PHARMACIST'S LETTER

Quality Measures and the Pharmacy Team's Role

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Accreditation, Goals and Objectives

Course Accreditation Information, Goals and Objectives

Introduction

Keep in mind that quality measures are constantly evolving. The commentary, cases, and examples discussed in this course illustrate how pharmacies can incorporate strategies to positively impact quality measures into practice, and are based on the measures in effect at the time of publication in early 2017. For the most current quality measures, refer to our toolbox, *Quality Measures for Pharmacies*.

The United States has the highest healthcare costs in the world. But this doesn't necessarily translate into higher quality care.[1] The U.S. healthcare system is ranked 37th in the world in overall performance, 36th for life expectancy, and 39th for infant mortality.[2] As a result, there are ongoing efforts to improve the quality of healthcare while reducing overall healthcare costs.

The healthcare system is evolving to achieve these goals. Traditional payment models have included "fee-for-service," (or FFS) where more services provided mean more payment. For example, a prescriber may receive a fee for services provided, such as an office visit, lab test, X-ray, or other procedure. Similarly, pharmacies have historically been primarily reimbursed based on the number of prescriptions they dispense. With "fee-for-service" payment models, there is an incentive to provide a higher volume of services. But a higher volume of services doesn't necessarily mean better quality of care. In fact, one-third of healthcare spending is wasted on unnecessary diagnostic tests, procedures, and medications.[3]

You may already be experiencing a shift away from getting paid for volume, to getting paid for the value and quality of care you provide. This is often referred to as "pay-for-performance," sometimes abbreviated as P4P. This is a payment model that is based on your ability to deliver high-quality care. These models may take the form of a shared savings approach, where the provider gets to share in a percent of the healthcare dollars saved as a result of their efforts to improve quality. On the other hand, providers may get penalized if quality-related goals aren't reached. You may also hear this referred to as "value-based care."

Although this is a fairly new idea for pharmacy practice, prescribers and health-systems have had incentives to improve the quality of care for years. Now pharmacies, like the rest of healthcare, are expected to focus on improving quality. There's also a bigger push to tie financial incentives to the quality of care provided in pharmacy practice.

Why do you think there is a shift away from fee-for-service payment models? What are the benefits of a pay-for-performance payment model? What might be some disadvantages?

Pay-for-performance models are intended to shift the focus from basic care to high-quality care. They are meant to incentivize providers to focus on improving long-term outcomes. The shift in focus on providing high-quality care at a low cost is guided by the Institute for Healthcare Improvement's "Triple Aim." The Institute for Healthcare Improvement is an independent, not-for-profit organization focused on healthcare improvement worldwide. The Triple Aim focuses on three core principles:[4]

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of populations
3. Reducing the cost of healthcare

The Centers for Medicare and Medicaid Services (CMS) is one of the biggest driving forces behind the focus on quality of care in the pharmacy setting through their Medicare Star Rating program. Other payers, such as state Medicaid programs and commercial payers, have followed suit and either are developing or have developed their own quality programs. Since the Medicare Star Rating program is what other payers often base their own programs on, it's important for you to understand this program in detail.

Medicare Star Rating Program

It's Medicare Open Enrollment and a patient comes into your pharmacy with a plan comparison print out from the Medicare Plan Finder tool. The patient has a question for you about the "Star Ratings" associated with each plan. The patient asks you what these stars mean. How would you explain the Medicare Star Rating program to the patient? How would you explain this program to a colleague? What is the purpose of the Medicare Star Rating program?

CMS is the federal agency in the U.S. that administers Medicare and works with individual states to administer Medicaid, among other responsibilities. CMS has a history of focusing on improving the quality of healthcare while lowering healthcare costs. For example, starting in late 2012, CMS started cracking down on preventable hospital readmissions. CMS now imposes financial penalties for hospitals with high readmission rates of patients with heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), and more.[5] The penalty may be as much as 3% of a Medicare-covered hospital stay.[6] For example, if a claim was submitted to Medicare for a $20,000 hospital stay, the hospital could be reimbursed just $19,400 with a 3% penalty. When considering the total number of Medicare-covered hospital stays, for some hospitals that penalty can translate into a million dollars or more annually. On the other hand, CMS offers incentives for eligible professionals and eligible hospitals who meet goals for clinical quality measures.[7]

CMS also holds Medicare Advantage (Part C) health plans and Medicare Part D prescription drug plans accountable for low-cost, quality care. These plans are rated on their quality using "Star Ratings." Star Ratings were created in 2006 as a way to report on plan quality and reward plans demonstrating high quality. Since Medicare Part D is a prescription benefit, and a portion of Medicare Part C plans often includes prescription benefits, there's a big focus on how pharmacy teams can help these plans improve quality.[8]

Differences between Medicare Part C and D

Do you know the "ABCs" of Medicare? Check out our technician tutorial, *The ABCs of Medicare* for more information on the different Medicare parts.

Medicare Part C plans are private health plans that contract with CMS to provide benefits to patients. Like "traditional" Medicare, these plans provide both Part A (hospital) and Part B (medical) coverage to patients. The difference with Medicare Part C plans is that instead of the government paying for the services directly, private companies provide the benefits, and CMS pays the private insurer.[9]

Medicare Advantage plans may or may not provide Part D (prescription) coverage. Medicare Advantage plans that also offer Part D coverage are known as MA-PD plans. Many Medicare Advantage plans do include Part D coverage.

Here is a chart to help keep the differences straight:

Type of Plan	Offers Hospital and Medical Coverage?	Offers Drug Coverage?
Medicare Advantage only (Part C MA plans)	**Yes**	**No**
Medicare Advantage and Part D plans (Part C MA-PD plans)	**Yes**	**Yes**
Medicare Part D only (PDP plans)	**No**	**Yes**

Since Medicare Advantage plans cover hospital and medical services, these plans are rated on a variety of quality measures related to overall healthcare. For example, they're rated on measures related to managing chronic conditions. In contrast, the quality measures for Medicare Part D plans include measures focused on medication use, since prescription drug coverage is the primary benefit of the Part D plans.

What are "quality measures?"

Quality measures provide a standardized, objective, and quantifiable definition of quality. Quality measures may look at patient outcomes, processes, or patient experiences with their care in order to evaluate the quality of care provided.[10]

Star Rating Domains

Star Ratings are calculated and assigned before the enrollment period each year in the fall. Plans receive a number of different ratings within a specific domain. Keep in mind that the measures used vary based on the type of plan. This makes sense, because the plans provide different services (as noted in the chart above).

The quality measures used to determine Part C and Part D Star Ratings can change every year. In 2017, Medicare Advantage plans are rated on five domains which include over 30 individual measures. Medicare Part D plans are rated on four domains with up to 15 measures. MA-PD plans are rated on all nine domains for Part C and Part D plans, which include over 40 unique measures.[11]

Here are some examples of the domains and measures for 2017:

2017 Domains and Measures for Star Ratings for Medicare Advantage plans (note: list is not all-inclusive):[11]

Domain	Example Measures
1. Staying healthy: screenings, tests, and vaccines	• Annual flu vaccine • Assessment of BMI • Breast cancer screening • Colorectal cancer screening • Improving or maintaining physical health

2. Managing chronic (long-term) conditions	• Annual medication review for certain elderly patients • Appropriate management of rheumatoid arthritis • Blood sugar control in patients with diabetes • Control of blood pressure in patients with hypertension • Kidney function testing for patients with diabetes • Osteoporosis management for women who have had a fracture • Reducing all-cause readmissions
3. Member experience with health plan	• Customer service • Ease of getting needed care and seeing specialists • Getting appointments and care quickly
4. Member complaints and changes in the health plan's performance	• Comparison of health plan's performance from prior year • Number of complaints about the health plan • Patients choosing to leave the plan
5. Health plan customer service	• Call center foreign language interpreter and TTY availability • Timely decisions about appeals if plan refuses payment or coverage

2017 Domains and Measures for Star Ratings for Medicare Part D and MA-PD plans (note: list is not all-inclusive):

Domain	Example Measures
1. Drug plan customer service	• Call center foreign language interpreter and TTY availability • Timely decisions about appeals if plan refuses payment or coverage
2. Member complaints and changes in the drug plan's performance	• Comparison of health plan's performance from prior year • Number of complaints about the drug plan • Patients choosing to leave the plan
3. Member experience with drug plan	• Ease of getting prescription drugs • Patients' rating of drug plan based on consumer surveys
4. Drug safety and accuracy of drug pricing	• Adherence to non-insulin diabetes medications • Adherence to renin-angiotensin system (RAS) antagonists (such as ACE inhibitors [lisinopril, enalapril, etc] or ARBs [losartan, valsartan, etc]) • Adherence to statins (atorvastatin, simvastatin, etc) • Appropriate use of high-risk medications in the elderly* • Medication Therapy Management (MTM) program completion rate for comprehensive medication reviews (CMR) • Plan provides accurate drug pricing information on Medicare Plan Finder website

*Although this was included in the 2017 Star Rating measurement, it will be moved to a display measure in 2018. Display measures are measures that aren't included in a Star Rating calculation, but are still calculated by CMS and provided to the plan in an effort to support quality improvement.

Each measurement within each domain is associated with a value that counts toward the overall summary Star Rating score. Some measures have a higher-weighted value. For example, measures related to customer service or patient satisfaction have a weight of 1.5. Adherence measures are triple-weighted, whereas CMR completion rate has a weight of 1. In other words, some measures count more toward the overall or summary rating for a plan than others. Plans are especially interested in improving performance on measures with a higher impact. Plan quality improvement from one year to the next has a weight of 5, which is a higher weight than any other individual measure. This means plans have an incentive to improve their quality and performance over time, since this measure is given more weight.[11]

Rating Scale

Plans are rated on a scale from one to five (at half-star increments), with five stars being the highest rating possible (see chart below).[8]

Star Rating	Description

★★★★★	Excellent
★★★★	Above average
★★★	Average
★★	Below average
★	Poor

A plan's Star Rating is made publicly available on the Medicare Plan Finder search tool. It's important to be aware that the data which goes into calculating a Star Rating score is from two years prior. This means 2017 Star Ratings are based on data gathered in 2015. So a plan's performance in 2017 will be reflected in 2019 Star Ratings. However, it's important to know that Medicare plans also look at current performance as compared to what is expected based on thresholds set by CMS.

Since Star Rating domains and measures can change from year to year, plans need to not only focus on what is being measured today, but what might be measured in the future. One way to get insight into what CMS might focus on in the future is to look at "display measures."

Display Measures

Display measures can also be important for pharmacy teams to be aware of. Although display measures are not used to determine Star Ratings, they may:[12]

- Be used to "test" a measure before it's formally included as part of the Star Rating
- Provide information and feedback about a plan's performance
- Include measures that have transitioned out of the Star Rating program

Even though display measures aren't formally included in the Star Rating, CMS still collects data on plans' performance on these measures. If plans have poor scores on the display measures, they may be subject to compliance actions by CMS. Therefore, plans are often also interested in how pharmacy teams can help with these measures. In fact, plans may hold pharmacies to certain expectations for these measures in order to be proactive in achieving high performance before the display measure becomes a Star Rating.

Like Star Ratings, display measures may change over time.

For example, the completion rate of comprehensive medication reviews (CMRs) changed from a display measure to a Part D Star Rating measure in 2016, and statin use in diabetes is a display measure for 2017, with planned inclusion in the 2019 Part D Star Ratings calculations.

Here are some examples of the 2017 display measures:[12]

Part C Display Measures	• Antidepressant medication management • Medication management for people with asthma • Medication reconciliation post discharge • Pneumococcal vaccine administration • Statin therapy for patients with cardiovascular disease
Part D Display Measures	• Avoidance of drug-drug interactions • Avoidance of excessive doses of diabetes medications • Reminders to fill or refill prescriptions • Statin use in persons with diabetes • Use of atypical antipsychotics (olanzapine, etc) by elderly patients in nursing homes

Which of these display measures is addressed by an activity your pharmacy is already performing? For example, is your pharmacy using strategies to avoid potential drug-drug interactions, or providing reminders to patients about filling or refilling prescriptions? How does your pharmacy evaluate whether patients are taking excessive doses of diabetes meds, or whether patients with diabetes are taking a statin? How could your pharmacy improve performance on some of these measures?

Implications of Star Ratings for Plans

Plans with a higher rating have a marketing edge. Remember that Star Ratings are publicly available. CMS touts plans with higher ratings as being higher quality.[13] Think of this as similar to ratings that compare hotels, movies, restaurants, etc. These ratings are often an important piece of the puzzle when deciding whether to use these services.

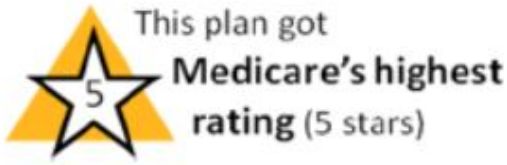
The same principle applies to Medicare Part C and Part D plans. Patients are able to consider a plan's quality, along with coverage and costs, when deciding which plans to use. The Medicare Plan Finder tool lets patients see the overall/summary rating for the plan along with ratings for domains and individual measures. Patients can easily compare the plans' ratings side-by-side. Higher plan ratings have been linked with higher patient enrollment.[14]

Plans with higher ratings have other marketing advantages, too. For example, plans with a five-star rating are eligible for open enrollment year-

round. This means patients can sign up or switch to these plans at any time during the year, rather than just in the annual enrollment period which occurs each fall.[15]

Plans with a five-star rating also get a special "high performing icon" next to their plan listing on the Medicare Plan Finder website. Plans are only able to display this icon if they have a summary/overall rating of five stars.[15]

Below is an image of the "high performing icon:"



Marketing advantages aren't the only benefits of higher ratings. Medicare Advantage plans (both stand-alone and MA-PD plans) are eligible for quality bonus payments based on their Star Rating. Only plans with at least a rating of four stars or higher are eligible for bonus payments.[16] The higher the rating, the higher the bonus payment. This can translate to millions of dollars for the plans. For example, an insurer with 16,000 Medicare members was able to increase their Star Rating from 3.5 to 4 stars, which set the plan up for as much as $8 million in extra federal funding for the following year. Plans with more members could benefit from even larger financial gains by increasing their Star Rating by as little as a half point.[17]

On the other hand, plans with consistent poor performance face several disadvantages. A "low performing icon" appears on the Medicare Plan Finder website if the plan has a rating of less than three for at least three years in a row.[11] This helps alert patients to the plan's low rating.

Below is an image of the "low performing icon:"

Plus, plans that fall into the low performance category are not able to offer online enrollment through Medicare Plan Finder. Instead, patients must contact the plans directly in order to enroll. The website also encourages patients to consider the low rating before they decide to enroll in the plan.

In addition, all patients who are current members of a low performing plan will receive notices that they are eligible to switch to a higher-quality plan. Patients receive the notice in the fall, and they have the remainder of the year as well as the following year to switch to a plan with at least three stars. Additionally, CMS can choose to issue a notice of non-renewal to the plan for the following year.[16]

These marketing advantages and potential bonus payments are clear incentives for plans to improve their ratings, and they recognize that pharmacy teams can help.

Understanding the Source of Quality Measures

Medicare plans aren't the only groups interested in how pharmacy teams can help impact patient care. Medicaid, private insurers, health insurance exchanges, Accountable Care Organizations (ACOs), and others are looking at how to involve pharmacy in improving care and meeting quality measures. There are several pilot programs evaluating pay-for-performance with pharmacies, where pharmacy teams that help improve quality measures are eligible for financial incentives.[18,19]

You may be wondering where the Star Rating program and other groups (such as payers) derive their quality measures from. You may also be curious as to why a group may focus on specific measures. The measures a particular group uses to evaluate performance could vary from group to group. For example, as part of internal quality improvement, payers may choose to focus on a quality measure based on a costly problem they are seeing across their population of covered lives. To illustrate further, many payers have an issue with asthma exacerbations, which costs the plan thousands of dollars per person per year. Pharmacy teams can help out with this problem by making sure patients who have asthma are using their controller medications as directed and that they are correctly using their inhalers. Pharmacy teams that work with groups who are evaluated based on quality measure performance must be familiar with the measures the group is focusing on, and should try to develop ways to have a positive impact on these measures.

There are many national organizations that develop, test, and maintain quality measures. These measures may apply to a variety of settings, including community pharmacies, hospitals, long-term care facilities, ambulatory surgery centers, and more. See the list below for just a few examples of groups that develop these quality measures.

Examples of Organizations That Develop Quality Measures

Measure Developer or Steward	Link to Additional Information
Centers for Medicare & Medicaid Services (CMS) develops some of its own measures, or may endorse measures from other groups.	http://cms.gov/
National Committee for Quality Assurance (NCQA) is a private, nonprofit organization that develops and maintains a collection of healthcare quality measures. This set of measures is known as the Healthcare Effectiveness Data and Information Set (HEDIS).	http://www.ncqa.org/ http://www.ncqa.org/HEDISQualityMeasurement.aspx
The Joint Commission is an independent, nonprofit organization that accredits and certifies healthcare organizations and programs based on their ability to meet certain performance standards.	http://www.jointcommission.org/
Agency for Healthcare Research and Quality (AHRQ) is the Federal agency, within the U.S. Department of Health and Human Services, charged with improving the safety and quality of America's healthcare system.	http://www.ahrq.gov/
Pharmacy Quality Alliance (PQA) is a nonprofit, multi-stakeholder, consensus-based membership organization. It works to develop measures related to safe and appropriate medication use and medication management services. These measures are often the most relevant to pharmacy practice, such as measures looking at adherence or medication safety. In fact, several of the quality measures used in the Star Rating program were developed by PQA.	http://www.pqaalliance.org/

Keep in mind that there are hundreds of quality measures that have been developed by various groups (in addition to those groups mentioned above). Insurance plans, healthcare providers, or institutions may have their own sets of internal quality measures too.

Once a quality measure is developed by a group (such as PQA), it can be adopted and possibly adapted by payers, including Medicare, Medicaid, pharmacy benefit managers (PBMs), health plans, etc. Payers may focus on different measures to evaluate quality. This can lead to confusion when different payers use different quality measures to evaluate performance.[8]

Quality measures may also be used for accreditation purposes. For example, hospitals are evaluated on measures from Joint Commission. Hospitals must meet certain standards for these measures to maintain their accreditation. Or URAC, which is an accreditation agency, has endorsed and uses some PQA measures in its accreditation processes for PBMs, mail order pharmacies, specialty pharmacies, and others.

Although your practice may not be directly impacted by all quality measures, it doesn't mean you're immune from thinking about them. Regardless of your practice setting, you are a key part of the overall healthcare system and team. Pharmacy teams should consider not only how their efforts will help the individual patient, but also how that care will help health plans, prescribers, health-systems, nursing homes, or hospitals.

Implications of Quality Measures for Pharmacy Teams

It's a new year and the pharmacy is busier than usual due to insurance changes and cough/cold/flu season. To add to your frustration, over the past few days some of your regular patients brought in letters from their insurance company saying they could get cheaper copays at a different pharmacy. You are confused as to why the insurance companies are trying to move patients to these pharmacies. Your patients were also upset because they didn't want to have to switch pharmacies. While some of the patients thought staying at your pharmacy was worth the extra few dollars, others transferred their prescriptions to the lower-cost pharmacy.

Has this ever happened to you? Why do you think some insurance companies offer cheaper copays at other pharmacies? What could you do to increase the chance that your pharmacy doesn't get left out in the future?

Payers have been trying a number of strategies to improve their ratings on quality measures. These include formulary restrictions, patient outreach, or case management services. But interventions from health plans are often impersonal and don't consider the patient's personal experiences. Since community pharmacy staff often have relationships with their patients and sometimes see the same patient multiple times per month, plans are looking more closely at how to collaborate with pharmacy teams to impact patient care and performance on these quality measures.[8]

Be aware that pharmacies don't actually get a Star Rating score from CMS. Only Medicare plans get Star Rating scores. However, pharmacy teams can help Medicare plans boost their Star Rating.

This is exciting news for the practice of pharmacy. Pharmacy teams have a history of having strong relationships with patients and providing high-quality care. Improving medication use is the "bread and butter" of pharmacy practice. Additional pharmacy services such as immunizations, health screenings, adherence programs, MTM, or medication reconciliation, all tie in to these national efforts to improve patient care AND can positively impact a variety of quality measures and Star Ratings.

The good news is that now providing good patient care goes hand-in-hand with potential business and financial rewards. Plans may evaluate pharmacy performance and whether they're contributing to the plans' Star Rating efforts (good or bad) or other quality measure programs. Pharmacies that demonstrate they can help improve quality measures can get a competitive advantage and will be viewed as a key asset in

improving patient care. This may eventually lead to incentives tied to the quality of care provided, such as financial bonuses based on performance, or inclusion in "preferred" pharmacy networks. For example, payers can select specific groups of pharmacies to include in their preferred network. These preferred pharmacies will likely be able to offer lower copays to patients, compared to pharmacies that are non-preferred, which could direct more new patients to these preferred pharmacies. In fact, more and more plans are creating pharmacy network contracts based partly on quality, not purely on costs alone.[8]

Key Quality Measures to Focus On

You are explaining quality measures to a colleague. You want to give your colleague some examples of quality measures that pharmacies can help positively impact. What are some examples of quality measures you can share? How are these measures calculated? Why are pharmacies in a good position to help out with these measures? How can pharmacy teams help?

As previously discussed, there are several quality measures that various groups use, and not all quality measures are directly related to medication management. While pharmacy teams can help improve many aspects of patient care that may be associated with a quality measure; such as increasing screening rates, offering immunizations, providing screenings, helping patients reach blood sugar and blood pressure goals, etc; it's important for pharmacy teams to thoroughly understand and know how to positively impact key medication-related quality measures. Recall most of the medication-related measures used in the Star Rating program have a higher weight than measures related to customer service, patient satisfaction, or other areas of care such as screenings and immunizations.

Pharmacy teams can begin by narrowing in on measures that fall into the following categories:

- Medication adherence
- Gaps in treatment
- Medication safety
- MTM CMR Completion

The quality measure examples provided in this section are related to what the industry is focusing on at the time of publication in early 2017. As time changes, some measures will start to get less of a focus and new measures not covered in this course may get the spotlight. Many of the strategies discussed here can be applied to a wide range of quality measures. Often the difference with the specific measures is in the drug or disease state that the measure focuses on.

Realize that the future will bring changes to quality measures. How you approach these changes will determine success. Whenever a new measurement becomes a focus, here are some things you can do to ensure your pharmacy is proactive in helping to positively impact patient care:

- Take time to understand details of the measure.
    - Which drug or disease state is it focusing on? What are the parameters? What patient population is it targeting?
- Determine if the measure is similar to a measure you already had/have to focus on.
    - For example, let's assume the Star Rating program adopts a new adherence measure focused on heart failure meds. In this case, you would apply the same strategies you use for adherence to statins, non-insulin diabetes meds, and RAS antagonists to heart failure meds.
- Consider what you already may be doing to positively impact the measure and develop additional strategies for improvement.
- Make sure the entire pharmacy team understands the measurement and what needs to be done to positively impact patient care.

Medication Adherence

You often hear about medication adherence and how important it is. But how can you determine if a patient is nonadherent? How are measures that assess medication adherence calculated?

Adherence is an extremely important opportunity for pharmacy teams to improve patient care. Medication adherence helps keep patients healthy, and improving adherence rates has the potential to save billions of healthcare dollars. For example, in 2017 there are three unique quality measures related to med adherence in the Medicare Star Rating program. The three measures evaluate adherence to:

- Non-insulin diabetes medications
- Statins
- Renin-angiotensin system (RAS) antagonists (such as ACE inhibitors or ARBs)

Patients qualify for inclusion in this measure if they have at least two fills of the target meds. All three of these measures look specifically at the Proportion of Days Covered (PDC) to calculate adherence. This is the percent of patients who have a prescription filled often enough to "cover" a certain percent of the time they should be taking the medication.[20] The threshold for adherence with these three measures is a PDC of 80%, because that's the number considered to be significant for improving clinical outcomes for those medications.[21] However, keep in mind that the percentage for a patient to be considered adherent may differ based on the medications evaluated (i.e., HIV or specialty medications may have higher adherence thresholds).

PDC is calculated by dividing the total number of days in a given time period that a patient would be "covered" by the medication (based on fill history), by the total possible number of days in that time period. Even if a patient refills an Rx early, the new Rx starts "counting"

only after the original Rx is due to be completely out. This improves accuracy since the "overlap" is accounted for in the calculation of PDC.[22]

For example, over the course of a year, if a patient had Rx fill data to show that they were "covered" 330 days, the PDC would be about 90.4% (330 days covered/365 days in a year). This means the patient is adherent because they are over the 80% cut-off.[22] Of course, just because adherence is defined as a PDC of at least 80%, patients should still be encouraged to try to achieve 100% adherence.

For Star Ratings, plans are evaluated on what percentage of their patients meet this level of adherence (PDC of 80%). The higher the percent of patients considered adherent, the better. Below is a summary of how the Star Rating for the individual measure is determined (specifically for the measure on adherence to non-insulin diabetes meds).

Cut points for 2017 adherence to non-insulin diabetes medications:[11]

Plan Type	One Star	Two Stars	Three Stars	Four Stars	Five Stars
MA-PD	< 70%	≥ 70% to < 76%	≥ 76% to < 79%	≥ 79% to < 83%	≥ 83%
Part D	< 74%	≥ 74% to < 78%	≥ 78% to < 82%	≥ 82% to < 86%	≥ 86%

For example, if 75% of patients with an MA-PD plan who take metformin have a PDC of at least 80%, the plan would be assigned a two-star rating for this measure. Note that the cut points are slightly different between MA-PD and Part D plans, and are based on overall industry performance on these measures. Industry performance helps guide CMS in determining appropriate cut points for quality measures.

Although not identical, the cut points for adherence to RAS antagonists and statins are similar, and cut points for all measures change from year to year. Note that in the adherence to non-insulin diabetes medications example and others, relatively small changes may be needed for plans to achieve a five-star rating compared to a four- or three-star rating.[8] For example, in 2017, a Part D plan that moves from 80% of its patients being adherent to diabetes meds to 86% can mean the difference between a three-star and a five-star rating for this measure. This makes each patient intervention by pharmacy teams that much more meaningful.

Keep in mind that measuring quality isn't perfect. Data for determining performance on quality measures can be pulled from Rx claims, patient surveys, or from electronic health records. If patients fill a prescription as "cash" rather than bill their Medicare Part D plan, the Rx won't show up in the data and won't count toward the measure, unless the pharmacy submits cash claims to the health plan. For example, it may look like a patient is not adherent if they fall into the "doughnut hole" and start filling the Rx at a cash price rather than through their Part D insurance. Encourage patients to run all claims through the plan, even if they're in the doughnut hole. Many plans have lowered the copays of low-cost generic medications included in these adherence measures as an incentive to use the health plan benefit rather than pay a cash price.

Gaps in Treatment

When it comes to treating a disease, there are medications that treat the disease directly, and medications that might not treat the disease directly, but are important for helping to improve the patient's overall health in the long term. For example, diabetes meds, such as insulin and metformin, directly treat diabetes by lowering the patient's blood sugar. But a medication like a statin can help prevent heart-related complications which diabetes patients might be at higher risk for. What other examples could you think of?

A gap in treatment refers to the complete absence of a drug(s) that has been found to help improve health outcomes in patients with certain conditions. Some examples of this include the absence of a(n): statin in a patient with diabetes, controller medication in a patient with uncontrolled asthma or COPD, or an ACEI or ARB and a beta blocker in patients with systolic heart failure. While medication nonadherence usually requires a discussion with the patient, gaps in treatment usually require outreach to the prescriber.

One example of a gap in treatment measure is the statin use in diabetes measurement. Recall that this is a display measure for 2017. However, CMS has communicated the intent to make this a full measure for 2019 Star Ratings. Recall that Star Ratings are calculated based on data from two years prior. So steps taken to positively impact this measure in 2017 will be reflected in the 2019 Star Rating score.

Statin Use in Diabetes

Use our conversation starter, *Improving Diabetes Care*, to get a discussion started with diabetes patients about important steps they can take to improve their health. Once a patient with diabetes starts a statin, it's important for him/her to be adherent to it. Use our conversation starter, *Dyslipidemia*, to talk to patients about statin therapy.

For many patients, diabetes increases the risk for a cardiovascular event (e.g., heart attack, stroke, etc). However, this risk is not the same for every patient with diabetes.

Statins are recommended for diabetes patients for whom the benefit outweighs the risk. According to the 2013 American College of Cardiology (ACC)/American Heart Association (AHA) lipid guidelines, these are patients with diabetes who also fall into at least one of the following categories:[23]

1. Atherosclerotic cardiovascular disease
2. LDL 190 mg/dL (5 mmol/L) or higher
3. **Age 40 to 75 years** with LDL 70 to 189 mg/dL (1.8 to 4.9 mmol/L)

4. Estimated 10-year risk of atherosclerotic cardiovascular disease of 7.5% or higher.

If a patient does not fit into one of these "benefit groups," but it is suspected that they may derive net benefit from a statin, additional factors can be taken into consideration. See our chart, *2013 ACC/AHA Cholesterol Guidelines*, for more details.

Item number three above is the focus for the statin use in diabetes PQA measure. This measure looks at the percentage of plan members between 40 and 75 years of age who receive at least two diabetes medication fills and a statin.[12,20] Patients within this age range with diabetes should get a high- or moderate-intensity statin. Most will get a high-intensity statin (i.e., lowers LDL on average by >50%)[23,24] In general, patients without additional cardiovascular risk factors may get a moderate-intensity statin. But pharmacists can use a risk calculator to fine-tune recommendations.

> Although the Medicare Part D Star Ratings don't currently focus on controller meds for asthma (or COPD), ACEI/ARB or beta blocker use in patients with heart failure, or other gaps in treatment measures, these measures may be a focus for some groups you might be working with. Also, these could be targets for the Star Rating program in the future. Be aware that PQA has many measures that have been tested and endorsed that are ready to be used by any group who is interested. Check out PQA's measure inventory to see a list of endorsed measures and measure concepts under development.

MTM CMR Completion

The Medicare Modernization Act of 2003 created more direct patient care opportunities for community pharmacists. This legislation included the requirement that eligible patients receiving drug coverage under Medicare be offered MTM services to improve drug therapy outcomes, particularly in patients with chronic diseases. For 2017, CMS has outlined the minimum criteria for plans to utilize when targeting members to offer MTM services to (keep in mind these criteria can change from year to year):[25]

- multiple chronic conditions (the minimum threshold can be set at 2 or 3, but plans cannot require MORE than 3 chronic conditions as the minimum number),
- multiple Part D drugs (plans can set the minimum threshold anywhere between 2 and 8), and
- likely to incur annual prescription drug costs greater than $3,919.

MTM services can involve a broad range of professional activities, including performing a comprehensive medication review (CMR), identifying and resolving drug-related problems, and providing patient education and training. The Star Rating program for Medicare MA-PD and Part D plans includes a CMR completion rate measurement. This measure looks at the percentage of patients enrolled in an MTM program who received a CMR during the measurement year.[11]

> A CMR is a systematic process which involves:[25]
>
> - Collecting patient-specific information
> - Assessing medication therapies to identify drug-related problems
> - Creating a current list of all meds (Rx, OTC, vitamins, and supplements) the patient is taking, known as a ***Personal Medication Record***
> - Developing a prioritized list of drug-related problems and creating a plan to resolve the identified drug-related problems with the patient, caregiver, and/or prescriber, known as a ***Medication Action Plan***
> - Providing a live, interactive medication review and consultation with the patient or caregiver either face-to-face or over the phone

Many plans work with MTM vendors (*OutcomesMTM*, *Mirixa*, etc) to help improve their CMR completion rates. Your pharmacy may be participating with one or multiple MTM vendors to help facilitate the payment and documentation for providing this service. Plans may also partner with companies that employ pharmacists who work remotely to provide CMRs over the phone. Be aware that these pharmacists could be reaching out to your patients. However, they may not be as successful as the local community pharmacist that the patient knows and trusts. Because of this relationship, plans will continue to look for community pharmacies to get involved in helping to improve the CMR completion rate. Review our CE, *Implementing MTM into a Community Practice* for tips on how to get involved in providing CMRs if you aren't already doing so. Approaches you can take include joining an MTM vendor's network of pharmacies and/or contracting directly with an MA-PD or Part D plan sponsor.

> Technicians can learn more about CMRs and how to help make the process more efficient by reviewing our technician tutorial, *Getting Involved in Medication Therapy Management and Medication Reviews*.

Medication Safety

> Why are elderly patients at a higher risk of adverse effects with drugs? What are some common drugs that are risky in the elderly? How does your pharmacy handle situations where elderly patients are prescribed a risky drug?

Several 2017 MA-PD and Part D display measures focus on medication safety: avoidance of drug-drug interactions, avoidance of excessive doses of diabetes medications, and use of atypical antipsychotics by elderly patients in nursing homes. One particular safety measure which will be included in the Part D 2017 Star Rating measurement (using 2015 data), but will move to a display measure for 2018 (using 2016 data), is the appropriate use of high-risk medications in the elderly measure. Despite this shift, this measure will still be important and monitored as a display measure. You also may encounter groups that will continue to focus on this measure and look for community pharmacies to help positively impact it. It's also important for overall quality of care and patient safety, which should always be top of mind.

High-risk Medications in the Elderly

Appropriate use of high-risk medications in elderly patients is often a challenging measure for plans to address. This measure looks at the percent of patients 65 and older who receive two or more fills for the same high-risk medication when there may be safer choices.[11] The measure was developed to promote patient safety in elderly patients who are more prone to problems with certain medications. Elderly patients are more sensitive to drug effects and don't eliminate meds as fast as younger patients. Plus, some medications have a higher risk of serious side effects in the elderly, which can outweigh the possible benefit of the drug.

The lower the percent of patients getting a high-risk med, the better. Below is a summary of how the Part D Star Rating for the individual measure is determined in 2017. This number is calculated based on the percent of the plan's patients getting two or more fills of a high-risk med during the measurement year.

Part D Cut points for 2017:[11]

One Star	Two Stars	Three Stars	Four Stars	Five Stars
> 15%	≤ 15% to > 9%	≤ 9% to > 5%	≤ 5% to > 3%	≤ 3%

So for example, if 6% of a plan's patients are getting two fills of a high-risk med, the plan would be assigned a three-star rating for this measure.

The target list of medications that are considered high-risk for the measure is a subset of the 2015 Beers criteria or "Beers list."

Common high-risk meds on the "target list" in 2017 include (note: list is NOT all-inclusive):[26]

Drug Class	Examples
First-generation antihistamines (alone or in combo products)	• Diphenhydramine (*Benadryl*, etc) • Chlorpheniramine (*Chlor-Trimeton*, etc) • Hydroxyzine (*Atarax*, etc) • Promethazine (*Phenergan*, etc)
Tricyclic antidepressants (alone or in combo products)	• Amitriptyline (*Elavil*, etc) • Clomipramine (*Anafranil*, etc) • Imipramine (*Tofranil*, etc) • Nortriptyline (*Pamelor*, etc)
Barbiturates	• Phenobarbital • Butalbital
Estrogens (oral and topical patch products, with or without progesterone)	• Estradiol (*Estrace*, *Climara*, etc) • Conjugated estrogens (*Premarin*, etc)
Long-duration sulfonylureas	• Glyburide (*Micronase*, etc) • Chlorpropamide (*Diabinese*, etc)
NSAIDs (oral and injectable)	• Indomethacin (*Indocin*, etc) • Ketorolac (*Toradol*, etc)
Skeletal muscle relaxants (alone or in combo products)	• Carisoprodol (*Soma*, etc) • Cyclobenzaprine (*Flexeril*, etc) • Metaxalone (*Skelaxin*, etc) • Methocarbamol (*Robaxin*, etc) • Orphenadrine (*Norflex*, etc)

Some of the other drugs included on the list have caveats. For example, the non-benzodiazepine hypnotics (zolpidem, eszopiclone, and zaleplon) are included if the cumulative days' supply for the measurement year is over 90 days (this applies to the drug class, and not for each individual medication). Nitrofurantoin is only included when used for more than 90 days during the measurement year. And digoxin is considered high-risk when it's used at a dose of higher than 0.125 mg per day.[26]

What You Can Do - Strategies for Improvement

A large Medicare Part D plan in your area reports that your pharmacy currently has the following percentages for the Star Rating adherence measure rate:

- Diabetes: 60%
- Statins: 58%

- RAS Antagonists: 63%

The plan also provides you with your high-risk medication measure score, which is 15%. The plan currently has a Star Rating of 3 and is reaching out to lower performing local pharmacies to help them improve their score.

What Star Rating scores do the diabetes adherence and high-risk medication measures line up with, assuming 2017 cut points? How can you improve upon these scores to help the plan get closer to a 4 or 5 Star Rating?

Now that you understand some of the quality measures getting a lot of attention in the industry, what can you do to help positively impact these measures? Review the table below for some improvement strategies. And keep in mind that even though the specific measure may change year to year, many of these strategies can be applied to new measures as well.

Selected 2017 Medication-Related Quality Measures and Strategies for Improvement

Medication-related measure/category	*How it's measured*	*Strategies for improvement*
Adherence	• % of patients with a PDC* >80% (Star Rating measures are specific to non-insulin diabetes meds, statins, and ACEI/ARBs) • The **higher** the %, the better	• Listen for patients complaining about cost, side effects, or multiple medications and alert the RPh • Watch for erratic refills in the patient profile and notify the RPh • Offer to enroll patients taking chronic meds in an automatic refill program or med sync, if your pharmacy offers it • Ask patients open-ended questions about how often they miss doses; for example, "I know it must be difficult to take all your medications regularly. How often do you miss taking them?" • Address cost concerns that could be causing nonadherence • RPhs should educate patients on the importance of their medication; use our patient education handouts to help • RPhs can use motivational interviewing techniques to help motivate patients who have difficulty with adherence • RPhs should recommend routines and reminders, such as linking doses with daily activities, smartphone apps or alarms, pillboxes, etc • Get more tips from our toolbox, *Medication Adherence Strategies*, our *Med Adherence Quick Guide*, our CE, *Optimizing Outcomes Through Medication Adherence*, and our technician tutorial, *Med Adherence 101*

Statin use in diabetes	• % of patients between 40 and 75 years with at least 2 diabetes med fills and a statin
	• The **higher** the %, the better
		• Keep patient profiles updated with age, medications, and medical conditions
		  ◦ A complete med list (including meds from other pharmacies, mail order, etc) can help the RPh see if a statin is missing
		• Techs should be familiar with meds used for diabetes and the names of statin medications
		  ◦ Get in the habit of scanning a diabetes patient's medication list and if a statin is missing, get the RPh involved
		• Pay attention to drug utilization review (DUR) messages from insurance companies flagging a missing statin and alert the RPh
		• Be familiar with reports your dispensing system can run - you may be able to generate a report to help identify gaps
		• RPhs can help prescribers understand why a statin may be beneficial with our letter, *A Note from Your Pharmacist: Using a Statin for Your Patient with Diabetes*
		• Keep in mind, once you succeed in getting a patient started on a statin, it's important to make sure they stay on the statin (and their diabetes meds) - refer to the "Adherence" section of this table

CMR completion rate	• % of patients enrolled in an MTM program who got a CMR
	• The higher the %, the better
		• Work with MTM vendors and popular plans in your area to help identify and reach out to eligible patients
		• Involve the entire team in helping out with the CMR process - each pharmacy team member should have a role
		  ◦ Techs can help obtain medication lists and histories, offer the service, identify patients, manage appointments, prepare documents, bill for the service, etc
		• Use a systematic process that works best for your pharmacy
		• Be familiar with the Medicare MTM standardized format
		• RPhs can use our worksheet to help streamline the review of med-related problems
		• RPhs should share what they are doing with prescribers to improve acceptance of recommendations
		  ◦ Use our letter, *Suggestion to Switch Medication*, to help with recommendations for drug therapy changes
		• Refer to our toolbox, *Medication Therapy Management* for more tips

High-risk medication (HRM) use in the elderly	• % of patients getting 2 or more fills of a high-risk med
	• The **lower** the %, the better
		• Know the list of meds considered high-risk
		  ◦ Print this out and keep it somewhere it could be easily referred to
		  ◦ Get familiar with HRMs that are common problems in your practice and address new Rxs for these right away by getting the RPh involved
		• Pay attention to DUR alerts warning of geriatric precautions and notify the RPh
		• Watch for insurance rejections since many plans aren't covering these meds; RPhs can use this as an opportunity to explain the risks of continuing to use HRMs
		• RPhs can use our chart, *Potentially Harmful Drugs in the Elderly: Beer's List* to identify alternative, safer options to suggest
		• RPhs can help prescribers understand why a different drug may be a better choice with our letter, *A Note from Your Pharmacist: Avoiding the Use of High-Risk Meds in Elderly Patients*

*PDC is the proportion of days covered. PDC is calculated by dividing the total number of days in a given time period that a patient would be "covered" by the medication (based on fill history), by the total possible number of days in that time period.

Collaborate and Communicate

You must be able to collaborate and communicate effectively with patients and other healthcare professionals in order to successfully provide high-quality care. For example, your ability to positively impact the statin use in diabetes measurement is only as good as your ability to communicate the needed therapy to the patient's prescriber. Collaborate with local prescribers and let them know upfront what types of initiatives you are focusing on and why. This way they will understand why you are reaching out to them. For example, some prescribers may not know very much about MTM and CMRs. So when they get CMR-related medication change requests from the pharmacy, they may disregard the requests without taking any action. They also may start to get irritated with the extra paperwork and request you to stop sending requests altogether. You are more likely to prevent this from happening by discussing upfront what you are doing and why. Find out how you can better communicate and collaborate with healthcare providers by reviewing our CE, *Healthcare Professional Communication - How to be More Effective*.

It's also important to make sure you are effectively communicating with patients. For example, adherence to medications cannot be improved without the patient's buy-in and cooperation. Check out our CEs, *Strategies for Communicating Effectively with Patients* and *Using Motivational Interviewing to Create Change* for patient communication strategies.

Tracking Performance

Knowledge of a pharmacy's baseline performance can be the key to understanding opportunities for improvement. Some plans may provide performance data to your pharmacy every so often such as once a quarter or once a year, but this information doesn't help much since it's providing data after-the-fact. Some pharmacy systems might track clinical parameters such as adherence in real-time based on dispensing data. If your system doesn't do this, there are several clinical software solutions available for purchase that may be able to integrate with your dispensing system. These products may be able to show you your scores on various quality measures based on your pharmacy's dispensing information. If you are looking to purchase clinical software for your pharmacy, make sure to spend time researching different companies and what they have to offer. Outline what you are looking to do now, but also think about what you might want to do in the future to help pick the best product. Develop a pro and con list for each product you review.

Another option that you may choose to pursue either in combination with clinical software or alone, is the Electronic Quality Improvement Platform for Plans and Pharmacies (EQuIPP). EQuIPP, managed by Pharmacy Quality Solutions, provides an online dashboard that allows pharmacy teams and health plans to evaluate their performance on various quality measures. It allows both plans and pharmacies to see where they are in impacting Star Ratings and other quality measures, where they can improve, and track progress toward achieving goals. It also helps pharmacy teams compare performance against other users. In some cases, pharmacy teams are accessing the platform at the pharmacy level, while in other cases the platform is being used by employers to track performance of groups of pharmacies. Check with your supervisor to find out if your pharmacy subscribes to EQuIPP and how to get access.

The Bottom Line

More focus on how pharmacies can impact Star Ratings and other quality measures will open the door for pharmacy teams to demonstrate the value they bring to patient care and the healthcare team. Pharmacy teams have a unique role in providing ongoing care and optimizing medication use for patients. Pharmacy collaboration with health plans, payers, prescribers, and health-systems is important for all groups to meet quality measures. Pharmacy teams that positively impact patient care, and help improve performance on quality measures, will increasingly be recognized and rewarded for their efforts.

Remember that new quality measures are continuously being developed, and CMS may change the quality measures it uses to determine Star Ratings. For the most up-to-date information, see the following resources:

- Medicare Part C and D performance data
  - http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html
- General Information on Quality Initiatives from CMS
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html
- Medicare Plan Finder
  - https://www.medicare.gov/find-a-plan/questions/home.aspx
- Pharmacy Quality Alliance (PQA)
  - http://www.pqaalliance.org/
- The National Quality Forum (NQF) is a nonprofit, membership-based organization that endorses quality measures that apply to a variety of healthcare settings. They offer a search tool to identify the quality measures that apply to your practice setting. You can also search by condition or measure steward.
  - http://www.qualityforum.org/Measures_Reports_Tools.aspx

Quiz Questions

Question #1

What would be an example of pay-for-performance?

- a. Reimbursement for flu vaccine administration
- b. Dispensing fee for a prescription
- c. Receiving payment for an office visit
- d. Getting a share of the cost savings from decreasing asthma exacerbations

Question #2

What is the main goal of shifting away from fee-for-service and towards pay-for-performance payment models?

- a. To provide a higher volume of services
- b. To increase healthcare utilization
- c. To provide high-quality care
- d. To increase provider satisfaction

Question #3

Which statement should you include as part of an in-service to educate your staff on the Medicare Star Rating program?

- a. Measures related to patient satisfaction have the highest weight.
- b. Quality measures don't change very often; maybe once every few years.
- c. Medicare Part C and D plans are assessed using the same quality measures.
- d. Star Rating scores reflect data from two years prior.

Question #4

Your colleague is explaining the Star Rating program to a new pharmacy technician. You overhear him telling the technician not to worry about display measures, since plans don't typically pay attention to them. How would you react to this statement?

- a. Disagree, and explain that plans with poor performance may be penalized.
- b. Agree, and explain that display measures don't count in the overall Star Rating score.
- c. Disagree, and explain that display measures count towards the Star Rating score.
- d. Agree, and explain that display measures aren't typically medication-related anyway.

Question #5

Why is it important for pharmacies to focus on helping plans improve quality measure scores?

- a. To get bonus payments for the pharmacy from CMS
- b. To increase the pharmacy's Star Rating score
- c. To improve the chances that the pharmacy will be included in preferred networks
- d. To obtain a marketing edge for the pharmacy on the Medicare Plan Finder website

Question #6

Your pharmacy manager asks the pharmacy staff to start focusing on quality measures that impact the Medicare Part D Star Rating program. Assuming it is the year 2017, what are the three drug groups that the pharmacy staff should start focusing on as part of the adherence category?

- a. Asthma meds, beta blockers, SSRIs
- b. Non-insulin diabetes meds, statins, RAS antagonists
- c. Heart failure meds, bisphosphonates, PPIs
- d. Behavioral health meds, blood thinners, NMDA antagonists

Question #7

A 50-year-old patient with diabetes requests a refill on their metformin for diabetes and losartan for high blood pressure. What type of drug should you look for on their medication list that can help decrease cardiovascular risk?

- a. Statin
- b. ACE inhibitor
- c. Bile acid sequestrant
- d. Nothing, metformin is enough

Question #8

According to the 2017 CMS criteria for MTM program member eligibility, which patient would be most likely to be targeted by a Part D plan for the provision of MTM services and be included in the CMR completion rate measurement?

- a. 65-year-old with diabetes taking metformin
- b. 67-year-old with anxiety and depression taking sertraline
- c. 70-year-old with COPD, high blood pressure, and high cholesterol using 3 inhalers, 2 blood pressure lowering drugs, and a statin
- d. 72-year-old with low iron, low calcium, and poor appetite taking OTC iron and calcium supplements and liquid oral nutrition

Question #9

How could technicians get involved in the CMR process to help improve a pharmacy's CMR completion rate?

- a. Identify medication-related problems and discuss them with the patient.
- b. Technicians cannot get involved in the CMR process since this is a pharmacist task.
- c. Sign off on and submit completed MTM standard format documentation to the plan.
- d. Get medication lists and histories from the patient to help create the Personal Medication Record.

Question #10

Mary is a 68-year-old patient who is taking metformin, insulin, lisinopril, rosuvastatin, and levothyroxine. You notice erratic filling patterns with her metformin, lisinopril, and rosuvastatin so you ask her, “I know it must be difficult to take all your medications regularly. How often do you miss taking them?” She admits she often forgets to refill or pick up some of her meds, but says she is good about refilling her insulin and levothyroxine on time because if she doesn’t take her levothyroxine she doesn’t feel good and if she doesn’t use insulin her blood sugar readings get too high. Which strategy can best help Mary improve adherence to her other meds?

- a. Offering to enroll her in a med sync program to get all refills on the same day each month
- b. Suggesting a drug that is a combination of metformin, lisinopril, and rosuvastatin
- c. Reaching out to the prescriber to see if the meds she is forgetting can be discontinued
- d. Providing suggestions to help lower the cost of her medications

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