Defining

Performance measurement, medication metrics, and their impact on community pharmacy practice

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Quality Care

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Do you remember Jan. 1, 2006?

This historic date marked the beginning of the Medicare Prescription Drug Program, or Medicare Part D. It was on that day that the single largest change was made to the Medicare program since it was created in 1965. Seniors were given the opportunity to enroll in a prescription drug program that would be overseen by the Centers for Medicare & Medicaid Services (CMS), but delivered through a variety of private-sector health insurance and prescription drug plans.

The CMS administrator at that time was Mark McClellan, and he emphatically

stated on numerous occasions that the government was not merely interested in paying for more medications. Instead, it was interested in paying for greater value. To assess value, CMS would need to find ways to measure quality in addition to measuring costs of medications, but there was no entity in place to identify measures of medication-use quality.

It was McClellan's vision that measures of quality for Part D be selected by a public-private partnership so that all stakeholders could participate in the selection process. So, just several months after the drug benefit program took effect, a consensus-based entity comprised of the leaders of pharmacy, together with the leaders within America's Health Insurance Plans (AHIP) was established and named the Pharmacy Quality Alliance (PQA). Today, as PQA is heading into its sixth year as a multi-stakeholder health care alliance, its mission is simply to:

Improve the quality of medication use across health care settings through a collaborative process in which key stakeholders agree on a strategy for measuring and reporting performance information related to medications.

Measuring Quality of Medication Use?

Improving the quality of medication use across health care settings can mean different things to different people. For consumers, the "quality of medication use" might mean an "error-free" drug dispensing system (as in, zero errors across all pharmacies, hospitals, and nursing homes). The right drug is getting to the right patient, every time. However, the practicing pharmacist might think of quality more broadly than error rates and include medication adherence rates, or the appropriate dosing of all chronic medications, or the avoidance of high-risk drug-drug interactions.

PQA has focused its attention on the aspects of medication-use quality that may be important to multiple stakeholders (such as pharmacies, health plans, consumers, employers, and government agencies) and that can be efficiently measured so that there is not a significant burden on pharmacies and plans to assess quality. Many of the PQA-endorsed measures of quality can be derived from prescription dispensing data or claims. Thus, quality can be assessed by pharmacies, pharmacy benefit managers, health plans, and CMS using data that are available to all of these organizations. This also allows the creation of benchmarks for each type of organization so that pharmacies and plans can compare their performance to that of their peers. It also means that we can more easily assess how improvements made in pharmacy quality may translate into improvements of value for health plans or for Medicare and Medicaid programs.

Examples of the PQA-endorsed measures of medication-use quality include the following:

Medication Adherence

The consistent, and sustained, use of chronic medications by patients is important to controlling chronic disease and optimizing outcomes; however, many patients do not maintain high levels of adherence to their medication regimen. PQA has endorsed the proportion of days covered (PDC) metric as the preferred method for using prescription fill data to estimate patients' adherence to medications. For most classes of medications, a patient is considered adherent if the patient's PDC is greater than 80 percent. The PDC rate for a pharmacy or plan is reported as the percentage of patients on a targeted class of medication who maintain high levels of adherence.

Appropriate Treatment of High-Blood Pressure in Patients with Diabetes

Clinical guidelines indicate that the preferred agents for management of hypertension in patients with diabetes should be angiotensin converting enzyme inhibitors (ACEIs), or angiotensin receptor blockers (ARBs). The quality measure identifies patients who are using a diabetes medication and antihypertensive medication,

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and determines the percentage of these patients who are using an ACEI or ARB.

High-Risk Medications in the Elderly

This measure was based on the Beer's list of medications that were deemed to put older patients at high risk of an adverse event. It is analogous to a quality measure used by the National Committee for Quality Assurance (NCQA) to evaluate medication safety in health plans. The most recent edition of the Beer's list was published in 2003 and contained 48 drugs or drug classes that should be avoided in elderly patients regardless of medical condition. The American Geriatrics Society (AGS) is about to launch an initiative to re-examine this list and assess the most appropriate way to measure the safe use of medications in older adults. PQA and NCQA will consider the recommendations of AGS in future updates of the quality measures.

Drug-Drug Interactions

PQA has identified a short list of drug-drug interactions (DDIs) that place the patient at high risk of an adverse event and where there may be safer alternatives. Out of the thousands of potential drug-drug combinations that may interact, PQA selected 14 "target drugs or drug classes" for inclusion in the quality measure. The quality measure assesses the percentage of patients on one of the 14 target drugs who receive a concurrent drug that is likely to precipitate a high-severity interaction.

How Are These Measures Being Used?

Several PQA measures have been adopted by CMS and other organizations. CMS evaluates the performance of Medicare Part D plans through two methods. CMS publishes plan ratings (more commonly known as star ratings) wherein each Part D plan is rated on a scale of one to five stars. The stars are based on a set of 17 performance measures, including two from PQA. The second method is called the "Display Measures," and this involves CMS providing feedback to Part D plans on many PQA measures related to medication safety as well as several non-PQA performance measures. The PQA measures included in the star ratings are *high-risk medications in the elderly and appropriate treatment of high blood pressure in patients with diabetes.* These two measures are also included in the Display Measures along with the PDC and DDI measures.

Two important changes will occur with the Medicare Part D quality measures for 2012. The 2012 star ratings for Part D will include the PDC measure of medication adherence. Thus, Medicare Part D plans will have their star ratings based, in part, on medication adherence as well as medication safety. Medicare beneficiaries are able to view the overall star ratings, and stars for the individual measures, for every Part D plan. CMS is encouraging beneficiaries to consider these ratings in their selection of the drug plan, although it is not clear how many people will base their choice of plans on the star ratings. Nonetheless, the Part D plans will have increased transparency on medication safety, adherence and other aspects of quality.

Another important change is that Medicare Advantage plans, including those that provide drug coverage (MAPDs) will have increased financial consequences from the star ratings. The Medicare Advantage plans will begin receiving quality bonus payments (QBPs) from CMS wherein a portion of the plan's revenue will be based on the star ratings. From 2012 to 2015, a demonstration project will be used to

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test the impact of the QBPs on all Medicare Advantage plans. The QBPs are based on a sliding scale according to the star ratings. For example a 3-star plan can receive a 3 percent bonus, while a 4-star plan receives 4 percent and a 5-star plan receives 5 percent. Plans that score below 3 stars are not eligible for a bonus. Since the base payments to MAPDs will be declining in the future, the QBPs represent a means for plans to retain, or increase, their revenues from Medicare. For the largest MAPDs, this may equate to several hundred million dollars.

Outside of CMS, there is also growing interest in measuring the quality of medication use. For example, URAC (formerly the Utilization Review Accreditation Commission) is an organization that accredits pharmacy benefit managers, mail-service pharmacies, specialty pharmacies, health plans, and several other health care programs. URAC is implementing a performance measurement system so that all of its accredited entities will be required to report several quality measures each year. These quality measures include several of PQA's measures of adherence and medication safety. URAC and several other organizations are considering the creation of accreditation programs for community pharmacies. Therefore, pharmacies that participate in accreditation would eventually be evaluated on explicit measures of quality.

Implications for Community Pharmacy?

When you look at the previous examples, you can see that the consequences for Medicare drug plans are significant. But how will that impact community pharmacy? As CMS pushes for greater transparency in quality for Medicare and Medicaid plans, and as the financial stakes for these plans grow larger, it is expected that health plans will take action to improve their quality scores. Plans and PBMs can make some improvements through adjustment of policies, but many of the quality measures will be most greatly impacted through the efforts of physicians and pharmacists to monitor patients' utilization of medications and to help those patients maintain good adherence to chronic regimens.

PQA is coordinating several demonstration projects that examine collaborative efforts of health plans and pharmacists to promote appropriate medication use.

Health plans may use a variety of incentives to engage their pharmacy networks in quality improvement. This will most likely go beyond payment for medication therapy management (MTM) services. Several plans are considering pay-for-performance (P4P) models to reward pharmacies that score highly on quality measures or that improve their quality scores. For example, a pharmacy that improves adherence among diabetes patients may receive a bonus for that achievement. This model has already been used by some health plans to reward pharmacies that boost generic dispensing rates. A slightly different model would include bonus payments to pharmacies that achieve the lowest rates of severe drug-drug interactions. In any P4P model, the payment is based on *results* instead of payment for providing a consultation.

We are likely to see a variety of "carrots and sticks" used by health plans and PBMs to drive improvements in quality related to medications. Hopefully, the focus can be on carrots (rewards for quality achievements) instead of sticks (such as removal from a network or withholding payments from pharmacies as a result of poor quality).

Nonetheless, there will be an increased demand for evidence of quality within drug plans and pharmacies, and increased financial accountability for quality. PQA will work with NCPA and other pharmacy associations in trying to promote *appropriate* use of quality measures in evaluating and rewarding community pharmacies. Stay tuned to these issues as they may rapidly evolve in the coming years. aP

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