Using Pharmacy Quality Measures in Medicaid DUR Programs

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Conflict of interest disclosure

No actual or potential conflict of interest
Learning objectives

At the completion of this presentation, you will be able to:

1. Explain the importance of quality measurement development in the United States health care system.
2. Describe the types of measures being proposed for medication use.
3. Illustrate the importance of benchmarking data for interpreting a State’s programs measures.
4. Identify methods for improving a state’s quality performance through prospective and retrospective DUR activities.
The healthcare future is increasingly about measuring and improving quality

Quantifying and improving the quality of health care is an increasingly important goal in American medicine.

- Federal government and other payers pushing measurement and improvement
- Consumers becoming accustomed to using measures for provider selection
- Payers exploring way to link payment to performance
Quality measurement and improvement

Hospitals, nursing home, surgical centers, dialysis centers, and many others have been dealing with quality measures for years.

Pharmacy related measures have occasionally been included in measures of these other entities.

Pharmacy has recently become directly involved in the development and use of pharmacy related quality measures.
Donabedian’s (1988) classic paradigm for assessing quality of care is based on a three-component approach—structure, process, and outcomes:

- **Structure** – relatively stable characteristics of the providers, the tools and resources at their disposal, and the physical and organizational setting (e.g., board certification, staffing ratios, availability of facilities, etc.)

- **Process** – the set of activities that go on between practitioners and patients (e.g., was appropriate medication prescribed, was patient compliant, etc.)

- **Outcome** – change in a patient’s current and future health status that can be attributed to antecedent health care (e.g., hospitalization rates, mortality rates, etc.)
What is good quality measure

A performance measure that:

• Reflects a structure, process, or outcome that is associated with quality of care
• Can be **reliably calculated** for the reporting unit (payer, plan, provider, etc.)
• Can be **calculated relatively easily** using existing data when possible
• Is a **valid measure** of quality (varies across reporting units in a way that is associated with actual quality of care)
• Has **benchmarks** available for evaluating relative performance
• Can be **used** to support quality improvement, decision making, and pay for performance
Pharmacy Quality Alliance (PQA)

How many of you know about the Pharmacy Quality Alliance?

How many of you or your organizations are members of PQA?

How many of you have been involved in PQA work groups or pilot programs?

WHY NOT?
PQA is an independent corporation with close ties to CMS

- Established in 2006 as a public-private partnership through the leadership of the Center for Medicare and Medicaid Services (CMS).
- Now operates as an independent, nonprofit corporation.
- Maintains close ties with measure development groups in CMS for Medicare Part D.
- This year expanding ties with CMS measure group for Medicaid.
PQA member organizations are diverse

A multi-stakeholder, consensus-based organization comprised of 140 stakeholder organizations.

- 5 Government agencies (CMS, FDA, Indian Health Service, etc.)
- 9 Professional/scientific associations (APhA, ASHP, AMCP, ACCP, etc.)
- 16 Health plans (Kaiser, Humana, United Health, etc.)
- 13 Community pharmacy organizations (Cardinal, CVS, Walmart, etc.)
- 15 Academic institutions (AACP, UAZ, UMS, UMD, UOK, etc.)
- 23 Pharma companies (AZ, BMS, Lilly, Novartis, Pfizer, etc.)
- 40 Health information technology orgs (First Databank, IMS, Mirixa, etc.)
- 4 Health quality and standards organizations (NCQA, NCDP, etc.)
- 6 PBMs (Catamaran, Express Scripts, Prime Therapeutics, etc.)
- 2 Research institutions/foundations, 5 trade associations, 5 Adherence package orgs
Involvement in PQA by different groups is important

- Potential measures are identified, discussed, and proposed by work groups.
- GOOD work groups have input from various organizations and can consider multiple issues and viewpoints:
  - Clinical relevance and appropriateness
  - Ability of appropriate entities to affect change in measure
  - Feasibility of measurement
  - Technical considerations in computing measurement
PQA involvement with CMS

• PQA develops the definitions and specifications for medication-related quality measures and supports the quality improvement efforts of health plans, prescription benefit management organizations and pharmacies.

• Since its inception, PQA has had a major focus on developing quality measures that were appropriate for use in Medicare Part D and private payer populations.

• This year, PQA is increasing its focus on quality measures appropriate for use in the Medicaid population.
PQA measures to date

- **Proportion of days covered (PDC)** for beta-blockers, CCBs, ACEI/ARB, biguanide, sulfonylurea, TZD, statins, anticonvulsant medications and antiretroviral agents.
- **Diabetes medication dosing** for biquanides, sulfonylureas, TZDs
- **Diabetes suboptimal treatment** regimen - patients dispensed medication for diabetes and hypertension not on ACEI/ARB.
- **Suboptimal asthma control** – asthma patients dispensed too many short-acting beta2 agonist inhalers.
- **Absence of controller therapy** – asthma patients with high use of short-acting beta2 agonist inhalers and no controller therapy.
- Use of **high-risk medications** in the elderly.
- Use of statins in patients with coronary artery disease.
- Use of antipsychotics in young children.
Measurement ALONE is not enough, must be part of quality improvement initiatives

- URAC accredits pharmacy benefit managers (PBMs), mail-service pharmacies and disease management organizations
  - They adopted PQA measures to evaluate PBMs & mail pharmacy
  - Accredited organizations must report PQA measures
- URAC and APhA/NABP have created community pharmacy accreditation. The standards may require pharmacies to have “adherence programs” and quality improvement programs
- Employers/purchasers are interested in quality and value:
  - National Business Coalition on Health evaluates health plans with PQA measures
  - FEHB is considering use of PQA measures to evaluate plans for federal employees
PQA measures are an important part of Medicare star ratings

- Medicare drug plans receive an overall rating on quality as well as four domain scores (18 individual measures in total)
- Domain on *pricing & safety* contains six measures:
  - 1 measure of price accuracy and stability
  - 2 measures of medication safety
    - High risk medications in the elderly
    - Appropriate treatment of blood pressure in persons with diabetes
  - 3 measures of medication adherence
    - Oral diabetes medications
    - Cholesterol medication (statins)
    - Blood pressure (renin-angiotensin-aldosterone inhibitors)
Pharmacy measures affect Star Ratings

Examples:

**Process Measure x1**
Price Stability / Accuracy

**Access / Patient Experience Measure x1.5**
Pharmacy Hold Time
Members choosing to leave the plan

**Intermediate Outcome Measure x3**
All five PQA measures

Due to the higher weighting of intermediate outcomes, the PQA pharmacy measures account for 47% of Part D summary ratings in 2012.
What about Medicaid?

CMS’ Adult Medicaid core measures:

- The Affordable Care Act required Health and Human Services to create a quality measurement and reporting program for Medicaid.
  - January 2011 – published recommended initial core set of measures (this included
  - January 2012 – published initial core set and established Medicaid Quality Measurement program to fund development, testing, and validation of evidenced-based measures
  - January 2013 developed standard reporting format / encouraging reporting by states
  - September 2014 - collect, analyze, and make publicly available information reported by states
## Medicaid-Eligible Adults Recommended Core Set

### Pharmacy Related Measures

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<thead>
<tr>
<th>Recommended but not included</th>
<th>Included in initial core set</th>
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<tbody>
<tr>
<td>Persistence of beta-blocker treatment after heart attack</td>
<td>Antenatal steroids</td>
</tr>
<tr>
<td>Use of statin therapy in patients with coronary artery disease</td>
<td>Antidepressant medication management</td>
</tr>
<tr>
<td>Use of appropriate medications for people with asthma</td>
<td>Adherence to antipsychotics for individual with schizophrenia</td>
</tr>
<tr>
<td>Proportion of selected schizophrenia patients with antipsychotic polypharmacy utilization</td>
<td>Annual monitoring of patients on persistent medications</td>
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<td>Proportion of days covered (PDC) for 5 therapeutic categories</td>
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Use of antipsychotics in Medicaid children is a major focus

Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established the Pediatric Quality Measures Program (PQMP), an initiative to support the development of new measures in child health care.

- Working with Centers of Excellence to increase the portfolio of measures to understand and improve the quality of health care for children in Medicaid and CHIP.

- May 2013 sought public feedback on list of potential measures for use by state and federal programs.
PQMP proposed measures for Medicaid children

Measures to assess appropriate overuse of medications

- Children on higher than recommended doses of antipsychotics (APs)
- Use of APs in very young children
- Use of multiple concurrent APs in children
- Use of APs in children without primary indication

Measure to assess use of needed services associated with medication use

- Follow-up care for children on APs
- Metabolic screening for children on APs
- Access to psychosocial care for children on APs
How does this fit into DUR activities?

DUR is about trying to improve quality and quality measures are very similar to events we typically identify for pro-DUR clinical edits and retro-DUR exception monitoring and interventions.

Example: Potential drug-drug interaction

Concomitant use occurs → count as exceptions → consider for intervention

DUR process tends to focus on how many occur (numerator). Quality measures focus on rates (numerator and denominator) and how performance compares to normative rates.

# Concomitant use events

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Number of PTs on medication
Different focus is important in setting priorities

Thinking of the things we measure as quality indicators can help set priorities and evaluate improvement.

Which should be a higher priority for intervention?

<table>
<thead>
<tr>
<th>Last month</th>
<th>This month</th>
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<tbody>
<tr>
<td>155</td>
<td>240</td>
</tr>
<tr>
<td>(\frac{155}{3,415}) = 4.5%</td>
<td>(\frac{240}{8,917}) = 2.7%</td>
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Numerator is going up / rate is going down

<table>
<thead>
<tr>
<th>Last month</th>
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<tbody>
<tr>
<td>155</td>
<td>75</td>
</tr>
<tr>
<td>(\frac{155}{3,415}) = 4.5%</td>
<td>(\frac{75}{1,120}) = 6.7%</td>
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Numerator is going down / rate is going up

Last year our rate improved and state ranking moved from 15 to 10

Last year our rate improved and state ranking moved from 15 to 20
Using quality indicators to assess a state’s performance requires benchmark data

When evaluating how your state is doing, it is not sufficient:

To Simply know what your state rate is on a quality measure.

- Your rate may appear low but is much better than everyone else’s

To know how your rate has changed in recent years.

- You could be improving but others are getting better faster and your ranking is getting worse.
- You could show no significant change but everyone else has gotten worse and your ranking is improving.
Antipsychotic Use in Children Under 5 Years Old (Lower rate is better)

<table>
<thead>
<tr>
<th>Description</th>
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<tr>
<td>The percentage of children under age 5 using antipsychotic medications during the measurement period.</td>
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<table>
<thead>
<tr>
<th>Definitions</th>
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<tbody>
<tr>
<td>Measurement period</td>
</tr>
<tr>
<td>The period of time over which the antipsychotic medication use is observed. (Most often a calendar year).</td>
</tr>
<tr>
<td>Antipsychotics (APs)</td>
</tr>
<tr>
<td>First generation (e.g., chlorpromazine, haloperidol, perphenazine) and second generation (e.g., risperidone, olanzapine, aripiprazole) antipsychotics.</td>
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<table>
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<tr>
<th>Methodology</th>
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<tbody>
<tr>
<td>Denominator</td>
</tr>
<tr>
<td>Beneficiaries under 5 years old any time during the measurement period.</td>
</tr>
<tr>
<td>Numerator</td>
</tr>
<tr>
<td>The number of beneficiaries with one or more prescription claims for an antipsychotic medication with days supply greater or equal to 30 days.</td>
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Recent example presented to Mississippi DUR Board

“The overall rate for Mississippi was 0.11%. As was found in the earlier MS-DUR white paper on mental health and children, the rate for foster children was significantly higher than for non-foster children. **On this specific measure, foster children were 6 times more likely to be using an antipsychotic than were non-foster children.** Although this may sound alarming, the earlier white paper found that use of antipsychotics among all foster children was three times higher than for all non-foster children. Since the increased use among foster children is associated with higher levels of trauma, often arising from dysfunctional or abusive home lives, it is not surprising that foster children would be more likely to begin using antipsychotics earlier than non-foster children”.

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>Use of Antipsychotics Among Children Under 5 Years Old</th>
<th>2012 Mississippi Medicaid Data</th>
</tr>
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<tbody>
<tr>
<td>ALL BENES</td>
<td>FOSTER CHILDREN</td>
<td>NON-FOSTER</td>
</tr>
<tr>
<td>Numerator</td>
<td>Rate</td>
<td>Numerator</td>
</tr>
<tr>
<td>167,482</td>
<td>184</td>
<td>0.11%</td>
</tr>
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</table>
“Table 3 and Figure 1 show the rates on this measure for 40 states and the District of Columbia Medicaid programs. Using the same methodology, these data show that in 2007 the rate for Mississippi was 0.13%, which would indicate a 15% decline between 2007 and 2013. Based on the 2007 analysis, Mississippi Medicaid was slightly above the national average and roughly in the middle of the states examined. As shown in Figure 1, Mississippi Medicaid had a much lower score than did the Medicaid programs in all but one (TN) of the surrounding states.”
Population characteristics can affect state Medicaid measures

- Obviously considerable variation exists among the states.

- Geographical patterns of performance indicate that beneficiary characteristics may be related to many performance measures.

- State Medicaid programs will need tools for doing a simple case-mix adjustments to their measures when comparing to national benchmark data.
Logistic regression analysis determined beneficiary age, sex and race were significantly related to AP use in children < 5.

Post weighting done using following procedure:

- Percentages for each race/sex/age category are computed for national Medicaid population in denominator of measure.
- State percentages are computed for each race/sex/age category.
- Weights for each category is computed as:
  national % / state %
- Weights are assigned to each beneficiary in denominator based on race/sex/age category.
- Weighted rates are computed for each state.
AP use in children < 5 non-adjusted and adjusted

% AP Use Among Children Under 5 (Unweighted)

% AP Use Among Children Under 5 (Weighted)

Rankings and rates do not always change in same direction
Availability of benchmark data

- Medicare Part D programs have lots of benchmark data and relatively real time feedback on the PQA measures used in the star ratings.
- However, Medicaid programs have very little benchmark data to help in evaluating performance on pharmacy quality measures.
- The CPMM is working with PQA to develop benchmark data for their existing measures, conduct validity studies for existing measures and to conduct preliminary analyses with Medicare and Medicaid data to support work groups.
- Priority will be given to benchmark data for measures that could be used in Medicaid programs.
How can DUR utilize pharmacy quality measures

- Evaluate your performance on relevant measures.
- If needed, develop strategies for improving performance.
- Pro-DUR can include clinical edits to prevent behavior that will decrease performance on measure.
  - Require manual PA for use of high risk drugs in elderly.
  - Require manual PA for use of APs below labeled ages.
  - Require manual PA before fill of potential drug-drug interaction.
- Retro-DUR can do education and provider feedback to improve performance on measure.
  - Detect large refill gaps and inform prescribers about potential adherence problem.
  - Detect standard of care deficiencies and send education information and patient specific information to prescribers.
Why is all this important to Medicaid DUR programs?

Quality measures are coming!!

Pharmacy specific measures lag behind medical measures, but they eventually get addressed.

Part D Start rating system is good example
Adult Medicaid measures may be another

Medicaid DUR programs can wait and only become involved when it is mandatory

OR

we can take the lead on helping identify, develop and implement appropriate pharmacy quality measures.
Questions?

Discussion

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