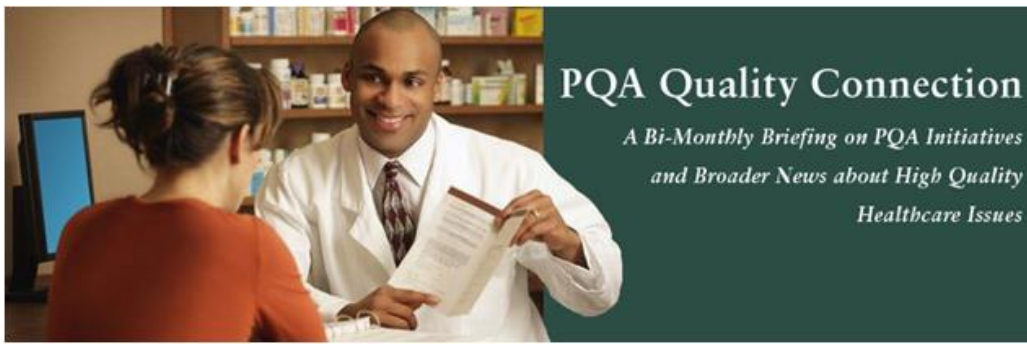

PQA Measure Development Update: December 2016

The Measure Development Teams and Task Forces have been meeting monthly via webinar, and the Stakeholder Advisory Panels have been meeting every other month since March. Additionally, the Risk Adjustment Advisory Panel, Patient & Caregiver 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 December 10, 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 sociodemographic status 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: **Medication Therapy Management Patient Survey Following Comprehensive Medication Review**

MDT 3 started developing a measure concept in 2015 to evaluate patient satisfaction and experience following a Comprehensive Medication Review (CMR). The HAIMM instrument was selected as the most relevant survey. It is a 10-question survey designed to evaluate patients' satisfaction and experience of care related to medication therapy management (MTM) services. In order to strengthen the HAIMM tool to align with standards for performance measures using survey data, additional survey development, validation, and psychometric testing is needed to establish relevant questionnaire

domains and a method for scoring the survey. MDT 3 is no longer meeting but will be reconvened as needed once a revised HAIMM survey is further along in development.

MDT 9: Medication Therapy Management: Medication Therapy Problem Resolution

MDT 9 has been working to complete and gain consensus on a SNOMED CT code crosswalk for the *Medication Therapy Problem Categories Framework*. The framework is intended to standardize how medication therapy problems identified during MTM encounters are categorized within measures. This will promote consistent documentation of medication therapy problems, recommendations or interventions to revolve those problems, and, ultimately, problem resolution. The MDT has incorporated consensus definitions and utilized the SNOMED CT pharmacy value set in the *Standardized Framework for Cross-Walking MTM Services to SNOMED CT Codes*, a framework recently produced by pharmacy professional organizations and other stakeholders for documenting MTM services (available at: http://www.amcp.org/SNOMED/). Similar to the standardized framework for MTM documentation, the medication therapy problem framework will be revised, updated, and refined as: 1) we receive feedback from pilot testing, implementation, and use in practice; 2) evidence from the Enhanced MTM Model becomes available; 3) innovation in the delivery and documentation of MTM service continues; *and* 4) the practice of pharmacy advances.

A subgroup of MDT 9 members has been meeting to discuss preliminary specifications for a measure concept related to medication therapy problem resolution. The measure will be based on the medication therapy problem framework described above. The data source will be SNOMED CT codes, and also Part D claims, when applicable and available. The group envisions developing two similar concepts: one for use within Medicare Part D, and the other for use in the Part D Enhanced MTM Model. MDT 9 will continue to meet in 2017 to work toward completing the measure concept(s).

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 is prescription claims data. To be included in the eligible population for the measure:

- Individuals whose index date occurs within 99 days of the end of the measurement year must be continuously enrolled for the 12-month measurement year and the 108 days after the end of the measurement year; *and*
- Individuals whose index date does NOT occur within 99 days of the end of the measurement year must be continuously enrolled for the 12-month measurement year and the 108 days before the measurement year.

Testing currently is underway with four testing partners and anticipates testing results using Commercial, Medicare, and Medicaid data in early 2017.

MDT 11: Polypharmacy: Use of Multiple CNS-Active or Anticholinergic Medications in the Elderly

MDT 11 completed development of a measure concept to evaluate the percentage of persons 65 years of age and older with concurrent use of three or more central nervous system (CNS)-active medications or two or more anticholinergic medications. Individuals receiving hospice care are excluded. The concept is based on recommendations in the American Geriatrics Society (AGS) 2015 Updated Beers Criteria, though the MDT also undertook a literature search for additional studies published since the AGS Beers Update. Concurrent use of three or more CNS-active agents is associated with an increased risk for falls (and fractures) and concurrent use of two or more anticholinergic medications is associated with an increased risk for cognitive decline.

The denominator includes individuals 65 years of age and older with 2 or more fills (unique prescription claims) for a unique CNS-active medication; or 2 or more fills for a unique anticholinergic medication. The numerator includes individuals from the denominator with concurrent use of 3 or more unique CNS-active medications, each with 2 or more fills; or 2 or more unique anticholinergic medications, each with 2 or more fills. Concurrent use is defined as overlapping covered days for 30 or more (cumulative) days. The MDT would like the measure tested as: a) two separate rates, one for individuals on multiple CNS-active medications and one for those on multiple anticholinergic medications; and b) as one combined rate (i.e., individuals on multiple CNS-active medications OR multiple anticholinergic medications). MDT 11 approved the measure concept to move forward for initial review by the Quality Metrics Expert Panel (QMEP). If approved to move forward, the draft measure will undergo testing.

MDT 12: Inappropriate Duplicate Therapy

Members of MDT 12 are developing a measure concept to evaluate the percentage of adults with prescriptions for one or more inappropriate duplicate therapies. *Inappropriate duplicate therapy* is defined as the prescribing and dispensing of two or more medications from the same pharmacologic or therapeutic class such that the combined use puts the patient at risk of an adverse medical result or incurs additional costs without additional therapeutic benefit (adapted from *therapeutic duplication* definition in 42 CFR 456.705). The group decided to generally focus on medications in the same pharmacologic class and distinguishes inappropriate duplicate therapy from drug-drug interactions (e.g., additive pharmacodynamic effects). The MDT will continue to meet in 2017 to formulate the measure concept specifications.

MDT 13: Concurrent Use of Opioids and Benzodiazepines

MDT 13 developed the draft measure, *Concurrent Use of Opioids and Benzodiazepines*, which examines the percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines. The denominator includes individuals 18 years and older by the first day of the measurement year 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. Patients in hospice care and those with a cancer diagnosis are excluded. The numerator includes 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.

The PQA membership will vote in December whether or not to endorse this measure.

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 (eCQMs) that assess appropriate monitoring of disease activity and treatment for patients with multiple sclerosis (MS). The measures use EMR data as the data source and will be used to assess physician (i.e., neurologist) performance. 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 completed its work on the specifications for the *Treatment with Disease Modifying Therapy (DMT) in Patients with Relapsing Forms of Multiple Sclerosis* measure

concept, which also has been approved by the QMEP to move forward with member/public comment and testing.

The measure concept includes adults who are at least 18 years old at the beginning of the measurement year and does not include an upper age threshold. 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." Patients on immunosuppressive therapy or with a diagnosis of primary progressive MS would be excluded from the denominator. Individuals with the following are only included if they meet the numerator criteria:

- Documentation of medical reason(s) for not receiving a disease modifying agent to treat MS (i.e. Patients: who are participating in a clinical trial; with cancer, either actively being treated or with history of cancer; who are pregnant or actively trying to become pregnant; who are breast feeding; with HIV/AIDS)
- Documentation of patient reason(s) for not receiving a disease modifying agent to treat MS (patient refuses or declines treatment for any reason, including socioeconomic reasons [i.e., not able to afford therapy])

The numerator is defined as the number of patients in the denominator receiving a disease modifying agent to treat MS during the measurement year. Receiving a disease modifying agent to treat MS is 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.

Additionally, the MS Task Force has been working to specify three measure concepts focused on the use of MRI in patients with multiple sclerosis being treated with DMT. The draft measure concepts include:

1. *Magnetic Resonance Imaging (MRI) Prior to Initiating or Switching Disease Modifying Therapy (DMT) in Patients with Relapsing Forms of Multiple Sclerosis*: The percentage of patients with relapsing forms of multiple sclerosis for whom a brain MRI was ordered within 12 months prior to initiating or switching disease modifying therapy.
2. *Magnetic Resonance Imaging (MRI) to Establish a New Baseline After Initiating or Switching Disease Modifying Therapy (DMT) in Patients with Relapsing Forms of Multiple Sclerosis*: The percentage of patients with relapsing forms of multiple

sclerosis for whom a brain MRI was ordered to establish a new baseline within the 12 months after initiating or switching disease modifying therapy.

3. *Magnetic Resonance Imaging (MRI) for Follow-Up in Patients with Relapsing Forms of Multiple Sclerosis Being Treated with Disease Modifying Therapy (DMT)*: The percentage of patients with relapsing forms of multiple sclerosis being treated with disease modifying therapy who had a brain MRI performed within 12 months after starting or switching DMT for whom a follow-up brain MRI was ordered within the following 12 months to evaluate subclinical disease activity.

The MS Task Force will continue its work on the above three measure concepts, which align with the "Revised Recommendations of the CMSC Task Force for a Standardized MRI Protocol and Clinical Guidelines for the Diagnosis and Follow-up of Multiple Sclerosis."

PQA currently is seeking neurology practices to test the four measure concepts being developed by the MS TF, each of which uses EMR data as the data source. Contact Lynn Pezzullo at lpezzullo@PQAalliance.org if your practice is interested in participating as a testing site.

Adult Immunization Task Force 1: *Immunization Information System Reporting*

The *Immunization Information System Reporting (IISR)* draft measure will identify the percentage of health plan immunization pharmacy and medical claims that have a corresponding documentation record within the immunization registry. It is intended to be used at the state level, rather than at the national level, as states' immunization registries differ. The draft measure has been voted by the QMEP to move forward for testing. PQA is currently in the process of drafting the testing plan and will seek potential testers beginning in the new year. Contact Hannah Fish at hfish@PQAalliance.org if your organization is interested in testing this draft measure.

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 members of Immunization Task Force 2 (IZ TF 2) are currently working to finalize the measure concept after receiving feedback from both Stakeholder Advisory Panels B and D. After much deliberation, influenza will be included

as part of the measure, however, the task force is now exploring the need to specify an altered measurement period to account for the seasonal nature of this vaccine. In addition, the members of the task force are creating a logic table that will contain instructions for how to code and document immunization status assessments for each vaccine included in the measure.

IZ TF 2 has also been working diligently to specify a second measure concept, *ACIP* Compliance Following Immunization Status* Assessment. This measure concept calculates the percentage of immunization status assessments that have been completed and are documented as ACIP compliant. The documented outcomes from the *IA-MTM* measure concept serve as the data source for this second measure. Both measure concepts should be finalized early in the new year and ready to be voted to QMEP for approval for testing.

*ACIP – Advisory Committee for Immunization Practices

Adult Immunization Task Force Relaunch

On December 6, 2016 PQA convened a multi-stakeholder group of individuals with expertise in measure development and adult immunization practices to relaunch the Adult Immunization Task Force. The goal of this one-day meeting was to identify and begin development of the next immunization measure concept for PQA to pursue. The meeting was highly interactive with robust discussion around current gaps in immunization practices and quality measurement. Over the next year members of the relaunched Task Force will work to specify the prioritized measure concept idea of improving vaccination rates for all ACIP recommended vaccines in patients with diabetes.

Implementation Advisory Panel

The Implementation Advisory Panel (IAP) was relaunched December 6, 2016, adding new members to the existing panel and having a full day face-to-face meeting in Alexandria, VA. The panel was provided a thorough introduction to PQA's history and mission, and walked through our measure development process. Then an actual measure implementation challenge was provided, using the PQA measure, *Use of Antipsychotics in Patients with Dementia* as an example of a measure developed several years ago, which initially could not be placed in a value-based program, despite very promising discussions with different branches of CMS, but that currently has been included in the Part D Patient Safety Reporting program for 2016 and will likely appear as a Display Measure by 2018. The panel members then rolled up their sleeves and got to work reviewing all measure

concept ideas prioritized by the PQA Measure Advisement Group (MAG) and the Patient & Caregiver Advisory Panel (PCAP), as well as weighing in on several PQA-endorsed measures that currently are not included in any value-based programs. Several new approaches to accomplishing measure implementation were raised and will be acted on by PQA staff. The IAP will continue meeting in its face-to-face format, with the next meeting planned at the PQA Annual Meeting in May 2017.

Measure Update Panel

In October, the Measure Update Panel recommended the approval of a more comprehensive cancer diagnosis code list for use when ICD-9 and ICD-10 codes are available to exclude patients with a cancer diagnosis from the *Use of Opioids at High Dosage or from Multiple Providers* measures. This recommendation will next be reviewed by the Quality Metrics Expert Panel. The Panel also discussed and approved clarifying language for how to accurately calculate the opioid measures and the adherence (*Proportion of Days Covered)* measures.

In November, the Panel also discussed and voted on whether or not to exclude patients with agitation from the numerator of the *Antipsychotic Use in Persons with Dementia* measure. The Panel voted nearly unanimously to not exclude patients with agitation because: it is difficult to identify patients with agitation; agitation is a symptom and not a diagnosis; such a change would contradict the intent of the measure; and, the measure is not likely to capture appropriate short-term use (<30 days) of antipsychotics.

Patient & Caregiver Advisory Panel

The Patient & Caregiver Advisory Panel (PCAP) met in October to provide input into one of the research projects supported as part of the PQA/CVS Foundations Scholars Program. The "What's the Value" research project is a survey of patients, caregivers, technicians, and pharmacists in Alabama. The Panel also reviewed the PQA process for identifying, prioritizing, and selecting new concept ideas for future development and discussed the need to move toward developing measures that focus on outcomes that matter to patients.

In November, the PCAP met to discuss the concept ideas rated most highly by the 2016 Measure Advisement Group. The group was then asked to rank the concept ideas considering the importance from a patient or caregiver perspective. The PCAP's input will be considered, along with input from the MAG and Implementation Advisory Panel, in

selecting measure concepts for development in 2017. The Panel also was asked to provide comments on the measure concept, *Polypharmacy: Use of Multiple CNS-Active or Anticholinergic Medications in Older Adults,* which was considered an important concept idea for development by the 2016 PCAP.

Quality Metrics Expert Panel

The Quality Metrics Expert Panel (QMEP) reviewed the testing results of two draft measures:

- *Adherence to Non-Infused Disease Modify Agents Used to Treat Multiple Sclerosis*
- *Concurrent Use of Opioids and Benzodiazepines*

Each measure was tested by two different organizations. Testing showed there is considerable variability and room for improvement in the measure, *Concurrent Use of Opioids and Benzodiazepines.* Testing results for the measure, *Adherence to Non-Infused Disease Modify Agents Used to Treat Multiple Sclerosis,* showed less variability and the rates were mostly above 80%. The QMEP voted to recommend both measures to the PQA membership for endorsement consideration. The PQA membership vote on whether to endorse these two measures currently is underway.

The QMEP also reviewed the measure concept, *Immunization Information System Reporting (IISR)*, developed by the Adult Immunization Task Force. The concept is designed for reporting by health plans at a state level due to differences in Immunization Information Systems in each state. The QMEP voted to move the concept forward for testing to address concerns of feasibility and measure burden to the health plan.

The QMEP reviewed the first PQA-developed electronic clinical quality measure (eCQM). The concept, *Use of Disease Modifying Therapy in Persons with Relapsing Forms of Multiple Sclerosis*, is a physician-level measure and uses electronic medical record data. The QMEP had questions about the language used in the numerator and the measure's exceptions. The QMEP voted in favor of moving the concept forward to a formal testing process that involves at least two practice sites and with different electronic medical record vendor products.

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: *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 are first focusing on the Bleeding Events measure. A thorough literature review was conducted to identify clinical risk factors associated with hospitalization or ED visits related to bleeding events. The RAAP discussed strategies to prioritize the relevant risk factors to include in a risk adjustment model, based on such factors as quality of the evidence, strength of the association with the outcome, and ability to operationalize within claims data. Additionally, the RAAP discussed how to group the variables into categories that were most appropriate to use for empirical risk adjustment testing. The next steps are to finalize the testing plan, and work with organizations who are interested in testing a risk adjustment model for this measure.

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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.