TO: Consensus Standards Approval Committee (CSAC)

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RE: Health and Well-Being Member Voting Results

DA: August 11, 2015

The CSAC will review recommendations from the *Health and Well-Being* project at its August 11, 2015 Conference Call. This serves as an addendum to the previous memo and contains the updated voting results as of the ending of the NQF member voting period on August 5, 2015.

NQF MEMBER VOTING RESULTS

Five of the six recommended measures were approved with 75% or higher. Measure 1516: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, received 50% approval by NQF Members. Representatives of 8 member organizations voted; no votes were received from Consumer, Public/ Community Health Agency, and Supplier/Industry Councils. Results for each measure are provided below. (Links are provided to the full measure summary evaluation tables.)

NQF Member Council	Voting Organizations	Eligible to Vote	Rate
Consumer	0	38	0%
Health Plan	2	21	10%
Health Professional	1	97	1%
Provider Organizations	1	110	1%
Public/Community Health Agency	0	20	0%
Purchaser	2	19	11%
QMRI	2	84	2%
Supplier/Industry	0	37	0%
All Councils	**8**	**426**	**3%**

0280: Dehydration Admission Rate (PQI 10)

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	0	0	1	1	
Provider Organizations	1	0	0	1	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%

QMRI	0	0	2	2	
Supplier/Industry	0	0	0	0	
All Councils	**5**	**0**	**3**	**8**	**100%**
Percentage of councils approving (>60%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

Voting Comments: AmeriHealth Caritas: We suspect that this measure will be applicable only to those facilities with significant numbers of admissions related to dehydration which will be dependent upon the demographic mix and the geography. So this measure is likely to have limited application.

1392: Well-Child Visits in the First 15 Months of Life

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	0	1	2	100%
Health Professional	0	0	1	1	
Provider Organizations	0	1	0	1	0%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	1	0	1	2	100%
Supplier/Industry	0	0	0	0	
All Councils	**4**	**1**	**3**	**8**	**80%**
Percentage of councils approving (>60%)					75%
Average council percentage approval					75%

*equation: Yes/ (Total - Abstain)

1407: Immunizations for Adolescents

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	0	0	1	1	
Provider Organizations	1	0	0	1	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	1	0	1	2	100%
Supplier/Industry	0	0	0	0	

All Councils	**6**	**0**	**2**	**8**	**100%**
Percentage of councils approving (>60%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

Voting Comments: AmeriHealth Caritas: This is important and may take having the pressure of a measure to gain greater traction for adolescent immunizations.

1516: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	0	2	0	2	0%
Health Professional	0	0	1	1	
Provider Organizations	0	1	0	1	0%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	1	0	1	2	100%
Supplier/Industry	0	0	0	0	
All Councils	**3**	**3**	**2**	**8**	**50%**
Percentage of councils approving (>60%)					50%
Average council percentage approval					50%

*equation: Yes/ (Total - Abstain)

Voting Comments: AmeriHealth Caritas: This measure is overly burdensome.

2689: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	0	0	1	1	
Provider Organizations	1	0	0	1	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	1	0	1	2	100%
Supplier/Industry	0	0	0	0	
All Councils	**6**	**0**	**2**	**8**	**100%**
Percentage of councils approving (>60%)					100%

Average council percentage approval	100%

*equation: Yes/ (Total - Abstain)

Voting Comments: AmeriHealth Caritas Family of Companies: Especially important in the Medicaid population.

2695: Follow-Up after Emergency Department Visit by Children for Dental Caries

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	0	0	1	1	
Provider Organizations	1	0	0	1	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	1	0	1	2	100%
Supplier/Industry	0	0	0	0	
All Councils	**6**	**0**	**2**	**8**	**100%**
Percentage of councils approving (>60%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

Voting Comments: AmeriHealth Caritas: Especially important in the Medicaid population.

NQF MEMBER VOTING RESULTS for Updated NQF Pneumococcal Vaccination Standard Specification (The updated standard specification is included in Appendix B)

Measure Updated NQF Pneumococcal Vaccination Standard Specification: Immunocompromised Individuals 6 to 18 Years

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	1	0	0	1	100%
Provider Organizations	1	0	0	1	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	0	0	2	2	
Supplier/Industry	0	0	0	0	
All Councils	**6**	**0**	**2**	**8**	**100%**

Percentage of councils approving (>60%)	100%
Average council percentage approval	100%

*equation: Yes/ (Total - Abstain)

Measure Updated NQF Pneumococcal Vaccination Standard Specification: Immunocompromised Individuals 19 to 64 Years

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	1	0	0	1	100%
Provider Organizations	1	0	0	1	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	0	0	2	2	
Supplier/Industry	0	0	0	0	
All Councils	**6**	**0**	**2**	**8**	**100%**
Percentage of councils approving (>60%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

Measure Updated NQF Pneumococcal Vaccination Standard Specification: Adults Aged >65 Years

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	1	0	0	1	100%
Provider Organizations	1	0	0	1	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	0	0	2	2	
Supplier/Industry	0	0	0	0	
All Councils	**6**	**0**	**2**	**8**	**100%**
Percentage of councils approving (>60%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

Appendix A-Measure Evaluation Summary Tables

LEGEND: Y = Yes; N = No; H = High; M = Moderate; L = Low; I = Insufficient

0280: Dehydration Admission Rate (PQI 10)
Submission |
Description: Admissions with a principal diagnosis of dehydration per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions. Numerator Statement: Discharges, for patients ages 18 years and older, with either a principal ICD-9-CM diagnosis code for dehydration; or any secondary ICD-9-CM diagnosis codes for dehydration and a principal ICD-9-CM diagnosis code for hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury. [NOTE: By definition, discharges with a principal diagnosis of dehydration, hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury cannot have an assignment of MDC 14 (pregnancy, childbirth and the puerperium). Thus, obstetric discharges are not considered in the PQI rate. See Prevention Quality Indicators technical specifications for additional details and in the supporting information. Denominator Statement: Population ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred. Exclusions: Not applicable Adjustment/Stratification: Level of Analysis: Population : County or City, Population : National, Population : Regional, Population : State Setting of Care: Hospital/Acute Care Facility Type of Measure: Outcome Data Source: Administrative claims Measure Steward: Agency for Healthcare Research and Quality
STANDING COMMITTEE MEETING 04/22/2015 **Note: Importance to Measure and Report was evaluated in Health and Well-Being Phase 1 1. Importance to Measure and Report: **The measure meets the Importance criterion.** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: Y-15; N-3; 1b. Performance Gap: H-6; M-12; L-0; I-1 Rationale: • Committee members questioned the continued use of this measure for quality improvement by highlighting changes in coding and the traditional treatment care setting for dehydration from inpatient to ambulatory or ED observation units. While the developer acknowledged the shift towards observation care and improved ED management of dehydration, subsequent analyses could not quantify the extent to which these changes obviated the need for the measure.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion. **Note: Reliability was evaluated in Health and Well-Being Phase 1 (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: H-3; M-15; L-0; I-1 2b. Validity: H-4; M-13; L-1; I-0 Rationale: • The Committee noted inconsistencies with the measure's title and description. While the title

0280: Dehydration Admission Rate (PQI 10)

specifically mentions dehydration, measure specifications also include adult gastroenteritis diagnosis and billing codes.

- The developer used the State Emergency Department Database (SEDD) and the State Ambulatory Surgery and Services Databases (SASD) to assess the observed decrease in inpatient hospitalization from 2006-2009 with a principal diagnosis of dehydration (24.5% decrease) and 2009-2012 (26.0% decrease). The developer also observed an increase in observation services with dehydration as a first listed diagnosis from 2006 to 2009 (29.6% increase) and less drastic increase between 2009 and 2012 (17.7% increase. However, further analysis found that PQI 10 rates (all Inpatient) are "moderately" correlated with rates of observation services for dehydration. This suggests that the relationship between inpatient stays for dehydration and outpatient services is not consistent across counties (e.g., counties with low inpatient rates have high rates of observation services for dehydration).
- The developer used these same data sets to test if substitution of observation services is replacing treatment of less complicated cases. The developer found only a marginal increase (10 percent) in the number of medical comorbidities in the medical records.
    - The developer's analysis revealed that 95 percent of the numerator accounts included individuals with a principle diagnosis of dehydration, as well as those with a principle diagnosis of acute renal failure, hypernatremia, and gastroenteritis.
    - The developer will consider whether to revise specifications to include a secondary diagnosis of dehydration.

3. Feasibility: H-15; M-4; L-0; I-0

**Note: Feasibility was evaluated in Health and Well-Being Phase 1

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The data elements are routinely generated and used during care delivery.
- All data elements can be found in defined fields in electronic claims.

4. Usability and Use: H-3; M-10; L-6; I-0

**Note: Usability and Use and Use was evaluated in Health and Well-Being Phase 1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The Committee identified overuse of dehydration care that takes place in the emergency department setting as a potential unintended consequence of this measure.
- This measure is currently in use for the CMS, Medicare Fee For Service Physician Feedback Program / Value-Based Payment Modifier, Quality and Resource Use Reports (QRUR).

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-18; N-0

6. Public and Member Comment: **May 29, 2015 – June 29, 2015**

Comments received:

- Two comments were submitted for this measure. One comment indicated that admitting patients in hyperosmolar states demonstrates good care. Another comment agreed with the Committee's endorsement recommendation, but cautioned that the measure is not widely used by health plans and may be more appropriate for use in non-acute settings such as nursing homes or long-term care facilities. The comment also noted that dehydration is often a

0280: Dehydration Admission Rate (PQI 10)
symptom of an underlying disease or condition and questioned the true value of using this measure to compare performance across facilities. NQF response: • NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the Standing Committee during the Post-Comment meeting. Developer response: • The purpose of the PQIs is to identify potentially preventable hospitalization. In the case of dehydration, hospitalizations may be preventable through access to community based care for high risk patients to prevent dehydration, identify and treat dehydration early before it requires hospitalization or proactive interventions for individuals at very high risk for dehydration (e.g. post gastrointestinal surgery). The PQIs can be used to help flag geographic areas that need further investigation; provide a check of community-level health care resources, evaluate hospital utilization, and to provide insight on burden of illness. The PQI are not designed to identify "inappropriate" hospitalizations, nor to imply that the hospitalizations captured are mild enough to be treated in an ambulatory setting. Many of the hospitalizations captured by the PQI are clinically indicated. The preventability is further upstream, before a patient develops a severe clinical state requiring hospitalization. • The PQI 10 indicator for dehydration was developed to provide insight into the community health care system or services outside the hospital setting. Even though there is a wide spectrum of underlying conditions related to dehydration, there is evidence that with high-quality, community-based primary care, a portion of hospitalizations can be avoided. The indicator is defined, tested, validated and endorsed at the geographic area (county and larger) level. The PQIs can be used to help flag geographic areas that need further investigation; provide a check of community-level health care resources, evaluate hospital utilization, and to provide insight on burden of illness. In 2009 AHRQ explored alternative specifications of the PQI which would measure quality and access to care for health plan populations or large physician groups (Davies et al, 2011, Med Care 49(8)). Incidentally, the panels recommended that the "dehydration" be adapted to measure quality of care for long term care facilities. However, AHRQ has not, tested or otherwise implemented the alternative specifications for health plans, large physician groups or long-term care facilities as part of the AHRQ QI program.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

1392: Well-Child Visits in the First 15 Months of Life

Submission |

Description: The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.

Numerator Statement: Children who received the following number of well-child visits with a PCP during their first 15 months of life:

- No well-child visits
- One well-child visit
- Two well-child visits
- Three well-child visits
- Four well-child visits
- Five well-child visits
- Six or more well-child visits

Denominator Statement: Children 15 months old during the measurement year.

Exclusions: None

Adjustment/Stratification:

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 04/22/2015

1. Importance to Measure and Report: **The measure meets the Importance criteria**

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: H-2; M-14; L-3; I-0; IE-0; 1b. Performance Gap: H-9; M-11; L-0; I-0

Rationale:

- The evidence supporting the measure is based on two clinical practice guidelines from the American Academy of Pediatrics (AAP) and Bright Future, both of which derive their evidence from expert consensus and not a systematic review of the evidence.
- Committee members also expressed concern about the measure's focus on confirmation of well-child visits instead of services provided during the visits. The Committee questioned why the measure specifications do not include specific care processes. The developer explained that the measure assesses the number of visits within the measurement year for children aged 0 to 15 months, and therefore it is a proxy for access to care.
- The measure is specified for six visits; however the guidelines recommend eight visits. The developer explained that the number of visits is aligned with the AAP periodicity chart, which recommends six visits.
- The Committee struggled to highlight an opportunity for improvement since the average performance for commercial plans is 78.04 percent and 61.57 percent for Medicaid plans (2014). The developer noted opportunities for improvements within commercial plans and Medicaid plans, exemplified by a significant gap between the 10th and 90th percentiles.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion.

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

1392: Well-Child Visits in the First 15 Months of Life

2a. Reliability: H-10; M-10; L-0; I-0 2b. Validity: H-11; M-9; L-0; I-0

Rationale:

- Utilizing beta-binomial testing, the developer provided measure score reliability for six or more visits. These data were derived from all plans submitting data to NCQA for HEDIS in 2014 (396 commercial plans and 175 Medicaid plans). No reliability data were provided for visits 0 through 5.
- The Committee debated if there could be variation in the performance gap among the individual number of visits and discussed whether stratification by the individual number of visits (ranging from 0 to 6) would improve the reliability of the measure.
- Committee members requested that the developer submit additional testing that includes measure score reliability for well-child visits ages 0 through 5 within one year. NCQA is willing to update the reliability testing, but given NQCA's three to four year review cycle, one year might not be enough time to update the measure.
- Some Committee members questioned the validity of the measure when well-child visits are combined with other visits, such as sick visits.
    - A Committee member confirmed that the measure contains a coding modifier that allows reporting of a well-child visit and a sick visit to occur concurrently - during the same visit.
    - Additionally, the developer offers a policy clarification support system that allows those reporting on the measure to call trained staff to confirm what qualifies as a well-child visit.

3. Feasibility: H-15; M-5; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Data elements are collected through administrative claims, electronic clinical data, and/or paper records. NCQA conducts independent audits to ensure that HEDIS specifications are met. The following functions are assessed: information practices and control procedures, sampling methods and procedures, data integrity, compliance with HEDIS specifications, analytic file production, and reporting and documentation.

4. Use and Usability: H-15; M-5; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- This measure is currently in use for public reporting of health plan data. These programs include NCQA's Annual State of Health Care Quality and Quality Compass, the Medicaid Child Core Set, and the Health Insurance Marketplace Quality Rating System. The measure is also a component of the CMS Core Measures.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-19; N-1

6. Public and Member Comment: **May 29, 2015 – June 29, 2015**

Comments received:

- A set of four similar comments submitted on this measure raised concerns that it is too broad and does not adequately assess access to specific services. The comments noted that measures specified for age-appropriate immunizations and developmentally appropriate screening should be considered in the future. Two comments supported the Committee's recommendation for

1392: Well-Child Visits in the First 15 Months of Life
endorsement. NQF response: • NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the Standing Committee during the Post-Comment meeting. Developer response: • This measure assesses whether or not children up to the age of 15 months old received the recommended number of well-child visits with their primary care provider. The measure is based on guidelines (AAP/Bright Futures) and evidence that children should be seen by their provider on a regular basis so they can receive the appropriate assessments such as initial/interval medical history, measurements (length/height and weight, head circumference, and weight for length), behavioral assessment, physical examination, immunization and anticipatory guidance.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

1407: Immunizations for Adolescents

Submission |

Description: The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday.

Numerator Statement: Adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.

Denominator Statement: Adolescents who turn 13 years of age during the measurement year.

Exclusions: Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Either of the following meet exclusion criteria:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday.
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

Adjustment/Stratification:

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 04/22/2015

1. Importance to Measure and Report: **The measure meets the Importance criterion.**

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: H-9; M-7; L-0; I-0; IE-0; 1b. Performance Gap: H-15; M-2; L-0; I-0

Rationale:

- The Committee cited strong evidence that is supported by CDC/ACIP guidelines. The ACIP guidelines for meningococcal, tetanus, diphtheria, and pertussis vaccines recommend vaccination for all children ages 11 and 12 years.
- Some Committee members suggested that the developer replace Td (tetanus toxoid only) with Tdap (tetanus, diphtheria, and pertussis).
- Committee members highlighted performance gaps between different types of health plans (e.g., Medicaid versus commercial).

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion.

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: H-15; M-2; L-0; I-0 2b. Validity: H-13; M-4; L-0; I-0

Rationale:

- There was general confusion about the inclusion of both a Td and Tdap. Some Committee members speculated that this may reflect the transition from Td to a newer Tdap vaccine. The CDC/ACIP and the Academy of Family Practice have not yet recommended Tdap only, and therefore Td will continue to be included in the measure specifications.
- The developer conducted beta-binomial reliability testing at the measure score level—i.e., a

1407: Immunizations for Adolescents
signal to noise analysis, where the reliability of the measure is represented as the ratio of signal (variation due to a health plan's performance) to noise (variation due to measurement error). The reliability scores for commercial plans (HMO and PPO combined) ranged from 0.99-1.00. The reliability score of Medicaid Plans (HMO only) was 0.98. The Committee agreed that the reliability testing and results were adequate. • The developer tested the validity of the measure using empirical validity data and a systematic assessment of face validity of the performance measure score. Performance on this measure was correlated to Tdap measure and to the measure Human Papillomavirus Vaccine (HPV) for Female Adolescents. For the Tdap measure, the developer noted a Pearson's coefficient of 0.79 and 0.66 for commercial and Medicaid plans, respectively. For the HPV measure, the observed Pearson's coefficients ranged from 0.37-0.46 for Medicaid plans, and 0.49-0.55 for commercial plans. The Committee agreed that the validity testing and results were adequate. • The Committee did not identify any threats to validity.
3. Feasibility: H-14; M-3; L-0; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* Rationale: • All of the required data elements are routinely generated and used during care delivery and are available in electronic form (administrative data from billing records). • NCQA conducts independent audits to ensure that HEDIS specifications are met. The following functions are assessed: information practices and control procedures, sampling methods and procedures, data integrity, compliance with HEDIS specifications, analytic file production, and reporting and documentation.
4. Usability and Use: H-16; M-1; L-0; I-0 *(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)* Rationale: • This measure is currently in use for public reporting of health plan data. These programs include NCQA's Annual State of Health Care Quality and Quality Compass, the Medicaid Child Core Set, the Health Insurance Marketplace Quality Rating System. The measure is also a component of the CMS Core Measures.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: Y-17; N-0
6. Public and Member Comment: **May 29, 2015 – June 29, 2015** Comments received: • This measure received four comments, all supporting the Committee's recommendation of endorsement for the measure.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

1516: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Submission |

Description: The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.

Numerator Statement: Children who received at least one well-child visit with a PCP during the measurement year.

Denominator Statement: Children 3-6 years of age during the measurement year.

Exclusions: None

Adjustment/Stratification:

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 04/22/2015

1. Importance to Measure and Report: **The measure meets the Importance criterion.**

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: H-1; M-4; L-5; I-1; IE-8; 1b. Performance Gap: H-10; M-10; L-0; I-0

Rationale:

- The measure is based on the AAP and Bright Futures guidelines, which recommend at least four well-care visits for children 3-6 years of age.
- The Committee acknowledged that child-well visits are good clinical practice, but questioned whether existing evidence supports the link between well-child visits during ages 3 to 6 and better health outcomes. The measure assesses the frequency of visits, rather than the care and services provided during those visits.
- Several Committee members contemplated whether 6-year olds should be included in the measure without evidence to support their inclusion. One Member noted that 6-year olds typically receive environmental screenings in school.
- Following detailed review of the guidance for evaluating the clinical evidence, the Committee decided to apply the "insufficient evidence with exception" option, agreeing that it was appropriate to hold providers accountable for performance in the absence of empirical evidence of benefit to the patient.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion.

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: H-10; M-8; L-0; I-2 2b. Validity: H-8; M-9; L-3; I-0

Rationale:

- Committee members asked clarification on the numerator time window, where a child has a visit at 4 years and 1 month and 4 years and 11 months but does not have a visit at 5 years. The developer explained that multiple visits during a single year of life do not count towards visits in a future year of life; therefore, the visit at 4 years and 11 months would not count as a 5-year visit.
- The developer conducted beta-binomial reliability testing at the measure score level—i.e., a signal to noise analysis, where the reliability of the measure is represented as the ratio of signal (variation due to a health plan's performance) to noise (variation due to measurement error). Observed Pearson's coefficient results for plans in the 10th percentile were between 0.7 and 0.9

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for the majority of plans. The Committee agreed that the reliability testing and results were adequate.

- The developer used both face validity and empirical data to test construct validity. Performance on well-child visits was correlated to the measure *Children and Adolescents' Access to Primary Care Practitioners* (children under the age of 24 months who had the recommended number of preventive care visits [8 visits total]. This measure is not in NQF's portfolio.) Commercial plan results positively correlated with the Pearson's coefficient of 0.80; for Medicaid plans the Pearson's coefficient was of 0.65. All correlations were statistically significant, with a p-values < 0.05. The Committee agreed that the validity testing and results were adequate.

3. Feasibility: H-17; M-3; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Data are collected through administrative claims, electronic clinical data, and/or paper records and the developer anticipates that as electronic health records become more widespread, the reliance on paper record review will decrease.
- NCQA conducts independent audits to ensure that HEDIS specifications are met. The following functions are assessed: information practices and control procedures, sampling methods and procedures, data integrity, compliance with HEDIS specifications, analytic file production, and reporting and documentation.

4. Usability and Use: H-11; M-7; L-2; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- This measure is currently in use for public reporting of health plan data. These programs include NCQA's Annual State of Health Care Quality and Quality Compass, the Medicaid Child Core Set, the Health Insurance Marketplace Quality Rating System. The measure is also a component of the CMS Core Measures.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-16; N-4

6. Public and Member Comment**: May 29, 2015 – June 29, 2015**

Comments received:

- A set of two similar comments affirmed the Committee's concerns about the rationale of the limited time ranges. The commenter also supported further review of an evidenced-based scheduling timeframe to increase the applicability of multiple annual well-visits. The commenter further noted that measures such as verification of school-entry immunizations may be a better way to measure access to care. While an additional comment supported this measure, another comment did not support endorsement of this measure because of the rigidity of the 4-year criterion and noted that this threshold becomes a burden on practices that would need to contact parents to schedule and meet the recommendation for visits through the third-sixth years of life.

NQF response:

- NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the Standing Committee during the Post-Comment meeting.

Developer response:

- This measure assesses whether or not children ages 3 to 6 years old received the recommended number of well-child visits with their primary care provider. This measure is based on

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AAP/Bright Futures guidelines that children ages 3 to 6 years old should be seen by their provider once per year to get the appropriate assessments. Appropriate assessments recommended by the guidelines include getting a medical history, getting a vision and hearing screening, conducting a surveillance of development, doing a behavioral/psychosocial assessment, conducting a physical examination, administering immunizations, assessing oral health and providing anticipatory guidance. You're correct that a visit at 4 years and 11 months would not count as a 5-year visit because the child should be seen again in their 5th year of life, even if it's later in the year.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2689: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children

Submission |

Description: Number of emergency department visits for caries-related reasons per 100,000 member months for all enrolled children

Numerator Statement: Number of ED visits with caries-related diagnosis code among all enrolled children

Denominator Statement: All member months for enrollees 0 through 20 years during the reporting year divided by 100,000.

NOTES:

1. Age range is 0 through 20 years (<21 years) to coincide with Medicaid Early and Periodic Screening, Diagnostic, and Treatment eligibility. (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html).

2. 100,000 member months of enrollment was selected instead of a per population approach due to enrollment variation. This is consistent with the approach that the Centers for Medicare and Medicaid Services has taken for the Medicaid Adult Health Care Quality measures of potentially preventable hospitalizations, which measures rates per 100,000 member months (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html)

Exclusions: The following standard exclusion is applied: Medicaid programs should exclude children who do not qualify for EPSDT benefits.

Adjustment/Stratification:

Level of Analysis: Integrated Delivery System

Setting of Care: Emergency Medical Services/Ambulance

Type of Measure: Outcome

Data Source: Administrative claims

Measure Steward: American Dental Association in behalf of the Dental Quality Alliance

STANDING COMMITTEE MEETING 04/22/2015

1. Importance to Measure and Report: **The measure meets the Importance criterion.**

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: Y-20; N-1; 1b. Performance Gap: H-12; M-6; L-2; I-1;

Rationale:

- The Committee contested the strength of presented evidence that linked prevention to caries-related emergency department (ED) visits. Data were presented from both the Texas Medicaid Program, which ranks among the highest for utilization of preventive dental services, and the Florida Medicaid Program, which ranks among the lowest. For these two programs, the measure shows an inverse relationship between use of preventive dental services and ED visits. Specifically, the Florida Medicaid program reported 2.5 times more ED visits than the Texas Medicaid program.
- Committee members debated whether this measure assessed availability and accessibility of preventive services, appropriateness of utilization, or under-utilization of appropriate oral care at the primary care level.
- The developer explained that high rates of ED visits reflect failures in outpatient management and care. The measure focuses specifically on caries-related visits to the ED because the frequency of these visits can be influenced by outpatient management and prevention, along with early identification of caries and disease management.
- Committee members noted that claims data from both the ED and dental office should be collected since the measure tracks follow-up care in individual patients. (These two settings

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traditionally use separate billing systems.) The developer explained that the measure is specified for Medicaid programs only. These programs have access to both medical and dental claims at the individual patient level and will be able to track follow-up visits within specified timeframe.

- The measure submission form indicates "integrated delivery system" as the level of analysis. The Committee raised concerns about endorsing this measure at the current level of analysis. The developer concurred, and noted that the primary measure focus is Medicaid programs. To minimize confusion, the developer and NQF will work together to ensure the appropriate level of analysis is selected from the NQF taxonomy selection.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion.

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: H-7; M-11; L-1; I-2 2b. Validity: H-6; M-14; L-1; I-0

Rationale:

- The developer tested validity at the data element level only. This is sufficient to meet NQF's testing requirements; additional reliability testing of the same data elements is not required.
- The developer evaluated agreement between the claims data and 300 ED records at one Florida ED by calculating the sensitivity, specificity, positive and negative predictive value, and kappa statistic. The 300 records of patients 0-20 years old were randomly selected for data abstraction. Other selection criteria included Medicaid payer type and those with a non-traumatic ED visit related to the oral cavity. Two emergency medicine physicians reviewed the records. Overall agreement was 87.7 percent, indicating high overall concordance between the administrative claims and ED records. The kappa statistic was 0.71. Sensitivity was 82 percent and specificity was 90 percent. The positive predictive value was 79 percent and negative predictive value was 92 percent. The Committee agreed that validity testing and results were adequate.
- The Committee asked the developer whether people utilized EDs due to convenience or lack of access to primary care. With the exception of rural communities with lower on provider numbers, the developer explained indicated that the main issue is the number of providers available to individuals who receive dental care via Medicaid.
- The Committee cautioned that the measure could show supply-driven and or process-driven access problems. The developer reiterated that the measure is intended to assess the severity of the disease unaddressed through any care mechanism.

3. Feasibility: H-12; M-9; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This measure relies on standard administrative data fields commonly used for a wide range of billing and reporting purposes. All required data elements are defined in electronic claims.
- This measure is intended for widespread adoption and is designed to eliminate software or other proprietary issues that would require licensing fees. The measure specifications will be accessible through a website and can be used free of charge for non-commercial purposes.

4. Usability and Use: H-10; M-10; L-0; I-1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The Committee acknowledged that implementation of this measure is a critical first step to encourage states to measure the number of ED visits with caries-related diagnosis code among

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all enrolled children in Medicaid programs. • Before expanding the measure to other care settings, the Committee suggested that the developer pilot the measure to learn about any potential unintended consequences.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: Y-20; N-1
6. Public and Member Comment**: May 29, 2015 – June 29, 2015** Comments received: • This measure received seven comments. The majority of the comments supported the Committee's recommendation to endorse the measure. A set of two similar comments pointed to the underlying assumption that emergency department visits for dental caries implies unaddressed disease and requested that the developer should specifically define how they intend to assess the severity of the unaddressed disease through any care mechanism. NQF response: • NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the Standing Committee during the Post-Comment meeting. Developer response: • Caries-related ED visits are ambulatory sensitive condition visits (e.g., they are potentially preventable). These visits signify a failure of the ambulatory oral healthcare system to prevent and proactively treat and manage dental caries in children. Children receive symptomatic relief in ED settings (antibiotics and pain medication), but they do not receive definitive care that addresses the underlying disease process. Significantly, these ED visits can be reduced through evidenced-based processes of care delivered in outpatient ambulatory settings. • This measure was developed and tested for implementation at the Medicaid program (or equivalent) level. The DQA appreciates the support for this measure and interest in applications for other delivery system levels. The DQA's measures development efforts are ongoing, and opportunities to adapt this measure for application at other levels will be considered.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2695: Follow-Up after Emergency Department Visit by Children for Dental Caries

Submission |

Description: Percentage of ambulatory care sensitive Emergency Department (ED) visits for dental caries among children 0 – 20 years in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit.

Numerator Statement: Number of ambulatory care sensitive ED visits by children for dental caries for which the member visited a dentist within (a) 7 days (NUM1) and (b) 30 days (NUM2) of the ED visit

Denominator Statement: Number of ambulatory care sensitive ED visits by children 0 through 20 years for dental caries in the reporting period.

Note: Age range is 0 through 20 years (<21 years) to coincide with Medicaid Early and Periodic Screening, Diagnostic, and Treatment eligibility. (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html).

Exclusions: The following standard exclusion is applied: Medicaid programs should exclude children who do not qualify for EPSDT benefits.

Adjustment/Stratification:

Level of Analysis: Integrated Delivery System

Setting of Care: Ambulatory Care : Clinician Office/Clinic, Emergency Medical Services/Ambulance

Type of Measure: Process

Data Source: Administrative claims

Measure Steward: American Dental Association on behalf of the Dental Quality Alliance

STANDING COMMITTEE MEETING 04/22/2015

1. Importance to Measure and Report: **The measure meets the Importance criterion.**

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: H-0; M-11; L-5; I-4; IE-0; 1b. Performance Gap: H-3; M-12; L-4; I-1

Rationale:

- The Committee was concerned that the measure holds health plans accountable for follow-up visits without consideration of other attributing factors like access barriers. The developer reiterated that the measure is not intended for use by health plans; it is intended to assess the relationship between care processes and access to care at the Medicaid program level.
- The measure is based on 12 studies that provided the following evidence statements: 1) Definitive care is not provided to children presenting with pain and/or swelling in an emergency department for dental caries-related reasons; 2) Definitive dental care is necessary to treat the disease but often is not received; and 3) Non-traumatic visits to an ED for dental problems by children (initial and repeat visits) are a resource burden for state Medicaid programs.
- The Committee examined the adequacy of the evidence linking follow-up visits at seven and 30-days after caries-related ED encounters to better health outcomes. The developer presented data that showed that shorter time intervals between ED and follow-up visits increased the probability that the next encounter would result in an outpatient visit instead of an ED visit.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion.

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: H-3; M-10; L-7; I-0 2b. Validity: H-2; M-13; L-5; I-0

Rationale:

- The absence of CDT codes for specified services made it difficult for the Committee to assess the impact of follow-up visits on health outcomes. The developer confirmed that the intent of the measures is to assess access to follow-up care. The developer conducted a thorough analysis to ensure the inclusion of wide range of services in the numerator, including identifying patterns

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for CDT coding for the wide variation of services performed during follow-up visits per patient need
- The developer tested validity at the data element level; therefore reliability testing is not required by NQF.
- The developer assessed critical data element validity at a Florida facility using 300 records, and face validity was used to test supplemental data. The testing assessed the accuracy of: 1) the proposed diagnosis code set to identify caries-related ED visits; and 2) CDT codes to identify dental services as the data elements that contribute most to the measure score. The Kappa statistic was 0.71. Sensitivity was 82 percent, and specificity was 90 percent. Positive predictive value and negative predictive value were 79 and 92 percent, respectively.

3. Feasibility: H-9; M-8; L-2; I-1

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:
- All of the required data elements are routinely generated and used during delivery of care and are available in electronic form (administrative claims).
- This measure is intended for widespread adoption and is designed to avoid using software or other proprietary materials that would require licensing fees. The measure specifications will be accessible through a website and can be used free of charge for non-commercial purposes.

4. Usability and Use: H-6; M-9; L-4; I-1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:
- This is a new measure and is not in current use. The developer specified that planned use includes: public reporting and quality improvement with external benchmarking to multiple organizations.

5. Related and Competing Measures
- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-13; N-7

6. Public and Member Comment: **May 29, 2015 – June 29, 2015**

Comments received:
- This measure received seven comments. The majority of the comments supported the Committee's recommendation to endorse the measure. A set of two similar comments raised concerns by noting that this measure would identify gaps in follow-up care, but the commenters felt that the measure is impossible to operationalize without relying on self-report via follow-up phone calls, tracking of returns to the ED for same reason, or establishment of relationships with a dental network to share patient information.

NQF response:
- NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the Standing Committee during the Post-Comment meeting.

Developer Response:
- This measure was developed and tested for implementation with Medicaid program integrated medical-dental administrative enrollment and claims data or equivalent integrated medical-dental data. Feasibility and validity testing demonstrated that this measure could be reliably operationalized with linked medical-dental administrative claims. Organizations that do not have linked medical-dental data would not report this measure. Identifying follow-up care using dental procedure codes is consistent with other previously endorsed program-level dental process of care measures and would not require patient self-report or other additional

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mechanisms to identify dental services. • This measure was developed and tested for implementation at the Medicaid program (or equivalent) level. The DQA appreciates the support for this measure and interest in applications for other delivery system levels. The DQA's measures development efforts are ongoing, and opportunities to adapt this measure for application at other levels will be considered.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

Appendix B- Pneumococcal Vaccination Draft Standard Specifications

	NQF Standard Specifications, Immunocompromised Individuals 6 to 18 years
Numerator	Number of persons specified in the denominator who, • ever received the PPSV23 (pneumococcal polysaccharide) vaccine and received the PCV13 vaccine ≥ eight weeks after receipt of PPSV23 • have documented administration of PPSV23 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider and documented administration of PCV13 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider ≥ eight weeks after receipt of PPSV23 OR • received pneumococcal vaccine of PCV13 first, followed by PPSV23 ≥ eight weeks following administration of PCV13 OR • have documented administration of PCV13 first by the provider or patient (or responsible party/legal guardian) reported receipt from another provider, followed by documented administration of PPSV23 ≥ eight weeks following administration of PCV13 by the provider or patient (or responsible party/legal guardian reported receipt from another provider OR • were assessed and offered but declined the vaccination (computed and reported separately) OR • were assessed and determined to have medical contraindication(s) (computed and reported separately) of anaphylactic hypersensitivity to component(s) of the vaccine, or bone marrow transplant within past 12 months (<12 months prior to encounters during the measurement year), or receiving course of chemotherapy or radiation therapy (<2 weeks prior to encounters during the measurement year)
Denominator	Number of persons, • in a facility, agency, or practice with an encounter (or in a defined population) during the measurement year (OR for health plan measures, enrolled with a plan during the measurement year) • age 6-18 years with prevalent high-risk conditions of cerebrospinal fluid leak, cochlear implant, sickle cell disease/other hemaglobinopathy, asplenia, congenital or acquired immunodeficiency, HIV infection, ESRD, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, iatrogenic immunosuppression, solid organ transplant, multiple myeloma *See* MMWR *62(25)*

	NQF Standard Specifications, Immunocompromised Individuals 6 to 18 years
	June 28, 2013.
Denominator Exclusions	Hospital patients who died before discharge

	NQF Standard Specifications, Immunocompromised Adults ≥19 to 64 years
Numerator	Number of persons specified in the denominator who, • ever received the PPSV23 (pneumococcal polysaccharide) vaccine and received the PCV13 vaccine ≥ 1 year after receipt of PPSV23 • have documented administration of PPSV23 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider and documented administration of PCV13 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider ≥ 1 year after receipt of PPSV23 OR • received pneumococcal vaccine of PCV13 first, followed by PPSV23 at least eight weeks following administration of PCV13 OR • have documented administration of PCV13 first by the provider or patient (or responsible party/legal guardian) reported receipt from another provider, followed by documented administration of PPSV23 at least eight weeks following administration of PCV13 by the provider or patient (or responsible party/legal guardian reported receipt from another provider OR • were assessed and offered but declined the vaccination (computed and reported separately) OR • were assessed and determined to have medical contraindication(s) (computed and reported separately) of anaphylactic hypersensitivity to component(s) of the vaccine, or bone marrow transplant within past 12 months (<12 months prior to encounters during the measurement year), or receiving course of chemotherapy or radiation therapy (<2 weeks prior to encounters during the measurement year)
Denominator	Number of persons, • in a facility, agency, or practice with an encounter (or in a defined population) during the measurement year (OR for health plan measures, enrolled with a plan during the

	NQF Standard Specifications, Immunocompromised Adults ≥19 to 64 years
	measurement year) • age ≥19-64 years with prevalent high-risk conditions of cerebrospinal fluid leak, cochlear implant, sickle cell disease/other hemaglobinopathy, asplenia, congenital or acquired immunodeficiency, HIV infection, ESRD, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, iatrogenic immunosuppression, solid organ transplant, multiple myeloma *See* MMWR *61(40) October 12, 2012.*
Denominator Exclusions	Hospital patients who died before discharge

	NQF Standard Specifications, Adults ≥ 65 years
Numerator	Number of persons specified in the denominator who, • ever received the PPSV23 (pneumococcal polysaccharide) vaccine and received the PCV13 vaccine≥1 year after receipt of PPSV23 • have documented administration of PPSV23 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider and documented administration of PCV13 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider ≥ 1 year after receipt of PPSV23 OR • received pneumococcal vaccine of PCV13 first, followed by PPSV23 at least eight weeks following administration of PCV13 OR • have documented administration of PCV13 first by the provider or patient (or responsible party/legal guardian) reported receipt from another provider, followed by documented administration of PPSV23 at least eight weeks following administration of PCV13 by the provider or patient (or responsible party/legal guardian reported receipt from another provider OR • were assessed and offered but declined the vaccination (computed and reported separately) OR • were assessed and determined to have medical contraindication(s) (computed and reported separately) of anaphylactic hypersensitivity to component(s) of the vaccine, or bone marrow transplant within past 12 months (<12 months prior to encounters during the measurement year), or receiving course of chemotherapy or radiation therapy (<2 weeks prior to encounters during the measurement year).
Denominator	Number of persons, • in a facility, agency, or practice with an encounter (or in a defined population) during the measurement year (OR for health plan measures, enrolled with a plan during the

	NQF Standard Specifications, Adults ≥ 65 years
	measurement year) • who is age 65 or older
Denominator Exclusions	Hospital patients who died before discharge

Public and Member Comment

One comment supported NQF's efforts to revise standard specifications for pneumococcal vaccination for immunocompromised individuals across both age groups; however, the commenter cautioned that in the absence of a national immunization administration database, there is potential risk for repeat vaccinations. Additionally the commenter noted that one of the vaccinations is cost-prohibitive, which may penalize physicians and other clinicians who care for underserved populations. Lastly, the commenter noted that exceptions should be made for patients with limited life expectancy (e.g., exclusion of hospice patients). One commenter agreed with standards and decision to defer measures based on changing evidence related to pneumococcal standards.