



**For Public Comment**  
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Comments due 11:59 p.m. ET  
November 3 2022

# Proposed Changes to the Diabetes Recognition Program (DRP)

## *Overview*

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# Background and Overview of Proposed Updates

## DRP Product Design

### *DRP Program Background & Strategy*

The DRP, launched in 1997, recognizes clinicians for the delivery of high-quality ambulatory care to adults with diabetes. Recognition is voluntary, status lasts for three years, and results are highlighted on NCQA's publicly available Report Card. Currently, more than 4,300 clinicians hold recognition. An individual clinician (e.g., primary care clinician, endocrinologist) or a group of clinicians may apply for recognition from the DRP.

The health care ecosystem has evolved significantly since our 2015 update of the DRP. Advances in diabetes technology and clinical practice drive the need to refresh the program. Over the course of the next 3 years NCQA will be updating the DRP program by modernizing the infrastructure to incorporate digital measures, automating the application process, expanding program use among providers, incorporating health equity, and developing new measures and standards to promote improved care and outcomes among patients with diabetes. The following changes are just the initial first steps to updating the program. We will seek public comment feedback on additional changes such as the formulation of new measures and standards.

### *DRP Product Updates*

NCQA is considering some design changes to the DRP to address customer and stakeholder needs, reduce manual reporting burden and adapt for a digital future.

- *Program eligibility:* NCQA plans to maintain current clinician eligibility (i.e., MD, DO, APRN, PA) for any specialty providing diabetes care. In response to stakeholder input emphasizing that high quality diabetes care is provided by care teams, NCQA plans to expand the care team member roles that can be associated with the recognition.
- *Annual renewal:* Currently to maintain diabetes recognition a clinician must renew every 3 years. We are aligning with other NCQA programs and proposing moving to annual measure submission.
- *Automated submission:* As part of the DRP application, currently clinicians manually pull and enter data from patients charts on the measures. We have heard this process is burdensome to customers and want to align NCQA's measures roadmap to CMS and the industry by moving to digital measures which also necessitates automated submission. Clinicians will submit measure results using digital options such as excel files or through using a NCQA developed measure calculator which requires compatibility with the Fast Healthcare Interoperability Resources (FHIR) standard.
  - **Note:** All EHRs will be required to be able to export records in FHIR by the end of 2022, so the technology will be in place.

#### Targeted Questions

1. What roles of the care team should be identified with the DRP?
2. Do you support annual measure submission and renewal for the DRP?
3. Do you support requiring digital submission methods for the DRP (e.g., excel files, NCQA-developed measure calculator)?

## DRP Measure Updates

### *DRP Measurement Background & Strategy*

Health care performance measures are in a period of transition to digital quality measures. CMS envisions a quality measure future that is digital, and that automatically pulls data generated from the normal course of care. NCQA has defined the future of HEDIS to be digital and has begun digitalizing performance measures and collecting data from health plans using the Electronic Clinical Data System (ECDS) reporting standard.

While the industry is evolving towards a digital measure future, we recognize that health plans and health systems may be at different stages of transition and may be progressing towards digital measures at different rates. As we update the DRP measures, our aim is to define a path that sets a goal of fully digital measures while accommodating varying levels of readiness for that future.

To that end, the DRP measures strategy includes the following features:

- Population based measures that require organizations to identify all patients that meet initial population requirements and report on all or a sample of 250 patients.
- Measures will be specified digitally but organizations may need to translate the digital measures into specifications their systems can use.
- Replacement of the current manual, individual record-based data submission method with a digital file upload.
- The need for NCQA to develop a measure calculator for organizations to calculate the DRP measures as digital measure capability becomes the norm throughout the delivery system.

### *Measure Set Updates*

NCQA is updating the current DRP measure set to better align with the evolving health care ecosystem. Proposed updates include retiring the *HbA1c Control <7.0%* measure, replacing the *Nephropathy Assessment* measure with the new *Kidney Health Evaluation* measure, including glucose management indicator (GMI) alongside hemoglobin A1c (HbA1c), and digitalizing the measure set. Table 1 provides an overview of proposed updates to the measure set.

**Table 1. Proposed Measure Updates**

Current DRP Measure Set	Updated DRP Measure Set
HbA1c Control <7.0%	Retire
HbA1c Control <8.0%	Add GMI; Rename to <i>Glycemic Control</i> ; Digitalize
HbA1c Control >9.0%	Add GMI; Rename to <i>Glycemic Poor Control</i> ; Digitalize
Blood Pressure Control $\geq 140/90$	Update to <140/90; Digitalize
Eye Examination	Digitalize
Smoking/Tobacco Use & Cessation/Treatment Assistance	Digitalize
Foot Examination	Digitalize
Nephropathy Assessment	Replace with <i>Kidney Health Evaluation</i> ; Digitalize

Listed below are the updated measure titles and descriptions proposed for the DRP refresh, with measure specific questions for feedback. Specifications for each digital measure may be referenced [here](#).

- ***Glycemic Control***: The percentage of patients 18–75 years of age with diabetes whose most recent hemoglobin A1c (HbA1c) or glucose management indicator (GMI) was <8.0% during the measurement period.
- ***Glycemic Poor Control***: The percentage of patients 18–75 years of age with diabetes whose most recent hemoglobin A1c (HbA1c) or glucose management indicator (GMI) was >9.0% during the measurement period.
  - GMI, formerly “estimated A1c,” is a calculation derived from Continuous Glucose Monitoring (CGM) devices that assesses average blood sugar values, typically based on 14 days of CGM data. GMI can provide information directly to patients and physicians at more frequent intervals than HbA1c. NCQA seeks feedback on the proposed inclusion of GMI alongside HbA1c in the *Glycemic Control* and *Glycemic Poor Control* measures as another method to meet numerator criteria.
  - The *Glycemic Control* and *Glycemic Poor Control* measures currently assess the patient’s most recent HbA1c result. Given the proposed addition of GMI, NCQA recommends that the measures continue to assess the most recent result, with no preference to GMI or HbA1c. If two values are found on the same day, the measure will evaluate the lower of the two values. This structure will allow reflection of the patient’s most current state of glucose control. NCQA seeks feedback on this measure structure.
- ***Blood Pressure Control***: The percentage of patients 18–75 years of age with diabetes whose blood pressure (BP) was controlled (<140/90 mmHg) during the measurement period.
- ***Kidney Health Evaluation***: The percentage of patients 18-75 years of age with diabetes who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement period.
- ***Eye Exam***: The percentage of patients 18–75 years of age with diabetes who had a retinal or dilated eye exam during the measurement period.
- ***Foot Exam***: The percentage of patients 18–75 years of age with diabetes who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement period.
- ***Smoking and Tobacco Use and Cessation and Treatment Assistance***: The percentage of patients 18–75 years of age with diabetes who were screened for smoking/tobacco use during the measurement period and received cessation counseling or treatment during the measurement period or in the six months prior to the measurement period if identified as a current smoker/tobacco user.

#### Targeted Questions

4. Do you support retirement of the HbA1c Control <7.0% measure from DRP?
5. Do you support adding the glucose management indicator alongside HbA1c in the numerator of the *Glycemic Control* measure (formerly HbA1c Control <8.0%) in DRP?
6. Do you support adding the glucose management indicator alongside HbA1c in the numerator of the *Glycemic Poor Control* measure (formerly HbA1c Control >9.0%) in DRP?
7. For the *Glycemic Control* and *Glycemic Poor Control* measures, do you support assessing the most recent result when two values are found on the same day, with no preference to GMI or HbA1c?
8. For the *Eye Exam* measure, NCQA acknowledges limitations on data exchange between a patient’s managing provider and their eye care professional. Where do managing providers leverage data to obtain Eye Exam information?

## **Measure Specifications**

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The DRP will use digital quality measures (dQMs) that leverage electronic clinical data. This will allow for better and greater insight on data, foster patient-specific care, align with interoperability and decrease measurement burden. Each DRP measure includes the following initial population: patients 18-75 years of age by the end of the measurement period, who had a visit during the measurement period, and a diagnosis of diabetes that is ongoing or starts during the first six months of the measurement period. The intent of this approach is to identify an active diagnosis of diabetes while providing a minimum six-month window for interventions (numerator events).

### **Targeted Question**

9. Do you support the initial population being defined as outlined above?

## **Sample Size**

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Currently clinicians submit data on a sample of 25 patients per clinician with the manual chart abstraction. With the implementation of automated digital submission, NCQA plans to expand the sample size to all of the patients that meet the initial population requirements (18-75 years of age, with a diagnosis of diabetes, and a visit with the clinician or practice) up to a maximum of 250 patients per clinician.

### **Targeted Question**

10. Do you support requiring the sample include all patients that meet the initial population specifications?

## **New Measure Development**

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NCQA is interested in identifying gaps in the DRP to explore areas for development involving new measure concepts. Development and implementation of new measures will take place following the initial DRP 2023 launch. However, NCQA continues to identify and prioritize measure concepts during this time. Measure considerations for potential development already identified include additional CGM data points such as Time In Range and Time Below Range, behavioral health, cholesterol management/statin therapy, cultural sensitivity, dental examination, diabetes self-management, digital therapeutics, health disparities and person reported social determinants of health, hearing examination and weight management.

### **Targeted Question**

11. Are there any additional concepts that, if included in the DRP, would facilitate improvement for care of patients with diabetes?

## Digital Therapeutics (DTx)

NCQA is exploring a program for digital therapeutic companies. We are interested in working with interested stakeholders to co-develop a potential product that evaluates digital therapeutic use in diabetes care.

Digital therapeutics (DTx) deliver to patients evidence-based therapeutic interventions that are driven by high-quality software programs to treat, manage, or prevent a disease or disorder. They are used independently or in concert with medications, devices, or other therapies to optimize patient care and health outcomes. DTx products incorporate advanced technology best practices relating to design, clinical evaluation, usability and data security. They are certified or cleared by regulatory bodies as required to support product claims regarding risk, efficacy and intended use. These entities exist for most chronic diseases with diabetes care representing approximately 28% of the market. They have varying coordination, communication and relationships with continuing care providers, either PCPs or specialists. Digital therapeutics have potential to empower patients, clinicians and payors with intelligent and accessible tools for addressing a wide range of conditions through high-quality, safe, and effective data-driven interventions, or they can contribute to care fragmentation by poor coordination with ongoing care delivery.

Digital therapeutics is trending and growing in market size and across segments by providing digital treatment and care to patients. NCQA wants to partner with DTx companies, providers, health plans/ACO's, and state organizations to develop a deeper understanding of the evolution of DTx, and its use, risk, challenges and impact on existing and future healthcare. NCQA is considering a program with standards and measures for DTx companies.

### Targeted Questions

12. How are you currently evaluating DTx solutions for use with patients?
13. Have you found DTx to be effective for treating diabetes?
14. Are there limitations to DTx use in diabetes care?
15. What challenges or barriers does DTx present for clinicians? For patients? For payers?
16. As we evolve the Diabetes Recognition Program are there measures or standards related to DTx we should consider adding?

# Public Comment Instructions

## How to Submit Comments

NCQA reviews all feedback submitted during the public comment period. To submit your comments:

1. Go to [My NCQA](#) and enter your email address and password.
2. Once logged in, scroll down and click **Public Comments**.
3. Click **Add Comment** to open the comment box.
4. Click to select **Proposed Updates for Diabetes Recognition Program 2023** from the drop-down box.
5. Click to select the **Topic** and **Element** (question) on which you would like to comment.
6. Click to select your support option (**Support, Do not support, Support with modifications**).
  - If you choose **Do not support**, include your rationale in the text box.
  - If you choose **Support with modifications**, enter the suggested modification in the text box.
7. Enter your comments in the **Comments** box.

**Note:** *There is a 2,500-character limit for each comment. We suggest you develop your comments in Word to check your character limit; use the “cut and paste” function to copy your comment into the Comments box.*

8. Use the **Submit** button to submit more than one comment. Use the **Close** button to finish leaving comments. You can view all submitted comments in the **Public Comments** module.

**All comments must be entered by October 28, at 11:59 p.m. ET**

## Acknowledgements

NCQA acknowledges the contributions of the Diabetes Expert Panel, and the Diabetes and Geriatric Measurement Advisory Panels.