Optimizing Health by Advancing the Quality of Medication Use

PQA Update on Development of Pharmacy Measures

September 26, 2019

The Pharmacy Quality Alliance (PQA) is developing a standard set of measures that would be appropriate for pharmacy-level accountability. The first phase of this work is the development of pharmacy measures adapted from existing PQA health plan measures. This work is taking place in the short term and is expected to be completed in January 2020. The development of de novo pharmacy measures, a longer-term effort, will begin in early 2020.

This document provides an update on PQA's short-term development of pharmacy measures. Periodic updates will be provided to ensure PQA members and stakeholders have timely information about this important work. This update is focused on:

- The process and timeline for developing pharmacy-level measures adapted from health plan measures; and
- Comments PQA received and PQA's responses to those comments.

PQA's Pharmacy Measure Development Process and Timeline

PQA is developing pharmacy measures that were prioritized by multi-stakeholder participants in a July 31-August 1 workshop. Background on the workshop and its consensus is provided in an August 22 PQA memo.

An open comment period on the "Proposed Standard Measure Set for Pharmacy Accountability in Value-Based Models" took place August 22-September 6. Appendix A of this update provides the comments' broad themes and PQA's responses.

Virtually all commenters had questions regarding data sources and data flow. Those comments are featured in the first "Broad Theme" addressed in Appendix A. Given the importance and complexity of this issue, Appendix B addresses "Differentiating Data Sources for Short-Term Development of Pharmacy-Level Performance Measures" in depth. All comments received help shape PQA's measure development and provide an opportunity for PQA to clarify the goals, opportunities and constraints of this work.

This month, PQA appointed a Pharmacy Measures Technical Expert Panel (TEP) to provide input on pharmacy-patient attribution models and draft measure concept specifications. The 15 members of the TEP are:

- Laurin Dixon, Humana
- Mike Duteau, Kinney Drug
- Richard Erickson, patient
- Laura Jester, Navitus
- Jacob Jolly, Vanderbilt
- Crystal Lennartz, HealthMart
- Tripp Logan, National Community Pharmacists Association
- Aliya Mansoor, UnitedHealthcare
- Arpana Mathur, CVS Health
- Matt Osterhaus, Osterhaus Pharmacy
- Brian Roland, Aetna
- Micaila Ruiz, Amber Pharmacy
- Arlene Salamendra, patient
- Stephanie Taylor, IngenioRx
- Mike Umbleby, Walgreens

PQA's Quality Metrics Expert Panel (QMEP) will review the draft measure specifications and testing plans. PQA staff will conduct testing to evaluate the reliability and validity of the measures. The QMEP will review the testing results, consider the draft measures against PQA's Measure Criteria (measure importance, scientific acceptability, feasibility and usability) and vote on recommending the draft measures for PQA endorsement consideration. Appendix C lists the 22 QMEP members and explains the panel's selection, terms, representation and charge. For draft measures recommended by the QMEP for endorsement consideration, a second open comment period and an all-member webinar will be held before a PQA endorsement vote. The following table (Table 1) summarizes the timeline for these activities.

Table 1.

PQA's Pharmacy Measure Development Timeline (September 2019-January 2020) for pharmacy measures adapted from existing PQA health plan measures	
TEP input into pharmacy-patient attribution models and draft measure concept specifications	September-December 2019
QMEP review of draft measure specifications, testing plans and testing results	September-December 2019
Open comment period	December 2019-January 2020
All-member webinar	January 2020
PQA endorsement vote	January 2020

After development of the pharmacy measures adapted from existing PQA health plan measures (a short-term development process), PQA's work on de novo pharmacy measures will begin in early 2020 (a longer-term development process.

Questions about PQA's pharmacy measure development should be directed to PQA's Performance Measurement Team at MeasureDev@pqaalliance.org.

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Appendix A

Public Comments Received on PQA's Short-Term Pharmacy Measure Development

Background

Community and specialty pharmacy providers have advocated for the development of a new standard set of measures that can be used in pharmacy-plan and pharmacy-PBM agreements. The Centers for Medicare & Medicaid Services (CMS) and the U.S. Congress, through proposed regulation and legislation, have also demonstrated interest in a new standard set of measures. To address this interest, PQA hosted an in-person, workshop to inform its measure development strategy and to gain input on and develop consensus for a standard set of measures that would be appropriate for pharmacy-level accountability. Workshop participants reached consensus on prioritized measures that could be incorporated in value-based models in Medicare Part D and other programs in the future.

To gain further insight on the proposed measure set and on PQA's approach to pharmacy-level measure development, PQA held an open comment period from August 22-September 6, 2019. A total of 30 comments were received. This document summarizes comments and provides PQA responses related to the short-term development of pharmacy-level measures to be adapted from existing PQA health plan measures. Please note that this is a summary-level document and is not intended to address every aspect of each comment received.

Broad Themes

Data Sources and Data Flow
Virtually all commenters had questions regarding data sources and data flow. Particular areas of focus included whether the measures will use pharmacy system data (often referred to as pharmacy dispensing data) or administrative claims, potential inclusion of cash claims or claims submitted to GoodRx, if or how pharmacies will report data to health plans or CMS (including whether third party entities would be involved), and how the measures will be tested. Commenters also noted that some data elements, both administrative (e.g. payer type) and clinical (e.g. lab values), may be difficult to obtain, and that the inability to capture measure exclusions may unfairly penalize pharmacies.

Some commenters advocated for use of pharmacy system data, while others advocated for the use of administrative data. Commenters noted that data reporting will need to be standardized and consistent and questioned if this would necessitate updates within NCPDP or require consideration of nomenclature differences across data sources (e.g. administrative vs. pharmacy system data).

PQA Response:
PQA is committed to ensuring that adapted measures are adequately tested to demonstrate reliability and validity before being deployed, including measure exclusion testing. Although PQA acknowledges that pharmacy system data provide rich information and may be valuable for future measure development, PQA plans to specify the adapted measures using administrative claims data for short-term feasibility reasons. Similarly, given the constrained timeframe for the short-term development efforts, PQA does not plan to include cash claims or claims submitted to GoodRx or other similar entities. These types of data can be explored for future measure development or refinement of existing

measures. PQA would also like to assure stakeholders that the pharmacy measures will be specified to promote consistent, standardized quality measurement.

Please see Appendix B, which provides more information on "Differentiating Data Sources for Short-Term Development of Pharmacy-Level Performance Measures."

Attribution and Denominator Sizes
Commenters had questions, either broadly or for specific measures, regarding how patients would be attributed to pharmacies. Commenters emphasized that consistency in attribution is critical for sound measurement and noted that measurement periods may need to be extended for pharmacy-level measures. Commenters also noted that these measures may encounter small (or even zero) denominators due to small patient populations and encouraged discussion of potential solutions such as chain-level scoring where applicable.

PQA Response:
PQA appreciates commenters' thoughtful questions on attribution and denominator sizes, which have been the subject of considerable discussion within PQA's Performance Measurement Team. With guidance and input from a multi-stakeholder Technical Expert Panel, and in keeping with principles outlined in consensus materials such as NQF's Attribution Project, PQA is developing attribution models to measure pharmacy quality in a fair and consistent way. PQA would also like to clarify that to ensure sufficient reliability, pharmacies should not be held accountable to measures for which they do not have an adequate denominator size. For example, PQA's health plan measures require a minimum denominator size of 30. PQA intends to test the pharmacy measures stratified by line of business (i.e., Medicare, Medicaid and commercial) and by plan. However, evaluating pharmacies by line of business, inclusive of all claims by payer type, may mitigate challenges with small denominators and may be more representative of performance.

Pharmacy Ability to Influence Measures
Commenters noted concerns about the ability of pharmacists to influence certain measures (e.g. versus prescribers). For example, a pharmacist could recommend that a patient receive a statin, but the ultimate decision to change the regimen may lie with the prescriber. Commenters recommended that PQA carefully consider the degree to which pharmacists can influence the desired result of a measure.

PQA Response:
It is imperative that pharmacists only be held accountable to measures that they are able to influence. PQA will continue to evaluate, through conversations with the Technical Expert Panel as well as internal and external stakeholders, the extent to which pharmacies are able to effectively influence the proposed measures.

Stratification
Commenters noted that performance varies based on payer type (i.e. Medicare, Medicaid, commercial) and requested information on whether specific measures might apply to specific payer types. Some commenters recommended stratification of results because payers are chiefly concerned with performance in their population, while other commenters noted that the data required to stratify by payer type may be difficult to extract.

PQA Response:
PQA acknowledges that performance on quality measures varies based on payer type due to the different characteristics of the underlying populations. For this reason, PQA anticipates that measures will be implemented by line of business, pending further discussion and input from the Technical Expert Panel and other stakeholders and testing. Regarding potential difficulty capturing payer data, PQA does not anticipate issues because these measures will be calculated using administrative claims data.

Terminology
Commenters asked for clarification on the specific definition of community versus specialty pharmacy, and whether these definitions will carry attribution implications. A handful of commenters requested that "pharmacy accountability" not be used in association with this measure set, and that a term that implies collaborative relationships with patients and providers be used.

PQA Response:
PQA appreciates the opportunity to clarify that the distinction between community and specialty pharmacy, while valuable in conceptualizing and discussing measures, should not carry operational or attribution implications. PQA envisions pharmacies reporting on individual measures based on meeting minimum denominator sizes, rather than based on a specialty or community pharmacy designation. PQA believes this approach is in keeping with measurement science and ensures that pharmacies are only held accountable to measures that are reliable and relevant to the populations they serve.

The pharmacy measures under development are intended to be performance measures which may be used in accountability programs (e.g., public reporting, benchmarking, external comparisons, performance payments). We will seek additional stakeholder input on terminology for a set of pharmacy performance measures.

Harmonization and Alignment
Commenters emphasized that pharmacy-level measures must align with health plan and physician measures to be effective. Commenters also noted that PQA should identify any other developers working on pharmacy-level measures and ensure that measures are harmonized and effort is not being duplicated. Commenters also noted that measures should take potential for duplicative services (e.g. clinical services performed by physicians and pharmacies) into account and should emphasize the importance of communication across the care team.

PQA Response:
PQA is aware of the need to develop measures that align incentives across the entire care team, including emphasizing coordination and communication to avoid duplicative services. PQA is committed to harmonizing with other developers to reduce reporting burden; however, PQA is not aware of any parallel efforts to develop standardized, nationally endorsed pharmacy performance measures at this time.

Timelines
Some commenters agreed with proposed timelines to meet short-term needs, while a handful of commenters voiced concerns that proposed timelines may be difficult to achieve, especially given infrastructure limitations and the burden associated with implementation. Commenters also requested clarification on whether medium- and long-term measures would replace short-term measures.

PQA Response:
PQA is grateful for commenters sharing their thoughts on proposed timelines. PQA acknowledges that the proposed timelines require an accelerated development and implementation process. However, based on extensive conversations during the multi-stakeholder workshop and in other venues, PQA strongly believes that these measures respond to a significant and immediate need in the market. Developing measures that are specifically designed and tested for pharmacy-level use will enable fairer, more consistent, and more transparent quality measurement that ultimately benefits pharmacies, health plans, and most importantly, patients.

PQA would also like to emphasize that in this context, 'short-term', 'medium-term', and 'long-term' refer to development timeline rather than intended measure use. Short-term measures are not planned to be phased out when medium- and long-term measures are completed. PQA will consider potential retirement of pharmacy measures using its defined transparent, multi-stakeholder process as would be used when considering retirement of any PQA-endorsed measure. Reasons for retirement may include but are not limited to the closing of a performance gap ('topping out'), lack of use, development of a new measure that addresses the need in a better way, or clinical guidelines no longer support the intent of the measure.

Implementation
Commenters recommended that PQA provide further guidance with implementation, especially regarding data flow and how measures will be reported.

PQA Response:
As the short-term measures are refined, PQA will continue to provide further information on envisioned measure use. As we approach completion of the development of this measure set (with endorsement vote in January 2020), we encourage the voluntary adoption of these measures for use within pharmacy-plan agreements and between pharmacy-PBM agreements for Medicare Plan Year 2021. We recognize that health plan measures are being used to hold pharmacies accountable in contractual arrangements, and this was not the intended use of these measures. PQA measures should be used as intended and specified, including the level of analysis for which the measures are tested and endorsed. Through our new licensing policy to be released in October 2019 and through the development of pharmacy-level measures, it is our intent to correct the inappropriate use of PQA measures to the extent within our control.

Inclusion of LTC and Mail Order pharmacy
Commenters asked for clarification on whether the pharmacy measures will include mail order or long-term care pharmacies.

PQA Response:
PQA appreciates commenters' opinions on the inclusion of mail order and long-term care pharmacies in the proposed measure set. PQA will continue to deliberate with the Technical Expert Panel and may also explore this question during measure testing.

New Measure Concepts
Commenters suggested a variety of new measure concepts for future inclusion in a pharmacy-level measure set.

PQA Response:
PQA deeply appreciates commenters' thoughtful suggestion for future pharmacy-level measure concepts. These concepts will be considered by a pharmacy measures advisory group that will be convened in early 2020 in order to refine and advance the mid- and longer-term pharmacy-level measure development efforts.

Measure-Specific Comments: Community Pharmacy

Concurrent Use of Opioids and Benzodiazepines (COB)
One commenter requested clarification on how the measure would be scored. One commenter expressed concern that this measure may not be directly influenceable by pharmacists as they do not have authority to change what is being prescribed, and recommended it be weighted accordingly.

PQA Response:
PQA would like to clarify that a lower rate on this measure indicates better performance. PQA will continue to carefully evaluate the degree to which pharmacists can influence what is being evaluated in each proposed measure. In the case of COB, pharmacists could coordinate with the prescriber to discuss potential alternatives. However, PQA staff are concerned that a pharmacy-level COB measure could have the unintended consequence of pharmacists refusing to fill prescriptions for opioids or benzodiazepines, which could adversely impact patient care. We will seek further stakeholder feedback on the appropriateness of COB as a pharmacy-level measure.

Statin Use in Persons with Diabetes (SUPD)
One commenter noted that not all patients on diabetes need statins. A pair of commenters recommended that development or implementation of this measure be deferred, noting that some pharmacists are currently struggling to influence the health plan version of the measure. One commenter expressed concern that this measure may not be directly influenceable by pharmacists as they do not have authority to change what is being prescribed, and recommended it be weighted accordingly.

PQA Response:
PQA notes that the SUPD measure is based on clinical evidence, including American Diabetes Association guidelines that recommend statins as first-line lipid lowering medication in patients with diabetes who are 40-75 years of age, regardless of risk factors. However, PQA does acknowledge that claims data may not include sufficient information to capture specific cases where statin prescription may be inappropriate, such as cases of adverse reactions; for this reason, expected performance is not 100%. PQA will continue to carefully evaluate the degree to which pharmacists can influence each proposed measure. In the case of SUPD, PQA believes that pharmacists are able to influence performance by coordinating with the prescriber to encourage appropriate prescription of statins, but PQA acknowledges that this degree of influence may be lower than other measures.

Proportion of Days Covered: Diabetes All Class, Renin Angiotensin System Antagonists, Statins (PDC-DR, PDC-RASA, PDC-STA)
A pair of commenters asked about the effects of auto-fills and potential skewing. One commenter noted that PDC performance can be affected by patient transfers between pharmacies and recommended greater reporting transparency to assess performance against industry averages. One commenter asked which group (e.g. pharmacists, physicians, etc.) should hold ultimate responsibility for adherence. One commenter noted that PDC is a surrogate measure of adherence and requested that PDC calculations be

standardized. One commenter requested confirmation that PDC target thresholds (i.e. 80%) are in keeping with clinical evidence. One commenter suggested that PDC measures are appropriate in the short term but should be phased out after other pharmacy-level measures are specified.

PQA Response:
PQA assures commenters that standard PDC logic will be clearly defined in measure specifications. The 80% PDC threshold is based on current clinical evidence. Regarding potential phase-out, as discussed above, PQA measures are considered for retirement using our standard consensus-based process. PQA appreciates the recommendation that performance be compared against benchmarks and will consider this during testing. Regarding responsibility, PQA acknowledges that adherence should be addressed at multiple levels of the care team but reaffirms pharmacists' critical role and ability to positively influence adherence.

MTM Program Completion Rate for Comprehensive Medication Review (CMR)
Some commenters expressed support for the measure, although several also expressed concerns. Many concerns were related to the lack of standardization of MTM programs and implementation across plan sponsors, especially due to utilization of vendors to complete CMRs, as well as variability in CMR completion due to volume caps, and targeted goals. Because not all community pharmacies provide MTM services, one commenter felt that MTM measures were not appropriate for pharmacy measurement. A pair of commenters asked how pharmacies will determine if patients are CMR eligible, and one asked whether CMRs will occur via phone or in-person. One commenter also noted that CMRs require a longer visit to the pharmacy, which may challenge patients' views of pharmacy visits and may take time to achieve.

PQA Response:
PQA appreciates the opinions of the commenters and is understanding of their concerns regarding the CMR measure. Due to testing barriers and additional work required to develop a fair attribution model, PQA does not anticipate that the CMR measure will be completed by January 2020. However, PQA is aware that CMR is a valuable service that is important to patients, pharmacists, and health plans, and will take these comments into consideration during the continued development of this measure. We will reach out to subject matter experts for more input.

Polypharmacy: Use of Multiple Anticholinergics in Older Adults (POLY-ACH)
A pair of commenters recommended that development or implementation of this measure be deferred until full detail is available on data capture and attribution. A pair of commenters expressed concern that this measure may not be directly influenceable by pharmacists and recommended that PQA consider how prescribers impact success on the measure. One commenter recommended that the measure be weighted to reflect pharmacies' limited ability to influence it. One commenter recommended removing "polypharmacy" from the name to avoid confusion and noted that pharmacies may struggle to obtain the data needed to mitigate polypharmacy when patients visit multiple pharmacies.

PQA Response:
PQA understands that establishing a fair attribution model for this measure will be essential and that pharmacies may not have visibility to all of the medications a patient is taking. In terms of the ability to influence the measure, a pharmacist could coordinate with the prescriber to discuss potential therapeutic alternatives. However, PQA will continue to carefully evaluate the degree to which pharmacists can influence each proposed measure.

Proportion of Days Covered: Antiretroviral Medications (PDC-ARV)
A pair of commenters noted that not all patients require three antiretroviral medications and asked how the measure would take this into account. One commenter asked if the 90% adherence rate applies to all three medications. One commenter asked about relative significance of results given potential small denominator sizes. One commenter was concerned that these medications can be dispensed at specialty, mail, or retail pharmacies under the same plan benefit, which may result in patients getting the first fill in one setting and the second fill in another setting. One commenter noted that the measure may be hard to control if it is implemented for both specialty and community pharmacy.

PQA Response:
Although most antiretroviral regimens include three medications, PQA acknowledges that it is critical that this measure stay up-to-date with the rapidly changing landscape of HIV therapies, including therapies that may not require three antiretroviral medications. We will bring this to the Measure Update Panel for consideration for the existing health plan measure and harmonize any changes with the proposed pharmacy measure. The 90% adherence rate applies to days covered by all three antiretroviral medications concurrently; the formula and steps involved in PDC calculation will be provided in detail within the measure specifications. Regarding the relative significance of results, PQA would like to clarify that pharmacies should not be required to report on measures for which they do not have adequate denominator sizes. PQA will continue to evaluate the effects of medications being dispensed at different types of pharmacies under the same benefit and the ways in which this affects the measure.

Measure-Specific Comments: Specialty Pharmacy

Treatment of Chronic Hepatitis C: Completion of Therapy (HCV)
One commenter recommended considering reporting sustained virologic response at 12 weeks after treatment completion. One commenter asked if this measure will mirror the URAC measure to only target direct acting HCV treatments with finite duration of treatment, and suggested completion based on recommended duration of treatment versus days' supply received. One commenter noted that lab values should not be a considered as a data source, because this data is difficult to obtain and may not be available until the patient has been discharged from specialty pharmacy services. One commenter noted that pharmacies may not be fully responsible for completion of treatment, as approval for treatment may be overturned and denied by health plans. A pair of commenters asked for clarification on the definition of a "significant gap" in therapy.

PQA Response:
PQA notes that URAC uses PQA's health plan-level version of this measure and anticipates that the pharmacy-level version will mirror that version. At this time, the measure is not anticipated to use lab data. A significant gap in therapy will be clearly defined in the measure specifications; for the health plan-version of this measure, a significant gap is defined as >15 days without supply between the first and last fill. While sustained virologic response at 12 weeks is a valuable outcome to track, it falls outside the scope of this measure and would require separate development, clinical data, and testing. PQA will continue to carefully evaluate the degree to which pharmacists can influence each proposed measure and appreciate commenters' notes on treatments for HCV being denied by health plans.

Adherence to Non-infused Disease Modifying Agents Used to Treat Multiple Sclerosis (PDC-MS)
One commenter voiced concern that patients may initially receive medications from one pharmacy type (e.g. retail) but then switch to another (e.g. mail-order). One commenter asked how in-office samples

for branded medication, and transfers of branded medication (e.g. to the manufacturer) for copay assistance, would be handled. One commenter noted that drug dosing adjustments may affect adherence scores and suggested that pharmacies have the opportunity to submit supporting evidence or disease assessment scores to demonstrate adequate treatment when patient-specific factors cause adherence to appear low.

PQA Response:
PQA appreciates these comments and will discuss the effects of transfers and in-office samples on measure performance. However, we do not believe this would impact some pharmacies more that others. PQA will also continue to consider how switching pharmacies affects attribution and will consider the effects of drug dosing adjustments and other situations that affect adherence scores.

Adherence to Non-infused Biologic Medications Used to Treat Rheumatoid Arthritis (PDC-RA)
One commenter noted that patients frequently "hold" a dose of medication in clinical scenarios of concomitant infection, surgical procedure, etc. which may impact adherence. One commenter noted concern regarding feasibility of measuring true adherence and potential unintended consequences. One commenter noted that drug dosing adjustments may affect adherence scores and suggested that pharmacies can submit supporting evidence or disease assessment scores to demonstrate adequate treatment when patient-specific factors cause adherence to appear low.

PQA Response:
PQA acknowledges that patients holding medications in certain situations and dosage adjustments could influence the refill patterns. However, we do not believe this would impact some pharmacies more than others. s. PQA notes that while proportion of days covered is an imperfect measure of adherence, it is correlated with improved outcomes and is feasible to measure.

Appendix B

Differentiating Data Sources for Short-Term Development of Pharmacy-Level Performance Measures

Background

PQA is in the process of adapting existing PQA health plan performance measures for a prioritized set of pharmacy-level performance measures. The data source for the short-term pharmacy measures will be prescription claims to accommodate the need for expedited development and testing of measures by December 2019. The use of pharmacy system data is not a feasible, short-term solution, and therefore, PQA will explore the use of pharmacy system data for longer-term measure development.

Current and Aspirational Sources for Pharmacy Performance Measures

Currently, prescription claims data are commonly used for performance measures and are considered a valid and reliable data source. However, there are known limitations to claims-based performance measurement. As technology advances, PQA is interested in testing pharmacy system data as little is known about the feasibility, reliability, validity, and usability of these data for performance measurement. This information will be essential because PQA measures must meet standard measure criteria to be used for performance-based accountability applications.

Prescription Claims Data

Prescription claims capture transactions between patients, pharmacy providers, and health care payers. For many health payers, pharmacy benefit management (PBM) companies serve as the fiscal intermediary between themselves and pharmacy providers. As a result, prescription claims data derived from PBMs, which are often shared with health payers, are a standardized source of prescription drug information used for retrospective pharmacy research and health plan performance measures. There are financial incentives for pharmacies to submit claims, however, there are many reasons why this may not occur:

- The pharmacy may not want the claim to be subject to a direct and indirect remuneration (DIR) fee
- The prescription may cost less than the amount of a copay, therefore the patient pays out-of-pocket
- The prescription may be for a non-covered item
- The prescription may require prior-authorization, and the patient may choose to pay out-of-pocket
- The patient may request confidentiality and ask the prescription not to be processed via insurance
- The patient may have exceeded a cap or maximum limit and must pay out-of-pocket
- The patient may have two insurance plans and not all prescription claims are captured at a single PBM

When prescription claims records are not provided to the PBM, there is the potential for measurement bias and underestimation of prescription utilization and costs. Therefore, while prescription claims are a reliable and standardized data source, the use of other supplemental data sources (e.g., pharmacy system data) may provide more information on patient medication use and exposure.

Pharmacy System Data

Pharmacy system data includes pharmacy operations, prescription processing and dispensing, and clinical services information for pharmacies. Pharmacy system data include prescription data from the

point of a prescription being received by a pharmacy (e.g., electronic prescription, in-person drop off) to the point of dispensing. These data include prescription pickup, transfer, or inactive/on-hold status information. Pharmacy system data include all fills, regardless of submission via a claim to a PBM. However, for patients filling at more than one pharmacy or pharmacy chain, the pharmacy system may not have a complete picture of a patient's medication exposure. Prior to use as a data source for performance measures, testing of pharmacy system data will be important to determine if these data can not only produce consistent and meaningful results but also that these data are a valid source for performance measurement. Last, implementation opportunities for PQA performance measures using pharmacy systems as a data source is not well understood and further multi-stakeholder discussion is needed.

Related Research Comparing Pharmacy Data Sources

Little is known about the validity and reliability of pharmacy system data. Research has compared these data to pharmacy claims data, with mixed results. In addition, to date, there is a dearth of literature regarding the use of pharmacy system data for performance measurement.

Martin et al. 2014[1] analyzed the completeness of prescription claims data at a large PBM using pharmacy system dispensing data as a comparator. They found that the majority (n=2,754, 92.5%) of prescription records appeared on both the pharmacy and PBM prescription sources with the remaining (n=207, 7.0%) that appeared only on the pharmacy profiles corresponding to a PPV=99.42% and sensitivity=93.01%. However, there was wide variability by drug class.

Marcum et al. 2014[2] explored the impact of multiple pharmacy use on medication adherence rates using pharmacy claims data. They estimated medication adherence using proportion of days covered ≥0.80. They found that 38.1% of their sample used multiple pharmacies and that those using multiple pharmacies (both concurrently and sequentially) consistently had higher adjusted odds of non-adherence (ranging from 1.10 to 1.31, $p<0.001$) across all medication classes assessed, compared to patients using a single pharmacy.

Research Gaps that Should be Addressed by Stakeholders in the Longer-Term

- Pharmacy systems data may be useful as health information technology and industry standards evolve. These data will need to be tested for validity as a data source for performance measures.
- How do pharmacy claims and pharmacy system dispensing data compare in regard to the complete picture of medication use/exposure?
- When doing research with pharmacy system data, is it feasible/impactful to group pharmacies by chain (pharmacies which share data)?
- What solutions are available to aggregate pharmacy system data across pharmacies? What regional or state-level variation exists across the county?
- How standardized are pharmacy systems for documentation and reporting for performance measurement?

Date prepared: 09/10/2019

[1] Martin BC, Shewale A. Validity of electronic prescription claims records: a comparison of commercial insurance claims with pharmacy provider derived records . Innov Pharm 2014;5(1). Accessed September 6, 2019.
[2] Marcum ZA, Driessen J, Thorpe CT, Gellad WF, Donohue JM. Effect of multiple pharmacy use on medication adherence and drug-drug interactions in older adults with Medicare Part D. J Am Geriatr Soc. 2014;62(2):244–252. doi:10.1111/jgs.12645. Accessed September 6, 2019.

Appendix C

2019 PQA Quality Metrics Expert Panel

First Name	Last Name	Organization
Ben	Banahan	University of Mississippi
Amanda	Brummel*	Fairview
Lynn	Deguzman	Kaiser Permanente
Marybeth	Farquhar	URAC
Jessica	Frank	OutcomesMTM
Shellie	Keast*	University of Oklahoma
Alice	Lee Martin	CMS
Crystal	Lennartz	McKesson
Jenny	Ciganic	University of Florida
Tripp	Logan	MedHere Today
Jonathan	Magness	Magellan Health
Jeff	Pohler	Enhanced Medication Services
Dan	Rehrauer	HealthPartners
Steve	Riddle	Wolters Kluwer Health
Craig	Schilling	AstraZeneca, LP
David	Stauffer	Walgreens
Stephanie	Taylor	InginioRx
Christi	Teigland	Inovalon
Jennifer	Van Meter	Novartis
Jenny	Weber	N/A
Keith	Widmer	Express Scripts
Salina	Wong	Blue Shield CA

* 2019 Co-Chair

Charge of the QMEP

- Evaluating measure concepts proposed by PQA measure development teams and task forces;
- Prioritizing measure concepts for specification and testing;
- Reviewing comments from PQA members on draft measures to determine whether modifications should be made or what variations should be considered during testing;
- Reviewing results of draft measure pilot testing; *and*
- Making final recommendations to PQA membership regarding endorsement consideration of draft measures and/or retirement of endorsed measures.

Panel Selection, Term Limits, and Representation

- QMEP members are selected from PQA membership through an application process and may serve up to two 3-year terms.

- QMEP applicants are selected for a limited number of available seats based on their leadership experience in PQA measure development as well as their specific expertise (clinical, analytics, measurement, and quality improvement).
- Selection of QMEP members is also based on maintaining a balanced representation of the membership. It is unlikely the QMEP will include two individuals from the same organization.
- If members are unable to fulfill their term, the position cannot be delegated to another person by the QMEP member. PQA staff will consider whether the vacant seat will be filled.
- QMEP members do not represent an organization.
- QMEP members who change jobs and are no longer affiliated with a PQA member organization should discuss their continued involvement on the QMEP with PQA staff.

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