



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0054

Corresponding Measures:

De.2. Measure Title: Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

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

De.3. Brief Description of Measure: The percentage of patients 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

1b.1. Developer Rationale: This measure assesses the use of disease-modifying anti-rheumatic drugs (DMARDs) in patients with rheumatoid arthritis (RA). The improvement in quality envisioned by the use of this measure is the consistent and early use of DMARDs for patients diagnosed with RA. Intervention with DMARDs presents an important opportunity to alter the course of this disease; DMARDs can slow the progression of RA and reduce further damage to joints.

S.4. Numerator Statement: Patients who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD) during the measurement year.

S.6. Denominator Statement: All patients, ages 18 years and older by December 31 of the measurement year, who had two of the following with different dates of service on or between January 1 and November 30 of the measurement year:

- Outpatient visit, with any diagnosis of rheumatoid arthritis
- Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis

Visit type need not be the same for the two visits.

S.8. Denominator Exclusions: Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who have a diagnosis of HIV. Look for evidence of HIV diagnosis as far back as possible in the patient's history through the end of the measurement year.

Exclude patients who have a diagnosis of pregnancy any time during the measurement year.

De.1. Measure Type: Process

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

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

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Nov 10, 2014

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

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

[0054_ART_Evidence_Final.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

This measure assesses the use of disease-modifying anti-rheumatic drugs (DMARDs) in patients with rheumatoid arthritis (RA). The improvement in quality envisioned by the use of this measure is the consistent and early use of DMARDs for patients diagnosed with RA. Intervention with DMARDs presents an important opportunity to alter the course of this disease; DMARDs can slow the progression of RA and reduce further damage to joints.

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

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

The following data demonstrate the variation in the rate of DMARD dispensation across health plans. In 2012, there was a 13 point difference between plans in the 10th percentile and plans in the 90th percentile for commercial HMO plans, 11 points for commercial PPO plans, 26 points for Medicaid plans, 25 points for Medicare HMO plans and 16 points for Medicare PPO plans. These gaps in performance underscore the opportunity for improvement.

Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Commercial Rate (HMO)

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	IQR
2012	88%	5.2%	81%	85%	89%	91%	94%	6
2011	88%	5.0%	81%	84%	88%	91%	94%	7
2010	88%	5.5%	81%	85%	88%	91%	94%	7

Commercial Rate (PPO)

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	IQR
2012	87%	4.7%	81%	84%	88%	90%	92%	6
2011	87%	4.8%	81%	84%	87%	90%	93%	5
2010	87%	4.5%	81%	85%	88%	90%	92%	5

Medicaid Rate

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	IQR
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2012	70%	10.6%	57%	65%	69%	76%	83%	11
2011	69%	9.8%	57%	64%	69%	75%	81%	12
2010	70%	11.5%	53%	64%	73%	78%	83%	15

Medicare Rate (HMO)

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	IQR
2012	76%	10.3%	62%	71%	77%	82%	87%	12
2011	73%	11.6%	59%	66%	75%	80%	85%	14
2010	73%	12.0%	58%	67%	75%	81%	85%	14

Medicare Rate (PPO)

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	IQR
2012	79%	6.4%	71%	76%	79%	83%	87%	7
2011	77%	7.3%	68%	73%	78%	82%	85%	10
2010	78%	7.3%	68%	75%	79%	83%	86%	8

The data shown above are from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2012, HEDIS measures covered 107.3 million commercial health plan members, 21.7 million Medicaid members, and 8.7 million Medicare members. Below is a description of the denominator for this measure. It includes number of health plans included in HEDIS data collection and the median eligible population for the measure across health plans.

Commercial HMO

YEAR	N Plans	Median Denominator Size per plan
2012	177	174
2011	177	181
2010	201	190

Commercial PPO

YEAR	N Plans	Median Denominator Size per plan
2012	178	261
2011	166	226
2010	154	226

Medicaid

YEAR	N Plans	Median Denominator Size per plan
2012	97	131
2011	84	117
2010	77	108

Medicare (HMO)

YEAR	N Plans	Median Denominator Size per plan
2012	262	191
2011	257	185
2010	241	173

Medicare (PPO)

YEAR	N Plans	Median Denominator Size per plan
2012	121	142
2011	114	132
2010	96	109

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

N/A

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

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

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 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Although HEDIS measures are not stratified by race and ethnicity, research has determined that there are disparities in this area of care.

Schmajuk et al. analyzed CMS data for 93,143 patients in Medicare managed care plans to assess plan performance on NCQA’s HEDIS rheumatoid arthritis (RA) measure between 2005-2008 to examine variations in DMARD receipt.

Overall, average performance on the HEDIS RA measure in the study sample was 63%. In 2005, 59% of the sample received a DMARD; in 2006, 58%; in 2007, 62%; in 2008, 67%. This study found that “Males (-3%, 95% CI (-5%, -2%), $p < .001$), blacks (-4%, 95% CI (-6%, -2%), $p < .001$), patients with low personal income (-6%, 95% CI (-8%, -5%), $p < .001$), and those with the lowest ZIP-code-based socioeconomic status (SES) (-4%, 95% CI (-6%, -2%), $p < .001$)” were less likely to receive a DMARD.

Solomon et al. studied data from the National Ambulatory Medical Care Survey data spanning 1996-2007 and found that African Americans were prescribed DMARDs 30% less often than whites.

Schmajuk, G., A.N. Trivedi, D.H. Solomon, et al. 2011. “Receipt of Disease-Modifying Antirheumatic Drugs Among Patients With Rheumatoid Arthritis in Medicare Managed Care Plans.” *JAMA* 305(5):480–6. doi:10.1001/jama.2011.67

Solomon, D.H., J.Z. Ayanian, E. Yelin, T. Shaykevich, et al. 2012. “Use of Disease-Modifying Medications for Rheumatoid Arthritis by Race and Ethnicity in the National Ambulatory Medical Care Survey.” *Arthritis Care Res.* 64(2):184-189. doi: 10.1002/acr.20674

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

Quality Data Model (QDM).
<p>De.5. Subject/Topic Area (check all the areas that apply): Musculoskeletal, Musculoskeletal : Rheumatoid Arthritis</p> <p>De.6. Non-Condition Specific(check all the areas that apply):</p> <p>De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any): Populations at Risk</p>
<p>S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.) N/A</p> <p>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:</p> <p>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: 0054_ART_Value_Sets-636502347518453852.xlsx</p> <p>S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available. No, this is not an instrument-based measure Attachment:</p> <p>S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available. Not an instrument-based measure</p> <p>S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2. Yes</p> <p>S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons. There have been minor changes to the value sets to reflect current practice.</p>
<p>S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure. IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14). Patients who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD) during the measurement year.</p> <p>S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b) IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).</p>

Patients who had at least one ambulatory prescription dispensed for a DMARD during the measurement year. There are two ways to identify patients who received a DMARD: by claim/encounter data and by pharmacy data. Organizations may use both methods to identify the numerator, but a patient need only be identified by one method to be included in the numerator.

Claim/encounter data. A DMARD prescription (DMARD Value Set) during the measurement year. (See corresponding Excel file for value sets)

Pharmacy data. Patients who were dispensed a DMARD during the measurement year on an ambulatory basis (DMARD Medications List).

DMARD Medications List

5-Aminosalicylates:

Sulfasalazine

Alkylating agents:

Cyclophosphamide

Aminoquinolines:

Hydroxychloroquine

Anti-rheumatics:

Auranofin, Leflunomide, Methotrexate, Penicillamine

Immunomodulators:

Abatacept, Adalimumab, Anakinra, Certolizumab, Certolizumab pegol, Etanercept, Golimumab, Infliximab, Rituximab, Tocilizumab

Immunosuppressive agents:

Azathioprine, Cyclosporine, Mycophenolate

Janus kinase (JAK) inhibitor:

Tofacitinib

Tetracyclines:

Minocycline

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

All patients, ages 18 years and older by December 31 of the measurement year, who had two of the following with different dates of service on or between January 1 and November 30 of the measurement year:

- Outpatient visit, with any diagnosis of rheumatoid arthritis
- Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis

Visit type need not be the same for the two visits.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

All patients, ages 18 years and older by December 31 of the measurement year, who had two of the following with different dates of service on or between January 1 and November 30 of the measurement year. Visit type need not be the same for the two visits.

- Outpatient visit (Outpatient Value Set), with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set)
- Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set). To identify nonacute

inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the discharge date for the stay.

See corresponding Excel file for value sets referenced above.

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

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who have a diagnosis of HIV. Look for evidence of HIV diagnosis as far back as possible in the patient's history through the end of the measurement year.

Exclude patients who have a diagnosis of pregnancy any time during the measurement year.

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

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Exclude patients who have a diagnosis of HIV (HIV Value Set; HIV Type 2 Value Set). Look for evidence of HIV diagnosis as far back as possible in the patient's history through the end of the measurement year.

Exclude patients who have a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year.

See corresponding Excel file for value sets referenced above.

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

N/A

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

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

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

Better quality = Higher score

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

Step 1: Determine the eligible population. To do so, identify all patients ages 18 years and older by December 31 of the measurement year who had two of the following with different dates of service on or between January 1 and November 30 of the measurement year:

- Outpatient visit (Outpatient Value Set), with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set)

- Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set). To identify nonacute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the discharge date for the stay.

Step 2: Exclude patients from the eligible population who had a diagnosis of HIV or female patients with a diagnosis of pregnancy. For HIV, look for evidence of a diagnosis (use HIV Value Set) as far back as possible in the patient's history through the end of the measurement year. For pregnancy, exclude female patients who have a diagnosis (use Pregnancy Value Set) any time during the measurement year.

Step 3: Determine the number of patients who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (see DMARD Value Set to identify a DMARD prescription using claims data, see DMARD Medications List to identify a DMARD prescription using pharmacy data) during the measurement year.

Step 4: Calculate the rate (the number of patients dispensed a prescription for a disease-modifying anti-rheumatic drug out of the number of patients in the eligible population after excluded patients have been removed)

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

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

N/A

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

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

N/A

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

If other, please describe in S.18.

Claims, Electronic Health Data, Electronic Health Records

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

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

This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Health Plan, Integrated Delivery System

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

2. Validity – See attached Measure Testing Submission Form

0054_ART_Testing_Form_Final.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)
If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in electronic claims

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

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

The HEDIS Compliance Audit addresses the following functions:

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

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

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

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

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

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
	<p>Public Reporting Health Plan Ranking http://reportcard.ncqa.org/plan/external/plansearch.aspx Annual State of Health Care Quality: http://www.ncqa.org/tabid/836/Default.aspx</p> <p>Payment Program Medicare STARS https://www.medicare.gov/find-a-plan/questions/home.aspx Physician Quality Reporting System http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html</p> <p>Regulatory and Accreditation Programs HEDIS Health Plan Accreditation: http://www.ncqa.org/Programs/Accreditation/HealthPlanHP.aspx HEDIS Accountable Care Organization (ACO) Core Performance Measures: http://www.ncqa.org/HEDISQualityMeasurement.aspx</p>

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

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

STATE OF HEALTH CARE ANNUAL REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2012 the report included measures on 11.5 million Medicare Advantage beneficiaries in 455 Medicare Advantage health plans, 99.4 million members in 404 commercial health plans, and 14.3 million Medicaid beneficiaries in 136 plans across 50 states.

MEDICARE ADVANTAGE PLAN RATING: This measure is included in the composite Medicare Advantage Star Rating. CMS calculates a Star Rating (1-5) for all Medicare Advantage health plans based on 53 performance measures. Medicare beneficiaries can view the star rating and individual measure scores on the CMS Plan Compare website. The Star Rating is also used to calculate bonus payments to health plans with excellent performance. The Medicare Advantage Plan Rating program covers 11.5 million Medicare beneficiaries in 455 health plans across all 50 states.

PHYSICIAN QUALITY REPORTING SYSTEM: This measure is included in the Physician Quality Reporting System, which is a national incentive program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals.

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, 336 commercial health plans covering 87 million lives and 77 Medicaid health plans covering 9.1 million lives. Health plans are scored based on performance compared to benchmarks.

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

QUALITY COMPASS: This measure is used in Quality Compass which is a 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.

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

N/A

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

N/A

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

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

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

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

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

NCQA measures are evaluated regularly. During this "reevaluation" process, we seek broad input on the measure, including input on performance and implementation experience. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

4a2.2.2. Summarize the feedback obtained from those being measured.

In general, health plans have not reported significant barriers to implementing this measure, as it uses the administrative data collection method. Questions have generally centered around minor clarification of the specifications, such as confirmation that information in claims meets the measure intent and questions about the supporting guidelines for the measure. NCQA responded to all questions to ensure consistent implementation of the specifications.

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

This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as the CMS Physician Quality Reporting Initiative.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Feedback has not required modification to this measure.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

The variation in scores between plans in the 10th percentile and 90th percentile indicate that plans with poorer performance can improve.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

During re-evaluation of this measure in 2012, the Bone Joint Measurement Advisory Panel discussed the concept of 'burnout', a condition in which a patient's condition plateaus and does not respond to additional treatment after many years with RA. Panel members offered their clinical judgment that the concept is more often invoked than actually happens and that there is not currently evidence to support this phenomenon as a critical consideration for this measure.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

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

0585 : Hydroxychloroquine annual eye exam
0589 : Rheumatoid Arthritis New DMARD Baseline Serum Creatinine
0590 : Rheumatoid Arthritis New DMARD Baseline Liver Function Test
0591 : Rheumatoid Arthritis New DMARD Baseline CBC
0592 : Rheumatoid Arthritis Annual ESR or CRP
0597 : Methotrexate: LFT within 12 weeks
0598 : Methotrexate: CBC within 12 weeks
0599 : Methotrexate: Creatinine within 12 weeks

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

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

No

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

NCQA will follow-up with the measure steward to discuss harmonizing relevant data elements.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

N/A

Appendix

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

No appendix Attachment:

Contact Information

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

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

Co.4 Point of Contact: Kristen, Swift, Swift@ncqa.org, 202-955-5174-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

Musculoskeletal Workgroup (2003)

Teresa Brady, PhD, Centers for Disease Control and Prevention

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Neil Wenger, MD, UCLA School of Medicine

Patience White, MD, Arthritis Foundation

Bone Joint Measurement Advisory Panel (BJMAP) (2012)

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Susan Reinhard, RN, PhD, AARP
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Natan Szapiro, Independence Blue Cross

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2005

Ad.3 Month and Year of most recent revision: 07, 2013

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?

Ad.6 Copyright statement: © 2005 by the National Committee for Quality Assurance

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Ad.7 Disclaimers: These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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

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