



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 #: 0108

Corresponding Measures:

De.2. Measure Title: Follow-Up Care for Children Prescribed ADHD Medication (ADD)

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

De.3. Brief Description of Measure: Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.

An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

1b.1. Developer Rationale: Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. Medications can improve function, but proper monitoring is recommended. The intent of this measure is to ensure timely and continuous follow-up visits for children who are newly prescribed ADHD medication. The goal is to encourage monitoring of children for medication effectiveness, occurrence of side effects and adherence.

S.4. Numerator Statement: Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.

S.6. Denominator Statement: Children 6-12 years of age newly prescribed ADHD medication.

S.8. Denominator Exclusions: Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date

Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.

De.1. Measure Type: Process

S.17. Data Source: Claims

S.20. Level of Analysis: Health Plan

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

[nqf_evidence_attachment_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.

Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. Medications can improve function, but proper monitoring is recommended. The intent of this measure is to ensure timely and continuous follow-up visits for children who are newly prescribed ADHD medication. The goal is to encourage monitoring of children for medication effectiveness, occurrence of side effects and adherence.

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

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

The following data demonstrate room for improvement among health plans.

These rates are extracted from HEDIS data collection and reflect the most recent years of measurement for this measure. For HEDIS 2019 (calendar year 2018), HEDIS measures covered 116 million commercial health plan members and 54 million Medicaid enrollees. Data are summarized at the health plan level and stratified by product line (i.e. commercial, Medicaid).

2017 -2019 Performance Data

INITIATION PHASE

Commercial

YEAR	MEAN	ST DEV	MIN	MAX	10TH	25TH	50TH	75TH	90TH
2017	39.5%	8.2%	11.3%	75.6%	30.5%	35.0%	38.6%	43.6%	50.0%
2018	40.7%	8.1%	22.2%	75.6%	31.2%	35.9%	41.2%	44.3%	51.8%
2019	40.0%	8.3%	14.0%	70.5%	29.8%	35.0%	40.0%	44.3%	50.4%

Medicaid

YEAR	MEAN	ST DEV	MIN	MAX	10TH	25TH	50TH	75TH	90TH
2017	44.5%	10.4%	0.0%	86.1%	31.7%	39.0%	44.8%	51.8%	57.1%
2018	44.6%	9.1%	20.4%	73.4%	34.3%	38.2%	45.0%	50.8%	55.9%
2019	44.2%	9.7%	22.5%	92.5%	33.9%	37.9%	43.4%	49.9%	56.6%

CONTINUATION AND MAINTENANCE PHASE

Commercial

YEAR | MEAN | ST DEV | MIN | MAX | 10TH | 25TH | 50TH | 75TH | 90TH
 2017 | 46.1% | 8.6% | 25.7% | 74.0% | 36.4% | 40.3% | 44.7% | 51.2% | 57.1%
 2018 | 47.2% | 8.7% | 22.7% | 76.6% | 33.2% | 41.1% | 45.9% | 52.9% | 59.0%
 2019 | 48.0% | 9.3% | 19.1% | 74.1% | 36.2% | 43.2% | 47.9% | 53.0% | 60.0%

Medicaid

YEAR | MEAN | ST DEV | MIN | MAX | 10TH | 25TH | 50TH | 75TH | 90TH
 2017 | 54.5% | 12.9% | 0.0% | 76.9% | 37.3% | 48.2% | 55.9% | 63.7% | 69.5%
 2018 | 55.0% | 11.8% | 20.4% | 76.7% | 33.1% | 41.7% | 50.0% | 63.7% | 69.1%
 2019 | 54.6% | 12.0% | 23.8% | 100.0% | 39.0% | 46.4% | 55.5% | 62.7% | 71.2%

2017 -2019 Denominator Data

Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the median eligible population for the measure across health plans.

INITIATION PHASE

Commercial

YEAR | N PLANS | Mean Denominator Size per plan
 2017 | 343 | 403
 2018 | 325 | 415
 2019 | 319 | 417

Medicaid

YEAR | N PLANS | Mean Denominator Size per plan
 2017 | 196 | 1,244
 2018 | 192 | 1,339
 2019 | 183 | 1,466

CONTINUATION AND MAINTENANCE PHASE

Commercial

YEAR | N PLANS | Mean Denominator Size per plan
 2017 | 214 | 163
 2018 | 203 | 165
 2019 | 205 | 162

Medicaid

YEAR | N PLANS | Mean Denominator Size per plan
 2017 | 175 | 305
 2018 | 173 | 334
 2019 | 169 | 340

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). 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. 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

Studies suggest children from minority families experience decreased access to and utilization of health services for ADHD, even after controlling for poverty and health insurance status (Miller, Nigg, & Miller 2009; Morley, 2011; Nasol et al., 2018). Although the prevalence of ADHD in minority children is believed to be equal to or even greater than the prevalence in non-minority children, studies indicate that rates of both diagnosis and treatment of ADHD are much lower among minority children compared to non-minority children. Specifically, children who are black, are raised in primarily non-English speaking households, have limited access to the health care system, and are poorer (Bailey et al. 2014; Morgan et al. 2014; Flores & Lin 2013; Froehlich et al. 2007). A 2016 study by Coker et al. found robust disparities in ADHD diagnoses and patient-reported medication use for youth enrolled in fifth through tenth grade, after controlling for sociodemographic factors, ADHD symptoms, and mental health comorbidities. In comparison to white children, Latino and African American children were less likely to have an ADHD diagnosis and to be taking ADHD medication. Further studies also indicate that, among children with ADHD, Hispanic and African American children were less often reported to use medication than white children (Bailey et al. 2014; Pastor & Reuben 2005). The NIMH Multisite Multimodal Treatment Study of Children with Attention-Deficit/Hyperactivity Disorder cited by American Academy of Child and Adolescent Psychiatry (AACAP) and American Academy of Pediatrics (AAP) indicates that certain disparities affected eight-year prospective follow-up. Participants lost to follow-up were "more often male, had younger mothers, had less educated parents, had lower parent income, and were more likely to have been on welfare at baseline" (Brooke et al. 2009). African American and Latino youth also discontinue medication and treatment at disproportionate rates (Cummings et al., 2017). A 2017 study of Medicaid enrolled children ages 6-12 found that compared to their white counterparts, "African American and Hispanic children were 22.4% and 16.7% points more likely to discontinue medication, and 13.1% and 9.4% points more likely to disengage from treatment" (Cummings et al. 2017). Studies suggest effective ADHD treatment in minority children may be affected by cultural norms surrounding ADHD. For example, some minority communities perceive that mental illness is a sign of personal weakness or that seeking treatment will jeopardize future employment or military service (Bailey et al. 2014). These perceptions lead to a lack of treatment seeking by these individuals and lack of appropriate screening (Price et al., 2013). Cost can also be a barrier to adequate care, since across racial and ethnic groups, an estimated 44% of school-aged children with a diagnosis of ADHD report an adverse family financial impact, and 11% indicate unmet need for ADHD treatment (Nasol et al. 2018).

Bailey, R. K., Jaquez-Gutierrez, M. C., & Madhoo, M. 2014. "Sociocultural issues in african American and Hispanic minorities seeking care for attention-deficit/hyperactivity disorder". The Primary Care Companion for CNS Disorders 16(4).

Brooke S.G. Molina Ph.D., Stephen P. Hinshaw Ph.D., James M. Swanson Ph.D., L. Eugene Arnold M.D., M.Ed., Benedetto Vitiello M.D., Peter S. Jensen M.D., Jeffery N. Epstein Ph.D., Betsy Hoza Ph.D., Lily Hechtman M.D., Howard B. Abikoff Ph.D., Glen R. Elliott Ph.D., M.D., Laurence L. Greenhill M.D., Jeffrey H. Newcorn M.D., Karen C. Wells Ph.D., Timothy Wigal Ph.D., Robert D. Gibbons Ph.D., Kwan Hur Ph.D. and Patricia R. Houck M.S. 2009. "The MTA at 8 Years: Prospective Follow-up of Children Treated for Combined-Type ADHD in a Multisite Study." Journal of the American Academy of Child and Adolescent Psychiatry 48(5):484-500.

Coker T., Elliot M., Toomey S., Schwebel D., Cuccaro P., Emery S., Davies S. Visser S., Schuster M. 2016. " Racial and Ethnic Disparities in ADHD Diagnosis and Treatment" . Pediatrics 138(3).

Cummings, J. R., Ji, X., Allen, L., Lally, C., & Druss, B. G. 2017. Racial and Ethnic Differences in ADHD Treatment Quality Among Medicaid-Enrolled Youth. Pediatrics, 139(6), e20162444. <https://doi.org/10.1542/peds.2016-2444>

Flores G. & H. Lin. 2013. "Trends in racial/ethnic disparities in medical and oral health, access to care, and use of services in US

children: has anything changed over the years?" International Journal for Equity in Health 12:10.

Froehlich T.E., B.P. Lanphear, J.N. Epstein. 2007. "Prevalence, Recognition, and Treatment of Attention-Deficit/Hyperactivity Disorder in a National Sample of US Children." Archives of Pediatric and Adolescent Medicine 161(9):857-64.

Miller T.W., J.T. Nigg, R.L. Miller. 2009. "Attention deficit hyperactivity disorder in African American children: what can be concluded from the past ten years?" Clinical Psychological Review 29(1):77-86.

Morley, C. P. 2010. Disparities in Adhd Assessment, Diagnosis, and Treatment. The International Journal of Psychiatry in Medicine, 40(4), 383–389. <https://doi.org/10.2190/PM.40.4.b>

Morgan P.L., M.M. Hillemeier, G. Farkas, S. Maczuga. 2014. "Racial/ethnic disparities in ADHD diagnosis by kindergarten entry." Journal of Child Psychology and Psychiatry, and Allied Disciplines 55(8):905-13.

Nasol E., Lindly O., Cheavez A., Zuckerman K. 2018. "Unmet Need and Financial Impact Disparities for US Children with ADHD.

Pastor P.N. & C.A. Reuben. 2005. "Racial and ethnic differences in ADHD and LD in young school-age children: parental reports in the National Health Interview Survey." Public Health Reports 120(4): 383–392.

Price, J. H., Khubchandani, J., McKinney, M., & Braun, R. 2013. "Racial/ethnic disparities in chronic diseases of youths and access to health care in the United States". BioMed Research International.

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, Behavioral Health : Attention Deficit Hyperactivity Disorder (ADHD)

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

Access to Care, Person-and Family-Centered Care

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

Children

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

NA

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

This is not an eMeasure **Attachment:**

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

Attachment Attachment: 0108_ADD_Spring_2020_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.

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.

Clarified that for the Continuation and Maintenance Phase Rate, visits must be on different dates of service.

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).

Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.

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).

RATE 1. INITIATION PHASE NUMERATOR

An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the earliest prescription dispensing date for a new ADHD medication. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Value Set).
- A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).

Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit. Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

RATE 2. CONTINUATION AND MAINTENANCE PHASE NUMERATOR

Children who are numerator compliant for Rate 1. Initiation Phase, AND have documentation of at least two follow-up visits on different dates of service with any practitioner from 31–300 days (9 months) after the earliest prescription dispensing date for a new ADHD medication.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Identify follow-up visits using the code combinations below, then identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) on the claim.

Any of the following code combinations identify follow-up visits:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).

- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Visit Value Set).
- A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set).
- A telephone visit (Telephone Visits Value Set).

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

Children 6-12 years of age newly prescribed ADHD medication.

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).

RATE 1. INITIATION PHASE DENOMINATOR

Children age 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year. who were dispensed a new ADHD medication during the 12-month Intake Period (Table ADD-A). Patients must have all of the following:(1) A 120-day (4-month) negative medication history on or before the Index Prescription Date. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

(2) Continuous enrollment for 120 days prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.

(3) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set)

Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

ADHD MEDICATIONS LIST

CNS stimulants: Amphetamine-dextroamphetamine, dexamethylphenidate, dextroamphetamine, lisdexamfetamine, methamphetamine, methylphenidate

Alpha-2 receptor agonists: Clonidine, guanfacine

Miscellaneous: Atomoxetine

RATE 2. CONTINUATION AND MAINTENANCE PHASE DENOMINATOR

Children who meet the eligible population criteria for Rate 1. Initiation Phase who have been continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date. Patients must have all of the following:

(1) The patient must have filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

(2) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

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

Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date

Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.

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 from the denominator for both rates, children who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date

Exclude from the denominator for both rates, children with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year

Exclude from the denominator for both rates 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 members 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).

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.)

INITIATION PHASE: ELIGIBLE POPULATION

Step 1: Identify all children in the specified age range (Children 6-12 years of age: 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year) who were dispensed an ADHD medication (ADHD MEDICATIONS LIST) during the 12-month Intake Period.

Step 2: Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3: Calculate continuous enrollment. Patients must be continuously enrolled for 120 days (4 months) prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.

Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after

the Index Prescription Start Date. An acute inpatient encounter (Acute Inpatient Value Set) in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set) AND/OR A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Step 5: Determine the number of patients in the eligible population with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date.

Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Value Set).
- A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).

Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit. Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

Step 6: Calculate a rate (number of children receiving a follow-up visit with a prescriber within 30 days of the Index Prescription Start Date).

CONTINUATION AND MAINTENANCE PHASE: ELIGIBLE POPULATION

Step 1: Identify all patients who meet the eligible population criteria for Rate 1—Initiation Phase.

Step 2: Calculate continuous enrollment. Patients must be continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date.

Step 3: Calculate the continuous medication treatment. Using the patients in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].) Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Step 5: Identify all patients in the eligible population who meet the following criteria:

(1) Numerator compliant for Rate 1—Initiation Phase, and

(2) At least two follow-up visits on different dates of service from 31–300 days (9 months) after the Index Prescription Start Date with any practitioner.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Visit Value Set).
- A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set).
- A telephone visit (Telephone Visits Value Set).

Step 6: Calculate a rate (number of children receiving two follow-up visits with any practitioner from 31–300 days after the Index Prescription Start Date).

ADDITIONAL EXCLUSION:

Exclude from the denominator for both rates, patients with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year

NOTE

- (1) Patients who have multiple overlapping prescriptions should count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).
- (2) Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the Index Prescription Start Date).

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 Management Organizations and Preferred Provider Organizations 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

[FINAL_nqf_testing_attachment_7.1-637260923824297151.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 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 organization'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 to questions in order to prevent possible errors or inconsistencies in the implementation of the measure. 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 usability 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

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).

CMS PROMOTING INTEROPERABILITY PROGRAM: This measure is used in the CMS Promoting Interoperability Program, which provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology, with an increased focus on interoperability and improving patient access to health information.

PHYSICIAN VALUE-BASED PAYMENT MODIFIER (VBM): This measure is used in the Physician Value-Based Modifier program, which provides differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS). 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.

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.

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

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 2012 the report included measures on 11.5 million Medicare Advantage beneficiaries in 455 Medicare Advantage health plans, 99.4 million members in 404 commercial health plans, and 14.3 million Medicaid beneficiaries in 136 plans across 50 states.

MEDICAID CHILD CORE SET: This measure is included in the Medicaid Child Core Set which is a set of children's health care quality measures developed as part of the Children's Health Insurance Program (CHIP) Reauthorization Act for voluntary use by State Medicaid and CHIP programs. The data collected with these measures will help CMS to better understand the quality of health care children receive through Medicaid and CHIP and assist CMS and states in moving toward a national system for quality measurement, reporting, and improvement. As per the CHIPRA legislation, state data derived from the core measures will become part of the Secretary's annual report on the quality of care for children in Medicaid and CHIP. The Secretary's annual report summarizes state-specific and national measurement information on the quality of health care furnished to children enrolled in Medicaid and CHIP.

NCQA HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of Medicare Advantage Health Plans. In 2012, a total of 170 Medicare Advantage health plans were accredited using this measure among others covering 7.1 million Medicare beneficiaries. [REPLACE or ADD as appropriate, 336 commercial health plans covering 87 million lives; 77 Medicaid health plans covering 9.1 million lives.] Health plans are scored based on performance compared to benchmarks.

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

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.

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.

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

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

N/A

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

N/A

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

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

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

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

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS 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, as described in Section 3c1.

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 information in claims meets the measure intent and questions about the supporting guidelines for the measure. NCQA responded to all questions to ensure consistent implementation of the specifications.

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

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

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.

2017 to 2019 data shows relatively stable performance and room for improvement across Commercial and Medicaid plans. For the 3 years of data analyzed, the mean performance for rate 1 – Initiation Phase was 40% for Commercial plans and 44.4% for Medicaid plans, while the mean performance for rate 2 – Continuation and Maintenance Phase was 47.1% and 54.7% for Commercial and Medicaid plans respectively. Performance rates vary slightly from year to year; however, Commercial plans reported the highest increase in performance for having at least two follow-up visits on different dates of service with any practitioner from 31–300 days (9 months) after the earliest prescription dispensing date for a new ADHD medication. Across both commercial and Medicaid plans, there continues to be fairly large variation between the 10th and 90th percentiles, suggesting room for improvement. For example, among commercial plans, the 2019 rate of children who had documentation of a timely follow-up visit ranged from 20% for plans in the 10th percentile to 60% among plans in the 90th percentile.

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 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.

No

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

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

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

No

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

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.

No appendix Attachment:

Contact Information

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

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

Co.3 Measure Developer if different from Measure Steward: [National Committee for Quality Assurance](#)

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

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

[Describe the members' role in measure development.](#)

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 Mary Jane F. Toomey, RN CPC, WellCare Health Plans, Inc.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2006

Ad.3 Month and Year of most recent revision: 07, 2014

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

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

Ad.6 Copyright statement: © 2020 by the National Committee for Quality Assurance

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Ad.7 Disclaimers: These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

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

Ad.8 Additional Information/Comments: NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged

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

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