4. Numerator Statement: One or more HbA1c tests and one or more LDL-C tests performed during the measurement year.
S.6. Denominator Statement: Patients age 18-64 years of age as of the end of the measurement year (e.g. December 31) with a schizophrenia and diabetes diagnosis.Patients age 18-64 years of age as of the end of the measurement year (e.g. December 31) with a schizophrenia and diabetes diagnosis.
S.8. Denominator Exclusions: 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.

Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

De.1. Measure Type: Process
S.17. Data Source: Claims
S.20. Level of Analysis: Health Plan, Integrated Delivery System, Population : Regional and State

IF Endorsement Maintenance – Original Endorsement Date: Nov 02, 2012 **Most Recent Endorsement Date:** Oct 26, 2018

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? Not applicable.

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
1934_SMD_MEF_7.1.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.
The evidence suggests a higher prevalence of diabetes and non-treatment rates for individuals with schizophrenia. Monitoring may lead to proper management for diabetes in this population and may reduce morbidity and mortality

1b.2. **Provide performance scores on the measure as specified (<u>current and over time</u>) 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 are 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 are stratified by year and product line (i.e. Medicaid).

Diabetes Monitoring for People With Diabetes and Schizophrenia– Medicaid Rate (HMO and PPO Combined)
MEASUREMENT YEAR| MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range
2015 | 69.4% | 0.1 | 57.9% | 65.7% | 69.9% | 75.5% | 79.3% | 9.8
2016 | 68.2% | 0.1 | 57.7% | 62.7% | 68.9% | 74.5% | 78.2% | 11.8
2017 | 69.7% | 0.1 | 59.6% | 64.4% | 70.1% | 75.3% | 78.8% | 10.9

The data references are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2016, HEDIS measures covered 47 million Medicaid health plan beneficiaries. 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.

Diabetes Monitoring for People With Diabetes and Schizophrenia– Medicaid (HMO and PPO Combined)
YEAR | N Plans | Median Denominator Size per plan
2015 | 110 | 132
2016 | 131 | 135
2017 | 151 | 159

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

1b.4. **Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*
HEDIS data are stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the

presence of health care disparities, if the data are available to a plan. The HEDIS 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. Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

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**

A number of research studies, including several meta-analyses, demonstrate that individuals with serious mental illness have an increased risk for diabetes as well as disparities in their care.

One review article estimated the prevalence of diabetes among individuals with SMI is approximately 12% (Holt and Mitchell, 2015), while the prevalence in the general population is approximately 9% aged =18 (CDC, 2017). Additionally, there is a known link between SMI treatments such as anticonvulsants and antipsychotic medications to adverse metabolic risks in patients, such as diabetes (Vancampfort, 2016).

A systematic review article assessed 118 cross-sectional, retrospective and prospective studies, and population versus non-population based studies comparing SMI individuals with non-serious mental illness control groups. Based on this evidence review, authors conclude that diabetes is more common among patients with SMI with a relative risk of 2.04 in patients with schizophrenia or related psychotic disorders compared to the general population (Vancampfort, 2016).

Evidence suggests that individuals with SMI, specifically those with schizophrenia, are at increased risk of developing diabetes due to a higher prevalence of risk factors including tobacco use, poor nutrition and obesity and weight gain from the use of antipsychotics (Mangurian, 2016). Furthermore, these risk factors result in increased morbidity, such as hospitalizations and complications from diabetes, and mortality in the SMI population (Mai et al., 2011; CDC, 2010).

Despite these risks, people with SMI and diabetes receive less ongoing diabetes monitoring and had higher risk for diabetes complications and diabetes-related mortality compared to non-mental health patients (Mai, 2011). In one study analyzing data from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia study, researchers found that the rate of non-treatment for individuals with schizophrenia and diabetes was approximately 30% (Nasrallah et al., 2006).

In an additional study examining a national cardiometabolic screening program for 10,084 patients attending mental health clinics, approximately 56% of patients with schizophrenia and metabolic syndrome were not receiving treatment for any metabolic syndrome component (Correll et al., 2010)

References
Banta JE, Morrato EH, Lee SW, et al. (2009) Retrospective Analysis of Diabetes Care in California Medicaid Patients with Mental Illness. J Gen Intern Med. 24:802-8.

Centers for Disease Control and Prevention (CDC). (2010) Diagnosed and undiagnosed diabetes in the United States, all ages, 2010. Retrieved from: http://www.cdc.gov/diabetes/pubs/estimates11.htm. Accessed on June 19, 2014.

Centers for Disease Control and Prevention (CDC). National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2017.

Correll, C.U., Druss, B. G., Lombardo, I., O'Gorman, C., Harnett, J.P., Sanders, K.N., Alvir, J.M., Cuffel, B.J. (2010). Findings of a U.S. National Cardiometabolic Screening Program Among 10,084 Psychiatric Outpatients. Psychiatric Services. 2010 Sep;61(9)

Holt R.I., Mitchell A.J. (2015). Diabetes mellitus and severe mental illness: mechanisms and clinical implications. Nat Rev Endocrinol. 2015 Feb;11(2):79-89. doi: 10.1038/nrendo.2014.203.

Mai Q, Holman CD, Sanfilippo FM, et al. (2011) Mental illness related disparities in diabetes prevalence, quality of care and

outcomes: a population-based longitudinal study. BMC Medicine. 9:118.

Mangurian, C., Newcomer, J.W., Modlin, C. et al. Diabetes and Cardiovascular Care Among People with Severe Mental Illness: A Literature Review. J GEN INTERN MED (2016) 31: 1083. https://doi.org/10.1007/s11606-016-3712-4

Nasrallah, H.A., Meyer, J.M., Goff, D.C., McEvoy, J.P., Davis, S.M., Stroup, T.S., Lieberman, J.A. Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: Data from the CATIE schizophrenia trial sample at baseline. Schizophrenia Research 86 (2006) 15-22. https://www.ncbi.nlm.nih.gov/pubmed/16884895

Vancampfort D, Correll CU, Galling B, et al. Diabetes mellitus in people with schizophrenia, bipolar disorder and major depressive disorder: a systematic review and large scale meta-analysis. World Psychiatry. 2016;15(2):166-174. doi:10.1002/wps.20309.

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):*
Behavioral Health, Endocrine : Diabetes

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

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

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.)*
Not Applicable

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:** 1934_SMD_Value_Sets.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.
No important changes since the last update.

S.4. Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.*
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).
One or more HbA1c tests and one or more LDL-C tests performed 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).
An HbA1c test (HbA1c Tests Value Set) and an LDL-C test (LDL-C Tests Value Set) performed during the measurement year (on the same or different dates of service), as identified by claim/encounter or automated laboratory data. The patient must have both tests to be included in the numerator. The organization may use a calculated or direct LDL.

See corresponding Excel document for the LDL-C Tests Value Set and the HbA1c Tests Value Set

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*
Patients age 18-64 years of age as of the end of the measurement year (e.g. December 31) with a schizophrenia and diabetes diagnosis.Patients age 18-64 years of age as of the end of the measurement year (e.g. December 31) with a schizophrenia and diabetes diagnosis.

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).
Follow the steps below to identify the eligible population.

Step 1: Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year:
• At least one acute inpatient encounter, with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:
- BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.
- BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.

• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:
- BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.
- ED Value Set with Schizophrenia Value Set.
- BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set.

Step 2 Identify members from step 1 who also have diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member need only be identified by one to be included in the measure. Members may be identified as having diabetes during the

measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):
•   At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.
•   At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set).
Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

(See corresponding Excel document for the above value sets)

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):
Alpha-glucosidase inhibitors:
Acarbose, Miglitol

Amylin analogs:
Pramlinitide

Antidiabetic combinations:
Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin
Insulin:
Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled

Meglitinides:
Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:
Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:
Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:
Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:
Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:
Alogliptin, Linagliptin, Saxagliptin, Sitaglipin

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

Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

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

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

Optional exclusion: Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

If a member was identified as a diabetic based on claim or encounter data, as described in step 2 of S.7, the optional exclusions do not apply because the member had a diagnosis of diabetes.

See corresponding Excel document for the value sets referenced above.

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.)*

None.

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: identify patients 18-64 years of age by the end of the measurement year

Step 2. Search for an optional exclusion in the patient's history: Exclude patients from the eligible population if the eligible population if they meet the following criteria:

-        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.

-        Exclude patients who do not have a diagnosis of diabetes during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes during the measurement year or the year prior to the measurement year.

Step 3. Determine the numerator: the number of patients who have one or more HbA1c tests and one or more LDL-C tests performed during the measurement year.

Step 4. Calculate the rate.

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, Integrated Delivery System, Population : Regional and State

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
1934-SMD-Testing_Form_v7.1_FINAL.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).

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 recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, 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 is vital to the regular re-evaluation of NCQA measures.

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

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified *(e.g., value/code set, risk model, programming code, algorithm)*.
Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

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)

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

PHYSICIAN VALUE-BASED PAYMENT MODIFIER (VBM): This measure is used in the Physician Value-Based Modifier which provides differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFSS). VBM is based on the quality of care provided in comparison to the cost of care within a performance period. The Value Modifier is an adjustment made to Medicare payments for items and services under the Medicare PFS.

NCQA STATE OF HEALTH CARE QUALITY 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. This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. In 2017, the report included results from calendar year 2016 for health plans covering over 171 million people.

NCQA HEALTH PLAN RATINGS/REPORT CARDS: This measure is used to calculate health plan ratings, which are reported in

Consumer Reports and on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2016, a total of 472 Medicare Advantage health plans, 413 commercial health plans and 270 Medicaid health plans across 50 states were included in the rankings.

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.

PHYSICIAN FEEDBACK/QUALITY AND RESOURCE USE REPORTS (QRUR): This measure is used in the Physician Feedback Program and Quality and Resource Use Reports which provide comparative performance information to
Medicare Fee-For-Service physicians. The Quality and Resource Use Reports show physicians the portion of their Medicare fee-for-service (FFS) patients who have received indicated clinical services, how patients utilized services, and how Medicare spending for their patients compares to average Medicare spending.

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, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System.

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. During this "reevaluation" process, we seek broad input on the measure, including input on performance and implementation experience. 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.**
In general, health plans have not reported significant barriers to implementing this measure, as it uses the administrative data collection method. Questions have generally centered around minor clarification of the specifications, such as confirmation that patients are correctly excluded from the measure according to the measure specification. NCQA responded to all questions to

ensure consistent implementation of the specifications.

4a2.2.3. Summarize the feedback obtained from other users
This measure has been deemed a priority measure by NCQA and other entities.

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 has not required modification to this measure.

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

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)
If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.
From 2015 to 2017, performance rates for this measure have been generally stable or shown slight improvement. In 2017, Medicaid plans had an average performance rate of 70 percent. There continues to be significant variation between the 10th and 90th percentiles, suggesting room for improvement. In 2017, Medicaid plans in the 10th percentile had a rate of 60 percent, compared to 79 percent among plans in the 90th percentile.

This measure was first introduced in HEDIS 2013. Rates for Medicaid were 67.8 percent. In the last 6 years, we have seen improvement of two percent.

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 consequences for this measure during testing or since implementation.

4b2.2. Please explain any unexpected benefits from implementation of this measure.
There were no identified unintended consequences for this measure during testing or since implementation.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria <u>and</u> 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)
1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
1933 : Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

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.
N/A

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.
 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: Kristen, Swift, Swift@ncqa.org, 202-955-5174-

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.
The Technical Advisory Group advised Mathematica Policy Research, Inc. and the National Committee for Quality Assurance during measure development. The TAG was responsible for providing feedback on measure concepts, specifications, results from field and data testing. The TAG consisted of a multistakeholder group of experts with knowledge in behavioral health and quality measurement.

Technical Advisory Group Roster:
Alisa Busch, MD, MS
Enola Proctor, PhD, MSW
David Shern, PhD

Wilma Townsend, MSW

Dan Ford, MD, MPH

Lorrie Rickman-Jones, PhD

Eric Hamilton

Alexander Young, MD, MHS

Peter Delany, PhD

Ben Druss, MD, MPH

Maureen Corcoran, MSN, MBA

Mike Fitzpatrick, MSW

Anita Yuskauskas

Bob Heinssen, PhD

Consultants:

Lisa Dixon, MD, MPH

Julie Kreyenbul, PharmD, PhD

COMMITTEE ON PERFORMANCE MEASUREMENT:

Bruce Bagley, MD, FAAFP, Independent Consultant

Andrew Baskin, MD, Aetna

Jonathan D. Darer, MD, Siemens Healthineers

Helen Darling, MA, Strategic Advisor on Health Benefits & Health Care

Andrea Gelzer, MD, MS, FACP, AmeriHealth Caritas

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

David Grossman, MD, MPH, Washington Permanente Medical Group

Christine Hunter, MD, (Co-Chair) US Office of Personnel Management

Jeffrey Kelman, MMSc, MD, United States Department of Health and Human Services

Nancy Lane, PhD, Independent Consultant

Bernadette Loftus, MD, The Permanente Medical Group

Adrienne Mims, MD, MPH, Alliant Quality

Amanda Parsons, MD, MBA, Montefiore Health System

Wayne Rawlins, MD, MBA, ConnectiCare

Rodolfo Saenz, MD, MMM, FACOG, Riverside Medical Clinic

Eric C. Schneider, MD, MSc (Co-Chair), The Commonwealth Fund

Marcus Thygeson, MD, MPH, Adaptive Health

JoAnn Volk, MA, Reforms

Lina Walker, PhD, AARP

Behavioral Health Measurement Advisory Panel:

Katharine Bradley, MD, MPH, Kaiser Permanente Washington Health Research Institute

Christopher Dennis, MD, MBA, FAPA, Landmark Health, LLC

Ben Druss, MD, MPH, Emory University

Frank Ghinassi, PhD, ABPP, Rutgers University Behavioral Health Care

Connie Horgan, ScD, Brandeis University

Laura Jacobus-Kantor, PhD, SAMHSA

Jeffrey Meyerhoff, MD, Optum

Harold Pincus, MD, College of Physicians and Surgeons, Columbia University, New York Presbyterian Hospital, RAND

Michael Schoenbaum, PhD, National Institute of Mental Health

John Straus, MD, Massachusetts Behavioral Health Partnership-A Beacon Health Options Company

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2012

Ad.3 Month and Year of most recent revision: 04, 2018

Ad.4 What is your frequency for review/update of this measure? Evrey 3-5 years.

Ad.5 When is the next scheduled review/update for this measure? 12, 2019

Ad.6 Copyright statement: The performance measures and specifications were developed by and are owned by the National

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

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

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