



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 subcriterion 1b).

Brief Measure Information

NQF #: 1799

Corresponding Measures:

De.2. Measure Title: Medication Management for People with Asthma

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

De.3. Brief Description of Measure: The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.

1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period.

2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.

1b.1. Developer Rationale: This measure assesses adherence to long-term asthma controller medications in patients with persistent asthma. The improvement in quality envisioned by the use of this measure is increasing adherence to long-term asthma controller medications in patients with persistent asthma. According to the Asthma Regional Council of New England, two-thirds of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines (Stillman 2010). Increasing adherence to asthma controller medications can prevent and control asthma symptoms, improve quality of life, reduce the frequency and severity of asthma exacerbations, and potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits and missed work and school days) (Akinbami 2009; (National Heart, Lung, and Blood Institute [NHLBI]/National Asthma and Education Prevention Program [NAEPP] 2007).

Akinbami, L.J., J.E. Moorman, P.L. Garbe, E.J. Sondik. 2009. Status of Childhood Asthma in the United States, 1980–2007. *Pediatrics* 123;S131-45. doi: 10.1542/peds.2008-2233C.

National Heart Lung and Blood Institute/National Asthma Education and Prevention Program. 2007. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Washington (DC): National Heart Lung and Blood Institute (NHLBI), NIH Publication No. 07-4051. <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf> (November 19, 2015).

Stillman, L. 2010. Living with Asthma in New England: Results from the 2006 BRFSS and Call-back Survey. A report by the Asthma Regional Council of New England (February). http://www.hria.org/uploads/catalogerfiles/living-with-asthma-in-new-england/HRIA_Living_with_Asthma_BRFSS_2010.pdf (November 19, 2015).

S.4. Numerator Statement: Numerator 1 (Medication Adherence 50%): The number of patients who achieved a PDC* of at least 50% for their asthma controller medications during the measurement year. A higher rate is better.

Numerator 2 (Medication Adherence 75%): The number of patients who achieved a PDC* of at least 75% for their asthma controller medications during the measurement year. A higher rate is better.

*PDC is the proportion of days covered by at least one asthma controller medication prescription, divided by the number of days in the treatment period. The treatment period is the period of time beginning on the earliest prescription dispensing date for any asthma controller medication during the measurement year through the last day of the measurement year.

S.7. Denominator Statement: All patients 5–64 years of age as of December 31 of the measurement year who have persistent asthma by meeting at least one of the following criteria during both the measurement year and the year prior to the measurement year:

- At least one emergency department visit with asthma as the principal diagnosis

- At least one acute inpatient claim/encounter with asthma as the principal diagnosis
- At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events. Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events

S.10. Denominator Exclusions: 1) Exclude patients who had any of the following diagnoses any time during the patient's history through the end of the measurement year (e.g., December 31):

- COPD
- Emphysema
- Obstructive Chronic Bronchitis
- Chronic Respiratory Conditions Due To Fumes/Vapors
- Cystic Fibrosis
- Acute Respiratory Failure

2) Exclude any patients who had no asthma controller medications dispensed during the measurement year.

De.1. Measure Type: Process

S.23. Data Source: Claims

S.26. Level of Analysis: Health Plan, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2012 **Most Recent Endorsement Date:** Jul 31, 2012

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 subcriteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[MMA_Evidence-635899392231961960.docx](#)

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., the benefits or improvements in quality envisioned by use of this measure)

This measure assesses adherence to long-term asthma controller medications in patients with persistent asthma. The improvement in quality envisioned by the use of this measure is increasing adherence to long-term asthma controller medications in patients with persistent asthma. According to the Asthma Regional Council of New England, two-thirds of adults and children who display asthma symptoms are considered “not well controlled” or “very poorly controlled” as defined by clinical practice guidelines (Stillman 2010). Increasing adherence to asthma controller medications can prevent and control asthma symptoms, improve quality of life, reduce the frequency and severity of asthma exacerbations, and potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits and missed work and school days) (Akinbami 2009; (National Heart, Lung, and Blood Institute [NHLBI]/National Asthma and Education Prevention Program [NAEPP] 2007).

Akinbami, L.J., J.E. Moorman, P.L. Garbe, E.J. Sondik. 2009. Status of Childhood Asthma in the United States, 1980–2007. *Pediatrics* 123;S131-45. doi: 10.1542/peds.2008-2233C.

National Heart Lung and Blood Institute/National Asthma Education and Prevention Program. 2007. Expert Panel Report 3:

Guidelines for the Diagnosis and Management of Asthma. Washington (DC): National Heart Lung and Blood Institute (NHLBI), NIH Publication No. 07-4051. <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf> (November 19, 2015).

Stillman, L. 2010. Living with Asthma in New England: Results from the 2006 BRFSS and Call-back Survey. A report by the Asthma Regional Council of New England (February). http://www.hria.org/uploads/catalogerfiles/living-with-asthma-in-new-england/HRIa_Living_with_Asthma_BRFSS_2010.pdf (November 19, 2015).

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

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

The following data demonstrate the variation in the rate of medication adherence to asthma controller medications for children and adults with persistent asthma across health plans. In 2014 for the Medication Adherence 50% indicator, there was a 16 percentage point difference between commercial plans in the 10th percentile and commercial plans in the 90th percentile and 26 percentage point difference for Medicaid plans. Similarly in 2014 for the Medication Adherence 75% indicator, there was a 20 percentage point difference between plans in the 10th percentile and plans in the 90th percentile for commercial plans and 26 percentage point difference for Medicaid plans. These gaps in performance underscore the opportunity for improvement.

Medication Management for People with Asthma Numerator 1 (Medication Adherence 50%)

Commercial Rate Ages 5-64 (HMO and PPO Combined)

| YEAR | MEAN | ST DEV | MIN | 10TH | 25TH | 50TH | 75TH | 90TH | MAX | Interquartile Range |
|------|------|--------|-----|------|------|------|------|------|-----|---------------------|
| 2012 | 66% | 7% | 16% | 58% | 62% | 66% | 70% | 74% | 92% | 8% |
| 2013 | 70% | 9% | 16% | 62% | 66% | 69% | 75% | 84% | 93% | 9% |
| 2014 | 69% | 7% | 46% | 61% | 65% | 69% | 73% | 77% | 91% | 8% |

Medicaid Rate Ages 5-64

| YEAR | MEAN | ST DEV | MIN | 10TH | 25TH | 50TH | 75TH | 90TH | MAX | Interquartile Range |
|------|------|--------|-----|------|------|------|------|------|-----|---------------------|
| 2012 | 51% | 9% | 23% | 41% | 45% | 51% | 56% | 62% | 90% | 11% |
| 2013 | 54% | 10% | 25% | 44% | 48% | 54% | 59% | 67% | 94% | 11% |
| 2014 | 54% | 10% | 34% | 42% | 47% | 54% | 60% | 68% | 87% | 13% |

Medication Management for People with Asthma Numerator 2 (Medication Adherence 75%)

Commercial Rate Ages 5-64 (HMO and PPO Combined)

| YEAR | MEAN | ST DEV | MIN | 10TH | 25TH | 50TH | 75TH | 90TH | MAX | Interquartile Range |
|------|------|--------|-----|------|------|------|------|------|-----|---------------------|
| 2012 | 43% | 8% | 8% | 34% | 39% | 42% | 47% | 51% | 82% | 8% |
| 2013 | 48% | 11% | 7% | 37% | 40% | 45% | 52% | 66% | 82% | 12% |
| 2014 | 45% | 8% | 12% | 35% | 40% | 45% | 50% | 55% | 72% | 10% |

Medicaid Rate Ages 5-64

| YEAR | MEAN | ST DEV | MIN | 10TH | 25TH | 50TH | 75TH | 90TH | MAX | Interquartile Range |
|------|------|--------|-----|------|------|------|------|------|-----|---------------------|
| 2012 | 29% | 9% | 9% | 19% | 22% | 28% | 33% | 39% | 77% | 11% |
| 2013 | 31% | 10% | 9% | 20% | 25% | 30% | 36% | 43% | 84% | 11% |
| 2014 | 31% | 10% | 13% | 19% | 24% | 30% | 35% | 45% | 75% | 11% |

The data references are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2013, HEDIS measures covered more than 171 million people from 814 HMOs and 353 PPOs. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the mean eligible population for the measure across health plans.

Commercial HMO

| YEAR | N Plans | Mean Denominator Size per plan |
|------|---------|--------------------------------|
| 2012 | 199 | 1,291 |

2013 | 200 | 1,169
2014 | 194 | 1,070

Commercial PPO

YEAR | N Plans | Mean Denominator Size per plan

2012 | 198 | 1,538
2013 | 196 | 1,566
2014 | 194 | 1,520

Medicaid HMO

YEAR | N Plans | Mean Denominator Size per plan

2012 | 154 | 1,640
2013 | 169 | 1,548
2014 | 192 | 1,628

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 endorsement maintenance. 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 subcriterion on improvement (4b.1) under Usability and Use.*

HEDIS data are stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). NCQA does not currently collect performance data stratified by race, ethnicity, or language. Escarce et al. have described in detail the difficulty of collecting valid data on race, ethnicity and language at the health plan level (Escarce, 2011). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities. The HEDIS Health Plan Measure Set contains two measures that can assist with stratification to assess health care disparities. The Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA's Multicultural Health Care Distinction Program outlines standards for collecting, storing and using race/ethnicity and language data to assess health care disparities. Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

Escare J.J., Carreon R., Vesolovskiy G., and Lawson E.H. 2011. Collection Of Race And Ethnicity Data By Health Plans Has Grown Substantially, But Opportunities Remain To Expand Efforts. *Health Affairs* 20(10): 1984-1991.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

Although HEDIS measures are not stratified by race and ethnicity, researchers have explored disparities in asthma outcomes and in utilization to health care services among people with asthma. Children of low-income families experience more urgent care visits, hospitalizations and mortality due to asthma when compared to the general public (CDC 2009). Poor asthma outcomes in low-income children may be partly due to the barriers they face in accessing care for asthma, including access to medications. One study found that children with asthma from low-income families were less likely to have prescriptions filled and/or receive annual primary health examinations (Kim et al. 2009). The study also examined insurance coverage, showing that children without insurance coverage utilized primary health care services for asthma less often (Kim et al. 2009).

Centers for Disease Control and Prevention (CDC). Asthma: A Presentation of Asthma Management and Prevention, September 2009. <http://www.cdc.gov/asthma/speakit/default.htm> (November 19, 2015).

Kim, H., G.M. Kieckhefer, A.A. Greek, J.M. Joesch, N. Baydar. 2009. Health Care Utilization by Children With Asthma. *Preventing Chronic Disease* 6(1): A12.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality, Severity of illness

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

Asthma is one of the most prevalent chronic diseases. In 2010, 25.7 million Americans had asthma, including 7 million children, 15.6 million adults under 65 and 3.1 million adults 65 and older (Akinbami et al. 2012). Asthma has also become increasingly more common over the past decade, occurring in 7.3 percent of the population in 2001 compared to 8.4 percent in 2010 (Akinbami et al. 2012). Asthma is responsible for over 3,000 deaths in the U.S. annually (American Lung Association 2014) and accounted for over \$50 billion spent on health care in the United States in 2007, an increase of almost \$2 billion from 2002 (CDC 2011).

Appropriate medication adherence could ameliorate the severity of many asthma-related symptoms (Akinbami et al. 2009). According to the Asthma Regional Council of New England, two-thirds of adults and children who display asthma symptoms are considered “not well controlled” or “very poorly controlled” as defined by clinical practice guidelines (Stillman 2010). Pharmacologic therapy is used to prevent and control asthma symptoms, improve quality of life, reduce the frequency and severity of asthma exacerbations, and reverse airflow obstruction (National Heart, Lung, and Blood Institute [NHLBI]/National Asthma and Education Prevention Program [NAEPP] 2007). Appropriate medication management could potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits and missed work and school days) (Akinbami et al. 2009). Indeed, several studies have found that higher medication adherence rates are associated with better outcomes; for instance, one study found that patients with asthma controller medication adherence rates of 75% or greater had fewer asthma exacerbations compared to patients with adherence rates of 25% or lower (Williams et al. 2011). The Asthma Regional Council has also stated that proper management could potentially save at least 25 percent of total asthma costs, or \$5 billion, nationally by reducing health care costs (American Lung Association 2012).

1c.4. Citations for data demonstrating high priority provided in 1a.3

Akinbami, L.J., J.E. Moorman, P.L. Garbe, E.J. Sondik. 2009. Status of Childhood Asthma in the United States, 1980–2007. *Pediatrics* 123;S131-45. doi: 10.1542/peds.2008-2233C.

Akinbami, L.J., J.E. Moorman, C. Bailey, H.S. Zahran, M. King, C.A. Johnson, X. Liu. 2012. “Trends in Asthma Prevalence, Health Care Use, and Mortality in the United States, 2001-2010.” NCHS Data Brief, no. 94 (May). <http://www.cdc.gov/nchs/data/databriefs/db94.pdf> (November 19, 2015).

American Lung Association. 2012. Trends in Asthma Morbidity and Mortality. <http://www.lung.org/finding-cures/our-research/trend-reports/asthma-trend-report.pdf> (November 19, 2015).

American Lung Association. 2014. Asthma & Children Fact Sheet, September. <http://www.lung.org/lung-health-and-diseases/lung-disease-lookup/asthma/learn-about-asthma/asthma-children-facts-sheet.html> (November 19, 2015).

Centers for Disease Control and Prevention (CDC). Vital Signs: Asthma in the US, May 2011. <http://www.cdc.gov/VitalSigns/Asthma/index.html> (November 19, 2015).

Stillman, L. 2010. Living with Asthma in New England: Results from the 2006 BRFSS and Call-back Survey. A report by the Asthma Regional Council of New England (February). <http://hria.org/resources/reports/asthma/living-with-asthma-in-new-england.html> (November 19, 2015).

Williams, L. K., E.L. Peterson, K. Wells, B.K. Ahmedani, R. Kumar, E.G. Buchard, V.K. Chowdhry, D. Favro, D.E. Lanfear, M. Pladevall.

2011. Quantifying the proportion of severe asthma exacerbations attributable to inhaled corticosteroid nonadherence. *Journal of Allergy and Clinical Immunology*, no 128.6 p. 1185-1191

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

N/A

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 subcriteria 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):

Respiratory, Respiratory : Asthma

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

Primary Prevention

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.)

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: 1799_MMA_Value_Sets.xlsx

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

There are no significant changes to the measure specification since the last endorsement maintenance completed on January 31, 2012.

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)
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Numerator 1 (Medication Adherence 50%): The number of patients who achieved a PDC* of at least 50% for their asthma controller medications during the measurement year. A higher rate is better.

Numerator 2 (Medication Adherence 75%): The number of patients who achieved a PDC* of at least 75% for their asthma controller medications during the measurement year. A higher rate is better.

*PDC is the proportion of days covered by at least one asthma controller medication prescription, divided by the number of days in the treatment period. The treatment period is the period of time beginning on the earliest prescription dispensing date for any asthma controller medication during the measurement year through the last day of the measurement year.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

Numerator: 12 month period (the measurement year)

Denominator: 24 month period (the measurement year and the year prior)

Exclusions: lookback through the patient's history through the last day of the measurement year

S.6. 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, 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.

Follow the steps below to identify numerator compliance.

Step 1: Identify the Index Prescription Start Date*. The Index Prescription Start Date is the earliest dispensing event for any asthma controller medication (refer to MMA-B Asthma Controller Medications) during the measurement year.

Step 2: To determine the treatment period, calculate the number of days beginning on the Index Prescription Start Date through the end of the measurement year.

Step 3: Count the days covered by at least one prescription for an asthma controller medication (refer to MMA-B Asthma Controller Medications) during the treatment period. To ensure that days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond the end of the measurement year (e.g., December 31).

Step 4: Calculate the patient's Proportion of Days Covered using the following equation. Round (using the .5 rule) to two decimal places.

(Total Days Covered by a Controller Medication in the Treatment Period (Step 3)
/Total Days in Treatment Period (Step 2))

Numerator 1 (Medication Adherence 50%): Sum the number of patients whose Proportion of Days Covered is > or =50% for their treatment period.

Numerator 2 (Medication Adherence 75%): Sum the number of patients whose Proportion of Days Covered is > or =75% for their treatment period

MMA-B: Asthma Controller Medications:

Antiasthmatic combinations: dyphylline-guaifenesin, guaifenesin-theophylline

Antibody inhibitor: omalizumab

Inhaled steroid combinations: budesonide-formoterol, fluticasone-salmeterol, mometasone-formoterol

Inhaled corticosteroids: beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone CFC free, mometasone,

Leukotriene modifiers: montelukast, zafirlukast, zileuton

Mast cell stabilizers: cromolyn

Methylxanthines: aminophylline, dyphylline, theophylline

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

All patients 5–64 years of age as of December 31 of the measurement year who have persistent asthma by meeting at least one of the following criteria during both the measurement year and the year prior to the measurement year:

- At least one emergency department visit with asthma as the principal diagnosis

- At least one acute inpatient claim/encounter with asthma as the principal diagnosis
- At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events. Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Populations at Risk

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, 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)

The eligible population for the denominator is defined by following the series of steps below:

Step 1: Identify patients as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one ED visit (refer to codes in ED Value Set) with asthma as the principal diagnosis (refer to codes in Asthma Value Set).
- At least one acute inpatient claim/encounter (refer to codes in Acute Inpatient Value Set) with asthma as the principal diagnosis (refer to codes in Asthma Value Set).
- At least four outpatient visits (refer to codes in Outpatient Value Set) or observation visits (refer to codes in Observation Value Set) on different dates of service, with any diagnosis of asthma (refer to codes in Asthma Value Set) AND at least two asthma medication dispensing events (see MMA-A). Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events (see MMA-A)

Step 2: A patient identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (refer to codes in Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., measurement year or year prior to the measurement year).

See attached value set Excel document for the following value sets:

- ED Value Set
- Asthma Value Set
- Acute Inpatient Value Set
- Outpatient Value Set
- Observation Value Set

MMA-A: Asthma Medications

Antiasthmatic combinations: dyphylline-guaifenesin; guaifenesin-theophylline

Antibody inhibitor: omalizumab

Inhaled steroid combinations: budesonide-formoterol; fluticasone-salmeterol; Mometasone-formoterol

Inhaled corticosteroids: beclomethasone; budesonide; ciclesonide; flunisolide; fluticasone CFC free; mometasone

Leukotriene modifiers: montelukast; zafirlukast; zileuton

Mast cell stabilizers: cromolyn

Methylxanthines: aminophylline; dyphylline; theophylline

Short-acting, inhaled beta-2 Agonists: albuterol; levalbuterol; metaproterenol; pirbuterol

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

1) Exclude patients who had any of the following diagnoses any time during the patient's history through the end of the measurement year (e.g., December 31):

-COPD
-Emphysema
-Obstructive Chronic Bronchitis
-Chronic Respiratory Conditions Due To Fumes/Vapors
-Cystic Fibrosis
-Acute Respiratory Failure

2) Exclude any patients who had no asthma controller medications dispensed during the measurement year.

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, 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)

1) Exclude patients who had any diagnosis of Emphysema (refer to codes in Emphysema Value Set or Other Emphysema Value Set), COPD (refer to codes in COPD Value Set), Chronic Bronchitis (refer to codes in Obstructive Chronic Bronchitis Value Set), Chronic Respiratory Conditions Due To Fumes/Vapors (refer to codes in Chronic Respiratory Conditions Due to Fumes/Vapors Value Set), Cystic Fibrosis (refer to codes in Cystic Fibrosis Value Set) or Acute Respiratory Failure (refer to codes in Acute Respiratory Failure Value Set) any time during the patient's history through the end of the measurement year (e.g., December 31).

2) Exclude any patients who had no asthma controller medications (see MMA-B) dispensed during the measurement year.

See attached value set Excel document for the following value sets:

- Emphysema Value Set
- Other Emphysema Value Set
- COPD Value Set
- Obstructive Chronic Bronchitis Value Set
- Chronic Respiratory Conditions Due to Fumes/Vapors Value Set
- Cystic Fibrosis Value Set
- Acute Respiratory Failure Value Set

MMA-B: Asthma Controller Medications:

Antiasthmatic combinations: dyphylline-guaifenesin, guaifenesin-theophylline

Antibody inhibitor: omalizumab

Inhaled steroid combinations: budesonide-formoterol, fluticasone-salmeterol, mometasone-formoterol

Inhaled corticosteroids: beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone CFC free, mometasone

Leukotriene modifiers: montelukast, zafirlukast, zileuton

Mast cell stabilizers: cromolyn

Methylxanthines: aminophylline, dyphylline, theophylline

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)

Four age stratifications and a total rate are reported for this measure. Age for each stratum is based on the patient's age as of the end of the Measurement Year (e.g., December 31).

- 1) 5–11 years
- 2) 12–18 years
- 3) 19–50 years
- 4) 51–64 years
- 5) Total (5–64 years)

The age strata align with both clinical practice guidelines and reporting requirements for child health quality improvement programs. Clinical guidelines specify appropriate age cohorts for measuring use of asthma medications as 5–11 years of age and 12–50 years of age, to account for the differences in medication regimens for children compared to adolescents and adults. Implementation requires further stratification of the age ranges to enable creation of comparable cohorts that align with child health populations.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

N/A

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

N/A

S.16. Type of score:

Rate/proportion

If other:

S.17. 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.18. Calculation Algorithm/Measure Logic (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; aggregating data; risk adjustment; etc.)

Refer to items S.6 (Numerator details), S.9 (Denominator details), S.11 (Denominator exclusions details) and S.2b (Data Dictionary) for tables.

This measure determines the number of days covered with a controller medication based on information available from the published NDC codes to calculate adherence to asthma medications. The measure calculation is detailed in the steps listed below:

Step 1: Determine the eligible population: Identify patients 5–64 years of age as of December 31 of the measurement year as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both year:

- a) At least one ED visit with asthma as the principal diagnosis; or
- b) At least one acute inpatient claim/encounter with asthma as the principal diagnosis; or
- c) At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events. Visit type need not be the same for the four visits; or
- d) At least four asthma medication dispensing events*

*A patient identified as having persistent asthma because of at least four asthma medication dispensing events where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., measurement year or year prior to the measurement year).

Step 2: Determine denominator exclusions:

- a) Exclude patients who had any diagnosis of Emphysema, COPD, Chronic Bronchitis, Chronic Respiratory Conditions Due to Fumes/Vapors, Cystic Fibrosis or Acute Respiratory Failure any time during the patient's history through the end of the measurement year
- b) Exclude patients who had no asthma controller medications dispensed during the measurement year.

Step 3: Determine numerator:

- a) Identify the Index Prescription Start Date. The Index Prescription Start Date is the earliest dispensing event for any asthma controller medication during the measurement year.
- b) To determine the treatment period, calculate the number of days beginning on the Index Prescription Start Date through the end of the measurement year.
- c) Count the days covered by at least one prescription for an asthma controller medication during the treatment period. To ensure that days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond the end of the of the measurement year (e.g., December 31).
- d) Calculate the patient's Proportion of Days Covered using the following equation. Round (using the .5 rule) to two decimal places: (Total Days Covered by a Controller Medication in the Treatment Period/Total Days in Treatment Period)
- e) Calculate Numerator 1: Sum the number of patients whose Proportion of Days Covered is > or =50% for their treatment period.
- f) Calculate Numerator 2: Sum the number of patients whose Proportion of Days Covered is > or =75% for their treatment period

Step 4: Calculate two rates:

- a) Number of patients whose PDC is > or =50% for their treatment period/Denominator
- b) Number of patients whose PDC is > or =75% for their treatment period/Denominator

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)
No diagram provided

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

N/A

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

N/A

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

N/A

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Claims

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(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.25. 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.26. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

Health Plan, Integrated Delivery System

S.27. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.28. 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

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

MMA_Testing-635899391933018060.docx

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)

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.

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.

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. Describe what you have learned/modified 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 a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) information practices and control procedures
- 2) sampling methods and procedures
- 3) data integrity
- 4) compliance with HEDIS specifications
- 5) analytic file production
- 6) reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

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

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

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

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

| Planned | Current Use (for current use provide URL) |
|---------|--|
| | Public Reporting Health Plan Rating http://www.ncqa.org/ReportCards/HealthPlans/HealthInsurancePlanRankings/HealthPlanRatingsPreview.aspx Annual State of Health Care Quality |

| | |
|--|---|
| | http://www.ncqa.org/tabid/836/Default.aspx Medicaid Children's Core Set https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf Quality Compass http://www.ncqa.org/tabid/177/Default.aspx Regulatory and Accreditation Programs NCQA Health Plan Accreditation http://www.ncqa.org/tabid/123/Default.aspx Health Insurance Marketplace: Quality Rating System (2016) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2015-QRS-Measure-Technical-Specifications.pdf |
|--|---|

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

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.

HEALTH PLAN RATINGS/REPORT CARDS: This measure is used to calculate health plan ratings which are reported in Consumer Reports and on the NCQA website. These ratings 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 ratings. In 2015 NCQA announced a change in methodology and changed Health Plan Rankings to Health Plan Ratings.

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

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

MEDICAID CHILD CORE SET: These are a core set of health quality measures for Medicaid and CHIP-enrolled children. The Medicaid Child 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 children enrolled in Medicaid and CHIP programs receive nationally. The initial core set was published in February 2011. CHIPRA required the Secretary to publish annual changes to the Child Core Set beginning in January 2013, and an annual Secretary's report on the quality of care for children enrolled in Medicaid and CHIP is released every September summarizing state-specific and national information on the quality of health care furnished to children enrolled in Medicaid and CHIP.

CMS HEALTH INSURANCE MARKET QUALITY RATING SYSTEM: This measure is used in the CMS developed, Quality Reporting Rating System (QRS) set of measures. The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability and management. The measure set includes a subset of NCQA's HEDIS measures and one PQA measure.

4a.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

4a.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

4b. 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.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (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

From 2012-2014, the Medication Adherence 50% indicator showed slight improvement (approximately 3 percentage points) across Commercial and Medicaid health plans (see section 1b.2 for summary of data from health plans). There was also improvement in performance for Commercial and Medicaid plans at the 90th percentile (+4 percentage points for Commercial plans and +6 percentage points for Medicaid plans). These data are nationally representative.

4b.2. 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.

More Medicaid plans reported the measure in 2014 compared to 2013 and 2012, which may help explain why the performance rates did not substantially improve. There is hope that with increasing attention to this measure in public reporting programs such as the Medicaid Child Core Set and in accreditation programs such as the Health Insurance Marketplace: Quality Rating System, performance rates on the Medication Adherence 75% indicator will begin to improve across more plans and performance rates on the Medication Adherence 50% indicator will continue to improve across plans.

4c. 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).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

There were no identified unintended consequences for this measure during testing or since implementation.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria 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)

0047 : Asthma: Pharmacologic Therapy for Persistent Asthma

0548 : Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT)

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

5a. Harmonization

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 completely harmonized?

No

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

0047 is a physician-level measure that assesses whether a patient was prescribed medication at least once during the measurement year, while our measure assesses patient adherence to asthma controller medications throughout the measurement year. 0548 is a health plan-level measure that assesses two rates of poor asthma control that indicate over-utilization of rescue medication and need for additional therapeutic intervention; meanwhile our measure assesses patient adherence to asthma controller medications during the measurement year. There is no impact on interpretability or added burden of data collection because the focus of each measure is different and the data for each measure is collected from different data sources by different entities.

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.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

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

Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728-

Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance

Co.4 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955--

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.

Respiratory Measurement Advisory Panel (RMAP) Members:

David Au, MD, MS, (CHAIR) Associate Prof. of Medicine/Investigator HSRD, Department of Veterans Affairs
Kurt Elward, MD, MPH, Clinical Professor of Family Medicine, Virginia Commonwealth University
Laura Feemster, MD, MS, Assistant Professor of Medicine, University of Washington Medical Center, VA HSR&D
Anne Fuhlbrigge, MD, Clinical Director, Division of Pulmonary and Critical Care Medicine, Brigham and Women's Hospital, Harvard Medical School
Min Joo, MD, MPH, FCCP, Assistant Professor of Medicine, University of Illinois at Chicago/ Jesse Brown VA Medical Center
Christine Joseph, PhD, MPH, BSc, Associate Director of Research, Epidemiologist, Henry Ford Health System
Jerry Krishnan, MD, PhD, Prof. of Medicine & Public Health, Director of Population Health Sciences, AVP, Office of the VP for Health Affairs, University of Illinois Hospital & Health Sciences System
Todd Lee, PharmD, PhD, Primary: Senior Investigator, Secondary: Associate Professor, University of Illinois at Chicago
Allan Luskin, MD, Physician Pulmonologist, Healthy Airways
Richard O'Connor, MD, Director, Dept. of Quality Management, Allergist/Immunologist, Sharp Rees-Stealy Medical Group

Committee on Performance Measurement (CPM) Members:

Peter Bach, MD, Director, Health Policy Center, Memorial Sloan Kettering Cancer Center
Bruce Bagley, MD, FAAFP, Senior Advisor to the Professional Satisfaction and Practice Sustainability effort at the American Medical Association
Andrew Baskin, MD, National Medical Director, Quality & Provider Performance Measurement, Aetna
Patrick Conway, MD, MSC, Chief Medical Officer and Deputy Administrator, Centers for Medicare and Medicaid Services
Jonathan D. Darer, MD, MPH, Chief Innovation Officer, Geisinger Health System
Helen Darling, Strategic Advisor, National Business Group of Health
Rebekah Gee, MD, MPH, FACOG, Assistant Professor, LSUHSC
Foster Gesten, MD, FACP, New York State Department of Health
Marge Ginsburg, Executive Director, Center for Healthcare Decisions
David Grossman, MD, MPH, Medical Director, Population Health
Christine S. Hunter, MD (Co- Chair), Chief Medical Officer, US Office of Personnel Management
Jeffery Kelman, MMSc, MD, Chief Medical Officer, United States Department of Health and Human Services
Bernadette Loftus, MD, Associate Executive Director for the Mid-Atlantic States, The Permanente Medical Group
J. Brent Pawlecki, MD, MMM, Chief Health Officer, The Goodyear Tire & Rubber Company
Susan Reinhard, PhD, RN, Senior Vice President, AARP Public Policy Institute
Eric C. Schneider, MD, MSc, FACP (Co-chair), Senior Vice President, Policy and Research, The Commonwealth Fund
Marcus Thygeson, MD, MPH, Chief Health Officer, Blue Shield of California

HEDIS EXPERT CODING PANEL Members:

Glen Braden, MBA, CHCA, Attest Health Care Advisors, LLC
Denene Harper, RHIA, American Hospital Association
DeHandro Hayden, BS, American Medical Association
Patience Hoag, RHIT, CPHQ, CHCA, CCS, CCS-P, Health Services Advisory Group
Nelly Leon-Chisen, RHIA, American Hospital Association
Tammy Marshall, LVN, Aetna
Alec McLure, RHIA, CCS-P, Verisk Health
Michele Mouradian, RN, BSN, McKesson Health Solutions
Craig Thacker, RN, CIGNA HealthCare
Mary Jane F. Toomey, RN CPC, Aetna Better Health

Technical Measurement Advisory Panel Members:

Andy Amster, MSPH, Kaiser Permanente
Kathryn Coltin, MPH, Independent Consultant
Lekisha Daniel-Robinson, Centers for Medicare and Medicaid Services
Marissa Finn, MBA, Cigna HealthCare
Scott Fox, MS, MEd, Independence Blue Cross
Carlos Hernandez, CenCalHealth
Kelly Isom, MA, RN, Aetna
Harmon Jordan, ScD, RTI International
Ernest Moy, MD, MPH, Agency for Healthcare Research and Quality

Patrick Roohan, New York State Department of Health
Lynne Rothney-Kozlak, MPH, Rothney-Kozlak Consulting, LLC
Natan Szapiro, Independence Blue Cross

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2011

Ad.3 Month and Year of most recent revision: 07, 2015

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

Ad.5 When is the next scheduled review/update for this measure? 07, 2016

Ad.6 Copyright statement: © 2010 by the National Committee for Quality Assurance
1100 13th Street, NW, Suite 1000
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.

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

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

These performance measures were developed and are owned by NCQA. They are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or physician that uses or reports performance measures, and NCQA has no liability to anyone who relies on such measures. NCQA holds a copyright in these measures and can rescind or alter these measures at any time. Users of the measures shall not have the right to alter, enhance or otherwise modify the measures, and shall not disassemble, recompile or reverse engineer the source code or object code relating to the measures. Anyone desiring to use or reproduce the measures without modification for a noncommercial purpose may do so without obtaining approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. © 2012 by the National Committee for Quality Assurance