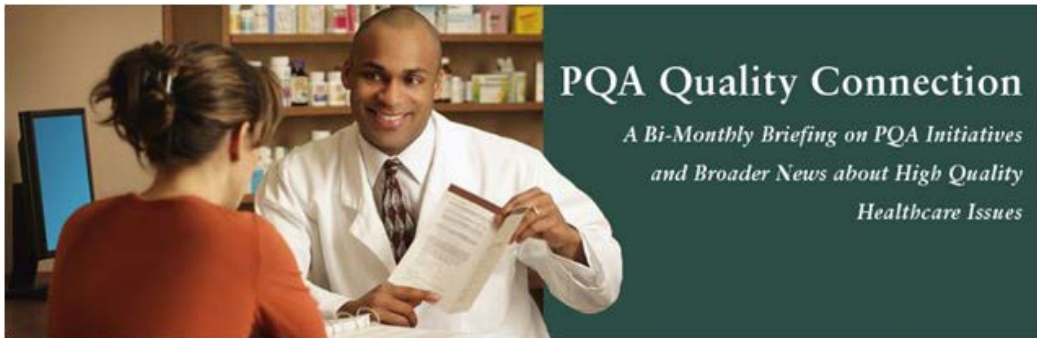




PQA Measure Development Update: August 2016

The Measure Development Teams (MDTs) and Task Forces have been meeting monthly via webinar, and the Stakeholder Advisory Panels (SAPs) have been meeting every other month since March. Additionally, the Risk Adjustment Advisory Panel, Implementation Advisory Panel, Measure Update Panel and Quality Metrics Expert Panel have been meeting regularly to continue their work.

PQA is pleased to provide a recap of activities completed year to date (through August 1, 2016):

MDT 1: Hospital Admission or Emergency Department Visit for Bleeding Events Associated with Anticoagulant Medications

Measure Development Team 1 (MDT 1) developed a measure concept intended for use at the health plan level to evaluate hospitalizations and emergency department (ED) visits related to bleeding events associated with anticoagulant medications. This draft measure, along with two additional draft outcome measures, have been approved by the QMEP to move forward with testing. The three draft outcome measures are listed below:

1. Hospital Admission or ED Visit for Bleeding Events Associated with Anticoagulant Medications (MDT 1)
2. Hospital, Emergency Department, and/or Urgent Care Utilization Related to Prescription Opioids (MDT 6)
3. Serious Hypoglycemic Events Requiring Hospital Admission or ED Visit Associated with Anti-Diabetic Medications (Medication Use Safety Workgroup)

The Risk Adjustment Advisory Panel is assessing these three draft measures to consider appropriateness of clinical and/or socio-demographic risk adjustment.

PQA currently is seeking testing partners who have access to prescription claims and medical claims data to calculate the measure rate. If your organization is interested in testing any/all of these draft outcome measures, please contact Kristen Butterfield at KButterfield@PQAalliance.org.

MDT 2: Adherence to Immunosuppressants Post Kidney Transplant

MDT 2 developed a measure concept intended for use at the health plan level to evaluate adherence to immunosuppressants post kidney transplant. The measure will use the standard 80% PDC threshold, and will exclude individuals under the age of 18 or in hospice. The data source will be prescription claims, and medical claims (diagnosis code) and Medicare Transaction Reply Report (TRR) codes to identify transplant and transplant failure. The group discussed the list of medications to include in the measure, the appropriate diagnosis codes and TRR codes to use, and how the complexity of dosing (i.e., dynamic medication regimens, variable dosing, increased or decreased medication levels due to antibiotics prescribed concurrently to treat opportunistic infections, etc.) could impact the measure.

MDT 2 currently is on hiatus. As next steps, PQA staff and MDT 2 co-chairs will convene a small expert panel of transplant physicians, pharmacists and nurses to review the current draft measure concept specifications. Following that process, we will re-convene MDT 2 to consider the expert panel's recommendations and then determine how best to proceed with the measure concept.

MDT 3: Patient Survey following Medication Therapy Management Services

MDT 3 was convened in 2015 to develop a metric related to patient satisfaction and experience with Comprehensive Medication Review (CMR), a common component of Medication Therapy Management (MTM) services. The goal of the concept is for organizations to use a patient survey tool administered after a CMR is completed to evaluate patient satisfaction and experience of care. The eligible population will include individuals 18 years and older who receive a CMR. The MDT selected the HAIMM instrument, a 10-question survey designed to evaluate patients' satisfaction and experience with MTM services. In order to strengthen the tool to align with standards for patient-reported outcome/experience-based-performance measures, additional survey development, validation, and psychometric testing will be conducted. This will establish

a method for scoring the survey to assess quality of care related to MTM services. The MDT is currently on hiatus and will meet on an *ad hoc* basis during the development and evaluation of HAIMM 2.0.

MDT 9: Medication Therapy Management: Medication Therapy Problem Resolution

With the announcement of the [Part D Enhanced MTM Model](#) by the Centers for Medicare & Medicaid Services' Center for Medicare & Medicaid Innovation (CMMI), the work of MDT 9 shifted toward generating ideas and developing concepts for possible use within the model. Incorporating input provided at the SAP meeting in May, members of the MDT generated a list of concept ideas for monitoring measures that recently was shared with CMMI for possible consideration, use or adaptation by participating Part D plans.

Members of MDT 9 are currently drafting suggestions for specifying three pilot monitoring measures listed in the [Enhanced MTM Model Encounter Data Specification Plan \(July 28, 2016\)](#) that will use SNOMED CT codes as one of the data sources:

- Percentage of Beneficiaries Discharged from the Hospital Who Received Enhanced MTM Services
- Percentage of Targeted Beneficiaries with at Least One Medication Therapy Issue
- Percentage of Enhanced MTM Recommendations That Were Implemented

The MDT will leverage the *Medication Therapy Problem Categories Framework* that they developed to promote consistent categorization and coding of medication therapy problems and the related recommendations and interventions intended to address those problems.

MDT 10: Treatment of Chronic Hepatitis C – Completion of Therapy

MDT 10 developed a measure concept intended for use at the health plan level to assess the percentage of patients 18 years and older who initiated antiviral therapy for treatment of chronic hepatitis C to obtain a sustained virologic response (SVR), and who completed the minimum intended duration of therapy and did not have a cumulative gap of >15 days between the first and last fill of the direct-acting antiviral medication.

The data source will be prescription claims data. In addition to data from the measurement year, the measure also will require a 108-day look back period (to

determine if therapy was initiated in the prior year) and a 108-day look forward period (to determine if those that initiated therapy later in the measurement year completed their therapy in the following year). In testing, we will assess which approach includes more individuals in the denominator: (a) using a look forward period of 108 days; or (b) using an index cut-off date, where the index date must occur at least 99 days (12 weeks [i.e., 84 days] + 15 days) prior to the end of the measurement year. One of these two options will be necessary to ensure that those included in the measure have the opportunity to complete therapy.

PQA staff and the MDT 10 co-chairs conducted interviews of hepatologists and gastroenterologists specializing in the treatment of chronic Hepatitis C to seek expert opinion on the draft measure concept. Overall, the experts believe this is a valuable measure to pursue.

In June, MDT members voted unanimously to forward the measure concept to the QMEP for review. The QMEP reviewed the measure concept in late July, and voted in favor of moving the draft measure forward with testing. If your organization is interested in testing the draft measure, please contact Kristen Butterfield at KButterfield@PQAalliance.org.

MDT 11: Polypharmacy: Use of Multiple CNS-Active Agents or Anticholinergics in the Elderly

Members of Measure Development Team (MDT) 11 are developing a concept to evaluate the percentage of persons 65 years of age and older with concurrent use of 3 or more central nervous system (CNS)-active medications or 2 or more anticholinergic medications. Individuals receiving hospice care will be excluded.

The measure concept is based upon recommendations in the [American Geriatrics Society \(AGS\) 2015 Updated Beers Criteria](#). The MDT also undertook a literature search for additional studies published since the AGS Beers Update. Use of 3 or more concurrent CNS-active agents is associated with an increased risk for falls (and fractures), the quality of evidence is moderate (to high), and the strength of the recommendation to avoid concurrent use is strong. CNS-active medications are defined as: antipsychotics, benzodiazepines, nonbenzodiazepine sedative hypnotics, opioids, tricyclic antidepressants, and selective serotonin re-uptake inhibitors. Use of 2 or more anticholinergic medications is associated with an increased risk for cognitive decline, the

quality of evidence is moderate, and the strength of the recommendation to avoid concurrent use is strong. The anticholinergic medications are listed in Table 7 of the AGS 2015 Updated Beers Criteria. Next steps for the group are to formulate the initial specifications for the denominator and numerator.

MDT 12: Duplicate Therapy

Members of MDT 12 are developing a measure concept to evaluate the percentage of adults with prescriptions for one or more duplicate therapies. The group decided to generally focus on medications in the same pharmacologic class in order to distinguish duplicate therapy from drug-drug interactions (e.g., additive pharmacodynamics effects). The MDT will continue identifying and reviewing potential duplicate therapy targets from the literature and drug utilization review programs. Evidence is generally lacking in support of safety concerns related to duplicate therapies. Therefore, in the absence of published literature supporting this measure concept, the MDT believes prescription claims analyses would be useful to quantify problematic medication classes. External expert (e.g., specialist) opinion may also be needed for specific duplicate therapies in order to support the position that they are considered “generally clinically inappropriate.” Next steps for the group are to formulate the initial measure concept specifications, including: denominator, numerator, and exclusions.

MDT 13: Concurrent Use of Opioids and Benzodiazepines

Members of MDT 13 completed their expedited development of the measure concept to evaluate the percentage of individuals 18 years and older with concurrent use of opioids and benzodiazepines. Individuals receiving hospice care and those with a cancer diagnosis are excluded. The draft specifications for the concept are described below:

- Denominator: The number of individuals from the eligible population with 2 or more prescription claims for opioids filled on 2 or more separate days, for which the sum of the days supply is 15 or more days during the measurement period.
- Numerator: The number of individuals from the denominator with: 2 or more prescription claims for benzodiazepines filled on 2 or more separate days, AND concurrent use of opioids and benzodiazepines for 30 or more cumulative days.

In June, the MDT voted (25 yes votes; 2 no votes) to approve the measure concept to move forward for review by the Quality Metrics Expert Panel (QMEP). The QMEP

reviewed the measure concept in early August and next will vote on whether or not to move it forward for testing.

MS TF: Multiple Sclerosis Treatment and Monitoring Task Force

The Multiple Sclerosis Treatment and Monitoring Task Force (MS Task Force) is charged with developing electronic clinical quality measures (eQMs) that assess appropriate monitoring of disease activity and treatment for patients with multiple sclerosis (MS). The measures will be used to assess physician (i.e., neurologist) performance – and PQA’s goal is to have the measures, once developed and endorsed, used in CMS’s Merit-Based Incentive Payment System (MIPS).

The Task Force currently is working on the specifications for the *Treatment with Disease Modifying Therapy (DMT) in Patients with Relapsing Forms of Multiple Sclerosis* concept and has made significant progress over the past couple of months. The measure concept will include adults who are at least 18 years old at the beginning of the measurement year; the concept does not include an upper age threshold. Currently, the denominator is defined as “patients with relapsing forms of MS in the EMR with two or more visits for MS within the measurement year or the three months prior.” The numerator is defined as “the number of patients in the denominator receiving a disease modifying agent to treat MS during the measurement year,” with “receiving a disease modifying agent to treat MS” being defined as: (1) DMT was prescribed (prescription provided to the patient or pharmacy) within the measurement period; OR (2) Documentation of DMT in the patient's current medication list. Individuals who: are pregnant or actively trying to become pregnant; are breast feeding; refuse or decline treatment for any reason; have cancer, either actively being treated or with history of cancer; are on immunosuppressive therapy; have primary progressive multiple sclerosis; or have a diagnosis of secondary progressive multiple sclerosis at any point during the measurement year would be excluded from the denominator.

The Task Force will continue to work on the specifications for the DMT concept and once complete, will move on to specifying one additional measure.

Adult Immunization Task Force 1: Immunization Information System Reporting

The PQA Adult Immunization Task Force (IZ TF) was convened in 2014 to address gaps in measurement for adult immunization. The group initially identified two key priority areas

for work and was divided into two groups in 2016 to focus more strategically on each priority.

The *Immunization Information System Reporting (IISR)* measure concept will identify the percentage of health plan immunization pharmacy and medical claims that have a corresponding documentation record within the immunization registry. This measure is intended to be used at the state level, rather than at the national level, as states' immunization registries differ. After addressing concerns received from the QMEP in November 2015 and refining the measure concept, the members of IZ TF 1 voted in favor of forwarding the IISR measure to QMEP for a second review.

Adult Immunization Task Force 2: *Immunization Status Assessment in Medication Therapy Management*

The *Immunization Status Assessment Within Medication Therapy Management (IA-MTM)* measure concept examines the percentage of patients enrolled within an MTM service who receive an immunization status assessment either within a comprehensive or targeted medication review. The group is currently working to finalize the data source for documenting immunization status assessment, and then will voted on whether or not the measure should move forward for QMEP review.

Further, IZ TF 2 members have begun work on a second measure concept that will evaluate gap closure in patients' immunization histories once they are identified by the IA-MTM measure. This measure concept is still in its infancy and the group is currently working to define the denominator that would be most appropriate.

Implementation Advisory Panel

The Implementation Advisory Panel (IAP) meets monthly to identify potential programs for implementation of PQA-endorsed measures and to understand and provide input into implementation strategies for measure concepts under development. Recently, the Panel has focused on implementation of Specialty drug products, including those for treatment of hepatitis C, multiple sclerosis, rheumatoid arthritis and other inflammatory diseases and to prevent rejection of kidney transplant. Greatest interest was focused on adherence to agents for treatment of hepatitis C, because treatment is potentially curative and definitely very expensive, thus emphasizing the importance of adherence. See the above update on MDT 10 for measure specifications and development progress.

Relying purely on prescription claims data, the measure could be suitable for Medicare Part D, Medicaid, and any commercial systems with access to drug claims.

Measure Update Panel

In May, the Measure Update Panel discussed mapping of ICD-9 to ICD-10 codes for the *Adherence to Long-Acting Inhaled Bronchodilator Agents in COPD Patients* measure. A systematic process was used to map the codes used to identify COPD diagnoses, including reviewing relevant value sets. There was consensus to approve the mapping.

In June, the Panel discussed potential clarifying language for the dose calculation of the *Diabetes Medication Dosing* measure. The Panel recommended further investigation into the optimal method to calculate the daily dose; this measure will be discussed in more detail at a future meeting.

Patient & Caregiver Advisory Panel

The Patient & Caregiver Advisory Panel (PCAP) met in June to discuss potential exclusions for the *Concurrent Use of Opioids and Benzodiazepines* measure concept. In general, the group was in favor of not excluding patients with a diagnosis of cancer or sickle cell disease. They were in favor of excluding products that are used for medication assisted treatment for opioid use disorder. Panel members also reviewed the draft measure, *Adherence to Non-Infused Biologic Medications Used to Treat Rheumatoid Arthritis and Other Inflammatory Conditions*, to discuss the implications of measures intended to evaluate adherence for relatively costly medications that are used in relatively small populations of patients. The general feedback from the Panel was that adherence to non-infused biologic medications in these populations is important to measure.

In July, the Panel reviewed the *Treatment of Chronic Hepatitis C: Completion of Therapy* measure concept. General discussion surrounded the importance of the topic, and the complexity in developing a measure with administrative data sources.

Quality Metrics Expert Panel

The Quality Metrics Expert Panel (QMEP) met in July to review the draft measure, *Adherence to Non-Infused Biologic Medications Treating Rheumatoid Arthritis and Other Inflammatory Conditions (RA&I)*. Currently the measure denominator does not include diagnosis data. The Panel reviewed additional testing indicating these medications are

used for some diagnoses such as psoriasis that may not require chronic therapy. This information impacts the validity of the measure. The Panel discussed whether the measure should be further specified to include diagnosis data or if the development of the measure should be stopped. Panel members voted to request the draft measure be referred to a Measure Development Team for further specification using ICD codes.

The Panel also discussed the measure concept, *Treatment of Chronic Hepatitis C: Completion of Therapy*, which was developed by Measure Development Team 10. The Panel discussed and voted in favor of the concept being further specified and tested. The Panel will contribute to the testing plan for the draft measure.

Risk Adjustment Advisory Panel

The Risk Adjustment Advisory Panel (RAAP) has been meeting monthly to discuss the appropriateness of clinical risk adjustment for the three draft PQA outcome measures related to serious adverse events resulting in a hospitalization or emergency department visit. These measures include: *Hospital Admission or ED Visit for Bleeding Events Associated with Anticoagulant Medications*, *Hospital, ED and/or Urgent Care Utilization Related to Prescription Opioids*, and *Serious Hypoglycemic Events Requiring Hospital Admission or ED Visit Associated with Anti-Diabetic Medications*. The RAAP members discussed processes for a thorough literature review to identify clinical risk factors for each measure. The next steps include performing the literature review, operationalizing the risk factors with claims data, and developing an analytic plan to build and test a clinical risk adjustment model.

For additional information about the MDTs, SAPs, Panels or Task Forces, please contact Lynn Pezzullo at lpezzullo@PQAalliance.org or Lisa Hines at lhines@PQAalliance.org.