



## 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 #:** 2371

**Corresponding Measures:**

**De.2. Measure Title:** Annual Monitoring for Patients on Persistent Medications (MPM)

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

**De.3. Brief Description of Measure:** This measure assesses the percentage of patients 18 years of age and older who received a least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report the following three rates and a total rate:

- Rate 1: Annual Monitoring for patients on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB): At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year.

- Rate 2: Annual monitoring for patients on diuretics: At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year.

- Total rate (the sum of the two numerators divided by the sum of the two denominators)

**1b.1. Developer Rationale:** The intent of the measure is to assess appropriate monitoring for persons who receive common therapeutic agents. By improving annual monitoring for those with long-term medication use, possible side effects and adverse drug events will be avoided.

**S.4. Numerator Statement:** This measure is reported as two rates and a total rate.

Rate 1: Annual monitoring for patients on ACE inhibitors or ARBs: the number of patients with at least one serum potassium and serum creatinine therapeutic monitoring test in the measurement year.

Rate 2: Annual monitoring for patients on diuretics: the number of patients with at least one serum potassium and serum creatinine therapeutic monitoring test in the measurement year.

Total rate: sum of the 2 numerators.

**S.6. Denominator Statement:** Patients age 18 and older as of the end of the measurement year (e.g., December 31) who are on selected persistent medications (ACE Inhibitors/ARB or Diuretics.)

**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 had an acute or nonacute inpatient encounter during the measurement year.

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

**S.17. Data Source:** Claims, Electronic Health Data, Electronic Health Records

**S.20. Level of Analysis:** Health Plan, Integrated Delivery System

**IF Endorsement Maintenance – Original Endorsement Date:** Nov 10, 2014 **Most Recent Endorsement Date:** Nov 10, 2014

**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

[Evidence\\_Form\\_MPM-635255650194915916.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.

### 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 intent of the measure is to assess appropriate monitoring for persons who receive common therapeutic agents. By improving annual monitoring for those with long-term medication use, possible side effects and adverse drug events will be avoided.

**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.

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

#### COMMERCIAL

ACE Inhibitors or ARBS - Commercial HMO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	82.9%	4.3%	78.1%	80.7%	83.2%	85.5%	87.5%
2011	82.5%	5.0%	78.1%	80.6%	82.9%	85.4%	87.4%
2010	81.6%	4.8%	77.0%	79.3%	82.0%	84.5%	86.5%

ACE Inhibitors or ARBS - Commercial PPO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	79.2%	3.7%	74.1%	77.2%	79.6%	81.6%	83.6%
2011	78.8%	4.3%	73.7%	77.0%	79.4%	81.7%	83.2%
2010	78.4%	4.2%	73.0%	76.5%	78.9%	81.2%	83.0%

Digoxin - Commercial HMO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	86.5%	6.4%	78.7%	82.8%	86.8%	91.5%	94.3%
2011	85.4%	7.1%	75.9%	82.8%	86.2%	89.8%	93.5%
2010	84.6%	7.5%	75.0%	82.0%	85.4%	89.5%	92.9%

## Digoxin - Commercial PPO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	80.6%	6.1%	71.8%	77.8%	81.0%	84.5%	87.8%
2011	79.2%	7.3%	69.3%	75.9%	79.9%	84.2%	87.3%
2010	79.1%	6.5%	71.0%	74.7%	79.7%	83.8%	85.9%

## Diuretics - Commercial HMO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	82.5%	4.5%	77.8%	79.9%	82.9%	85.2%	87.2%
2011	82.1%	5.0%	77.7%	79.7%	82.4%	84.9%	87.0%
2010	81.0%	4.9%	76.0%	78.6%	81.4%	84.1%	86.1%

## Diuretics - Commercial PPO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	78.8%	3.8%	74.1%	76.7%	79.1%	81.1%	83.3%
2011	78.4%	4.4%	73.0%	76.4%	79.0%	81.3%	82.9%
2010	78.1%	4.3%	72.9%	75.8%	78.5%	81.0%	83.1%

## MEDICARE

## ACE Inhibitors or ARBS - Medicare HMO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	92.0%	4.9%	88.5%	90.8%	92.6%	94.5%	96.1%
2011	91.3%	5.0%	87.4%	90.2%	92.1%	93.9%	95.2%
2010	90.7%	5.6%	86.1%	89.7%	91.8%	93.6%	94.5%

## ACE Inhibitors or ARBS - Medicare PPO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	91.6%	3.4%	88.0%	90.0%	91.9%	93.2%	94.5%
2011	91.4%	3.0%	87.9%	89.8%	91.6%	92.8%	93.7%
2010	90.8%	2.9%	87.6%	89.2%	91.0%	92.4%	93.6%

## Digoxin - Medicare HMO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	94.5%	3.5%	90.6%	93.3%	95.0%	96.5%	98.1%
2011	93.4%	3.6%	88.9%	91.8%	94.2%	95.8%	97.1%
2010	93.1%	4.3%	88.4%	91.5%	94.0%	95.6%	97.0%

## Digoxin - Medicare PPO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	93.2%	3.3%	89.0%	91.7%	93.6%	95.0%	96.9%
2011	93.2%	3.4%	89.3%	91.0%	93.4%	95.0%	97.2%
2010	92.7%	3.1%	89.9%	90.5%	92.7%	94.0%	96.8%

## Diuretics - Medicare HMO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	92.2%	5.0%	88.4%	91.1%	93.0%	94.8%	96.1%
2011	91.6%	5.0%	87.9%	90.5%	92.6%	94.1%	95.5%
2010	90.9%	5.7%	86.2%	89.9%	92.1%	93.8%	95.1%

## Diuretics - Medicare PPO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	91.9%	3.2%	88.7%	90.4%	92.2%	93.4%	94.4%
2011	91.8%	2.9%	88.5%	90.6%	92.0%	93.3%	94.3%
2010	91.2%	2.8%	87.9%	89.8%	91.2%	92.8%	94.0%

**MEDICAID**

## ACE Inhibitors or ARBS - Medicaid HMO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	86.3%	4.6%	80.8%	84.6%	87.1%	89.2%	91.2%
2011	85.9%	5.4%	80.2%	83.7%	86.9%	89.2%	91.3%
2010	86.0%	4.1%	79.9%	83.6%	86.5%	88.6%	90.6%

## Digoxin - Medicaid HMO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	90.2%	4.3%	83.7%	87.5%	90.8%	93.2%	95.0%
2011	90.3%	4.9%	83.3%	87.9%	91.0%	93.4%	95.6%
2010	89.7%	5.3%	80.4%	87.5%	90.3%	93.3%	95.5%

## Diuretics - Medicaid HMO Plans

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2012	86.0%	5.0%	80.0%	83.8%	86.7%	89.1%	91.3%
2011	85.4%	5.4%	78.5%	83.2%	86.4%	88.9%	91.3%
2010	85.5%	4.5%	79.3%	82.8%	85.8%	88.6%	90.7%

## Total Rate (All Product Lines)

Due to changes in the measure specification, the total rates was only calculated for the most recent measurement year (2012).

Product Line	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
Commercial HMO	82.8%	4.3%	78.1%	80.2%	83.1%	85.4%	87.5%
Commercial PPO	79.0%	3.7%	74.6%	77.0%	79.4%	81.3%	83.3%
Medicare HMO	92.1%	4.9%	88.6%	91.0%	92.9%	94.6%	96.1%
Medicare PPO	91.8%	3.3%	88.6%	90.2%	92.0%	93.2%	94.6%
Medicaid HMO	86.1%	4.7%	80.4%	84.0%	87.0%	89.2%	91.1%

Sample: In 2011, HEDIS measures covered 99.4 million commercial health plan members, 14.3 Medicaid members, and 11.5 million Medicare Advantage beneficiaries. The tables below indicate the number of health plans included in the HEDIS data collection for this measure, the average denominator size (eligible population) per health plan for this measure, and the standard deviation (SD) of that average across health plans.

**COMMERCIAL HMO**

Year | N Plans | Avg Eligible Population per Plan | SD

2010	231	17128.5	37033.7
2011	212	16954.3	37870.4
2012	212	17196.1	37726.9

**COMMERCIAL PPO**

Year | N Plans | Avg Eligible Population per Plan | SD

2010	171	18292.0	28081.5
2011	188	19957.6	30636.7
2012	199	23707.5	41368.6

**MEDICARE HMO**

Year | N Plans | Avg Eligible Population per Plan | SD

2010	309	15366.6	31099.2
2011	313	16620.6	31464.9
2012	350	16397.4	32151.6

#### MEDICARE PPO

Year | N Plans | Avg Eligible Population per Plan | SD

2010 | 127 | 8193.8 | 13440.7

2011 | 139 | 11326.8 | 19805.7

2012 | 152 | 12553.0 | 22672.6

#### MEDICAID HMO

Year | N Plans | Avg Eligible Population per Plan | SD

2010 | 132 | 4370.9 | 5424.3

2011 | 157 | 4663.4 | 5745.8

2012 | 176 | 5449.1 | 6722.9

**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 is 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 were designed to promote standardized methods for collecting these data. These measures 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.

Escarce JJ, Carreón R, Veselovskiy G, Lawson EH. Collection of race and ethnicity data by health plans has grown substantially, but opportunities remain to expand efforts. *Health Aff (Millwood)*. 2011;30(10):1984-1991. - See more at: <http://www.ajmc.com/publications/issue/2012/2012-7-vol18-n7/exploring-health-plan-perspectives-in-collecting-and-using-data-on-race-ethnicity-and-language/4#sthash.23sL3Luc.dpuf>

**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**

We identified no literature that documented disparities in monitoring for those with persistent medication use. However, several studies have examined racial and gender disparities in the use of medications by older adults and have found differences in rates of medication-related problems (Gaskin et al., 2006; Lewey et al., 2013; Qato et al., 2010; Roth et al., 2011). In particular, it has been found that women and non-white patients have higher non-adherence rates for their prescribed medications (Lewey et al., 2013). Medication monitoring may therefore be particularly relevant to those populations who experience higher rates of medication-related problems.

Gaskin, D. J., Briesacher, B. A., Limcangco, R., & Brigantti, B. L. Exploring racial and ethnic disparities in prescription drug spending and use among Medicare beneficiaries. *The American journal of geriatric pharmacotherapy*. 2006; 4(2), 96-111.

Lewey, J., Shrank, W. H., Bowry, A. D., Kilabuk, E., Brennan, T. A., & Choudhry, N. K. (2013). Gender and racial disparities in

adherence to statin therapy: A meta-analysis. American heart journal. 2013; 165(5), 665-678.  
 Qato, D. M., Lindau, S. T., Conti, R. M., Schumm, L. P., & Alexander, G. C. Racial and ethnic disparities in cardiovascular medication use among older adults in the United States. Pharmacoepidemiology and drug safety. 2010; 19(8), 834-842.  
 Roth, M. T., Moore, C. G., Ivey, J. L., Esserman, D. A., Campbell, W. H., & Weinberger, M. The quality of medication use in older adults: methods of a longitudinal study. The American journal of geriatric pharmacotherapy. 2008; 6(4), 220-233.

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

Cardiovascular

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

Safety, Safety : Complications, Safety : Medication

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

Elderly, Populations at Risk, Populations at Risk : Dual eligible beneficiaries

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

N/A

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

This is not an eMeasure Attachment:

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

Attachment Attachment: 2371\_MPM\_Value\_Sets-636502394553629302.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.

NCQA removed the "Annual monitoring for patients on digoxin" rate from the measure.

Additionally, there have been minor changes to the value sets and medication tables to reflect current practice.

**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).

This measure is reported as two rates and a total rate.

Rate 1: Annual monitoring for patients on ACE inhibitors or ARBs: the number of patients with at least one serum potassium and serum creatinine therapeutic monitoring test in the measurement year.

Rate 2: Annual monitoring for patients on diuretics: the number of patients with at least one serum potassium and serum creatinine therapeutic monitoring test in the measurement year.

Total rate: sum of the 2 numerators.

**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:ACE Inhibitors/ARBs:**

At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet numerator criteria:

- A lab panel test (Lab Panel Value Set)

OR

- A serum potassium test (Serum Potassium Value Set) and a serum creatinine test (Serum Creatinine Value Set).

Note: The tests do not need to occur on the same service date, only within the measurement year.

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**RATE 2:Diuretics:**

At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set).

OR

- A serum potassium test (Serum Potassium Value Set) and a serum creatinine test (Serum Creatinine Value Set).

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Total: Sum the numerators for the two rates described above.

See attachment for all value sets.

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

Patients age 18 and older as of the end of the measurement year (e.g., December 31) who are on selected persistent medications (ACE Inhibitors/ARB or Diuretics.)

**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).*

**Eligible population:**

Patients who received at least 180 treatment days of ambulatory medication in the measurement year. Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond December 31 of the measurement year. Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

Rate 1: ACE Inhibitor/ARB: 180 days supply of a medication in the ACE Inhibitor/ARB Medications List

Rate 2: Diuretics: 180 days supply of medication in the Diuretic Medications List

Total Rate: Sum of the two denominators

**ACE Inhibitors/ARB Medications List**

Angiotensin converting enzyme inhibitors: Benazepril; Captopril; Enalapril; Fosinopril; Lisinopril; Moexipril; Perindopril; Quinapril; Ramipril; Trandolapril

Angiotensin II inhibitors: Azilsartan; Candesartan; Eprosartan; Irbesartan; Losartan; Olmesartan; Telmisartan; Valsartan

Antihypertensive combinations: Aliskiren-valsartan; Amlodipine-benazepril; Amlodipine-hydrochlorothiazide-valsartan; Amlodipine-hydrochlorothiazide-olmesartan; Amlodipine-olmesartan; Amlodipine-perindopril; Amlodipine-telmisartan; Amlodipine-valsartan; Azilsartan-chlorthalidone; Benazepril-hydrochlorothiazide; Candesartan-hydrochlorothiazide; Captopril-hydrochlorothiazide; Enalapril-hydrochlorothiazide; Eprosartan-hydrochlorothiazide; Fosinopril-hydrochlorothiazide; Hydrochlorothiazide-irbesartan; Hydrochlorothiazide-lisinopril; Hydrochlorothiazide-losartan; Hydrochlorothiazide-moexipril; Hydrochlorothiazide-olmesartan; Hydrochlorothiazide-quinapril; Hydrochlorothiazide-telmisartan; Hydrochlorothiazide-valsartan; Sacubitril-valsartan; Trandolapril-verapamil

Note: Patients may switch therapy with any medication listed in above during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a patient who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition).

**Diuretics Medications List**

Antihypertensive combinations: Aliskiren-hydrochlorothiazide; Aliskiren-hydrochlorothiazide-amlodipine; Amiloride-hydrochlorothiazide; Amlodipine-hydrochlorothiazide-olmesartan; Amlodipine-hydrochlorothiazide-valsartan; Atenolol-chlorthalidone; Azilsartan-chlorthalidone; Benazepril-hydrochlorothiazide; Bendroflumethiazide-nadolol; Bisoprolol-hydrochlorothiazide; Candesartan-hydrochlorothiazide; Captopril-hydrochlorothiazide; Chlorthalidone-clonidine; Enalapril-hydrochlorothiazide; Eprosartan-hydrochlorothiazide; Fosinopril-hydrochlorothiazide; Hydrochlorothiazide-irbesartan; Hydrochlorothiazide-lisinopril; Hydrochlorothiazide-losartan; Hydrochlorothiazide-methyldopa; Hydrochlorothiazide-metoprolol; Hydrochlorothiazide-moexipril; Hydrochlorothiazide-olmesartan; Hydrochlorothiazide-propranolol; Hydrochlorothiazide-quinapril; Hydrochlorothiazide-spirolactone; Hydrochlorothiazide-telmisartan; Hydrochlorothiazide-triamterene; Hydrochlorothiazide-valsartan

Loop diuretics: Bumetanide; Ethacrynic acid; Furosemide; Torsemide

Potassium-sparing diuretics: Amiloride; Eplerenone; Spironolactone; Triamterene

Thiazide diuretics: Chlorothiazide; Chlorthalidone; Hydrochlorothiazide; Indapamide; Methyclothiazide; Metolazone

Note: Patients may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days supply for those medications count toward the total 180 treatment days.

**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 had an acute or nonacute inpatient encounter during the measurement year.

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

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).

Exclude patients from each eligible population who had an acute inpatient encounter (Acute Inpatient Value Set) or nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

See attachment for all value sets.

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

N/A

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Rate/proportion

If other:

**S.13. Interpretation of Score** (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

**S.14. Calculation Algorithm/Measure Logic** (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Step 1 – Determine eligible population. To do so, identify all patients in the specified age range who were on persistent medication for at least 180 days (as defined in S.9) during the measurement year:

- Determine number of patients who had persistent use of ACE Inhibitors or ARBs.

- Determine number of patients who had persistent use of diuretics.

Step 2 – Identify Denominator. Exclude patients from the eligible population who had an acute or nonacute inpatient encounter during the measurement year or who received hospice services during the measurement year.

Step 3 – Identify Numerators. Determine the number of patients in the denominator who had a monitoring event (as defined in S.6) during the measurement year:

- Determine the number of patients on ACE Inhibitors or ARBs who had a monitoring event during the measurement year.

- Determine the number of patients on diuretics who had a monitoring event during the measurement year.

Step 4 – Calculate the rate for each medication by dividing the numerator (step 3)/denominator (step 2).

Step 5 – Calculate the total rate by taking the sum of the two numerators (step 3) and dividing by the sum of the two denominators (step 2).

**S.15. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

**S.16. Survey/Patient-reported data** (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

**S.17. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims, Electronic Health Data, Electronic Health Records

**S.18. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

This measure is based on administrative claims 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, Integrated Delivery System

**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

Template\_MeasSubm\_MeasTesting\_ERGv3.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.

### 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.

### 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.

### 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).**

N/A

## 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

STATE OF HEALTH CARE ANNUAL REPORT: This measure is publically 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 ADULT CORE SET: These are a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers for Medicare & Medicaid (CMS) in partnership with the Agency for HealthCare Research and Quality (AHRQ). The data collected from these measures will help CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, beginning in September 2014, state

data on the adult quality measures will become part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid.

**HEALTH PLAN RANKINGS:** This measure is used to calculate health plan rankings which are reported in Consumer Reports and on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2012, a total of 455 Medicare Advantage health plans, 404 commercial health plans and 136 Medicaid health plans across 50 states were included in the rankings.

**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.

**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 information in claims meets the measure intent and questions about the supporting guidelines for the measure. Most questions submitted to NCQA's Policy Clarification Support asked clarification questions about the measure specification in order to report the measure. 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, as illustrated by its use in programs such as the Core set of Health Care Quality Measures for Medicaid-Eligible Adults and NCQA's Health Plan Accreditation program. During the last reevaluation of the measure in 2014, most stakeholders and advisory panels supported the proposed revisions to the measure. Since that time NCQA has received very little feedback on the measure.

**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.

N/A

#### 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.**

## 5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

#### 5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

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

0555 : INR Monitoring for Individuals on Warfarin

0586 : Warfarin\_PT/ INR Test

0612 : Warfarin - INR Monitoring

**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.**

The specifications of this measure are not harmonized with NQF-endorsed measures 0586, 0612, and 0555 because this measure has a different target population. NQF-endorsed measures 0586, 0612, and 0555 are concerned only with INR monitoring for individuals on warfarin. Therefore the specifications for this measure and the warfarin measures are necessarily different.

**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.)**

This measure does not conceptually address both the same measure focus and target population as any other NQF-endorsed measure.

## 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** [Attachment: Supplemental\\_MPM\\_Complete\\_Evidence\\_Review-635255477654391916.docx](#)

## 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:** Kristen, Swift, [Swift@ncqa.org](mailto: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.**

Geriatric Measurement Advisory Panel (GMAP)

Wade Aubry, MD, BCBS Association

Arlene Bierman, MD, MS, University of Toronto and St. Michael's Hospital

Joyce Dubow, MUP, AARP

Peter Hollmann, MD, BCBS of Rhode Island

Jerry Johnson, MD, University of Pennsylvania

David Martin, MD, Ovations

Adrienne Mims, MD, MPH, Alliant Health Solutions and Georgia Medical Care Foundation

Steven Phillips, MD, Sierra Health Services, Inc.

Scott Sarran, MD, MM, BCBS of Illinois

Eric G Tangalos, MD, FACP, AGSF, CMD, Mayo Clinic

Joan Weiss, PhD, RN, CRNP, Health Resources and Services Administration



Neil Wenger, MD, UCLA Division of General Internal Medicine and RAND

Committee on Performance Measurement (CPM)

Peter Bach, MD, Memorial Sloan Kettering Cancer Center

Bruce Bagley, MD, American Academy of Family Physicians

Andrew Baskin, MD, Aetna

A. John Blair III, MD, Taconic IPA, Inc

Patrick Conway, MD, MSC, Center for Medicare & Medicaid Services

Jonathan D. Darer, MD, Geisinger Health System

Helen Darling, National Business Group on Health

Foster Gesten, MD, NYSDOH Office of Managed Care

Marge Ginsburg, Center for Healthcare Decisions

Christine Hunter, MD, US Office of Personnel Management

George J. Isham, MD, MS, HealthPartners

Jeffrey Kelman, MMSc, MD, Centers for Medicare & Medicaid Services

Arthur Levin, MPH (Co-Chair), Center for Medical Consumers

Philip Madvig, MD, The Permanente Medical Group

J. Brent Pawlecki, MD MMM, The Goodyear Tire & Rubber Company

Susan Reinhard, RN, PhD, AARP

Eric C. Schneider, MD, MSc (Co-Chair), RAND Corporation

Marcus Thygeson, MD, MPH Blue Shield of California

Medication Management Expert Workgroup

Emerald Foster, Pharm.D., CGP, Social HMO Pharmacy Service

Jerry Gurwitz, MD, Meyers Primary Care Institute

Joseph T. Hanlon, Pharm.D., Institute for the Study of Geriatric Pharmacotherapy, University of Minnesota

Mark E. Lehman, Pharm.D. FASCP, Janssen Pharmaceutica Inc.

Edward Westrick, MD, PhD, MagnaCare Health Services Improvement, 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:** 12, 2013

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

**Ad.5 When is the next scheduled review/update for this measure?** 12, 2015

**Ad.6 Copyright statement:** © 2006 by the National Committee for Quality Assurance

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Washington, DC 20005

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

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