

Intersection of Quality Metrics and Medicare Policy

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The importance of medications to the treatment of chronic disease has received increased attention since implementation of the Medicare Part D drug benefit. The use of medications by the elderly increased after the implementation of Part D. The Congressional Budget Office has projected that Medicare annual expenditures on Part D medications will triple from \$53 billion in 2009 to nearly \$160 billion in 2019.¹ Unfortunately, there is evidence that many patients experience preventable adverse medication-related events or fail to receive appropriate drug therapy because of the shortcomings of our complex and disjointed medication use system in the US.² Researchers have estimated that for every dollar we spend on pharmaceuticals, we spend another dollar on treating the problems that stem from suboptimal medication use, thus wasting billions of dollars in health care resources every year.³

Although the costs of health care are well documented and highly publicized, the quality of the health care system has been more challenging to measure. The Department of Health and Human Services is repositioning the federal government to be a value-based purchaser of health care services that seeks to maximize quality while also controlling costs. To drive improvements in quality, the Centers for Medicare & Medicaid Services (CMS) has implemented a performance evaluation system for Medicare Parts C and D, as well as a quality-based payment program for Medicare Advantage plans.⁴ Medicare Part C is also known as Medicare Advantage, wherein Medicare beneficiaries enroll in private health plans that provide them with

The federal government is increasing its push for a high-value health care system by increasing transparency and accountability related to quality. The Medicare program has begun to publicly rate the quality of Medicare plans, including prescription drug plans, and is transforming its payment policies to reward plans that deliver the highest levels of quality. These policies will have a cascade effect on pharmacies and pharmacists as the Medicare plans look for assistance in improving the quality of medication use. This commentary describes the Medicare policies directed toward improvement of quality and their effect on pharmacy payment and opportunities for pharmacists to affirm their role in a high-quality medication use system.

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medical coverage. Medicare Part D is the optional drug benefit for Medicare beneficiaries who remain in traditional Medicare (Parts A and B) and add a prescription drug plan or select a Medicare Advantage plan that also provides prescription drug benefits (MA-PD). The public reports on Medicare plan quality take the form of star ratings that are available to Medicare beneficiaries when choosing a Part C/D plan. The star ratings provide an overall rating of the plan as well as stars for different domains of care and specific quality measures, all of which are presented on a scale of 1-5 stars.

The star rating system for Medicare Part C contains 36 measures of quality and is largely based on the Health Plan Employer Data Information Set measures from the National Committee for Quality Assurance (NCQA).⁵ The evaluation system for Part D is multifaceted and includes not only 17 measures of quality to determine the star ratings for drug plans but also several more measures of medication safety that are used only for performance feedback to the drug plans (known as the Display Measures). It is important to note that MA-PD plans are evaluated using both the Part C and Part D measures of quality. Many of the quality measures for Parts C/D address issues that can be

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affected by pharmacists. For example, the Part C measures include rates for adult immunizations, appropriate use of medications for rheumatoid arthritis and osteoporosis, and achievement of therapeutic targets for blood pressure, blood glucose, and cholesterol. Additionally, the plans that serve special needs populations are also evaluated on whether the patients receive an annual medication review.

Most of the Part D measures address operational and enrollment issues for the prescription drug plans, including measures of telephone wait times, disenrollment rates, and complaints. However, a growing number of measures (currently 5 of the 17) address medication adherence and safety.⁵ These 5 measures of adherence or safety are more heavily weighted than the other measures in the Part D ratings and thus account for nearly half of the plan's overall stars. The measures are (1) high-risk medications in the elderly; (2) use of angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) in patients with diabetes; and measures of medication adherence for (3) oral diabetes medications; (4) ACE inhibitors/ARBs; and (5) statins. Additionally, 2 other safety measures are used in the Display Measures that provide feedback to prescription drug plans. These include rates for drug-drug interactions and excessive doses of oral diabetes medications.

The quality measures for Medicare Parts C/D are becoming intertwined with policies for enrollment, marketing, and payment for the Medicare plans. CMS makes the star ratings available to Medicare beneficiaries at the time of enrollment by listing the stars next to each plan in the Medicare Drug Plan Finder. Starting in 2012, Medicare plans that achieve a 5-star rating will have open enrollment throughout the year and beneficiaries will be allowed to switch into a 5-star plan at any time. Very few plans achieve a 5-star rating but those that do are able to promote their 5-star status within marketing materials, and CMS encourages beneficiaries to use the star ratings when choosing a Medicare plan.

A very noticeable change to Medicare policy for 2012 is the implementation of Quality-Based Payments (QBPs) for the Medicare Advantage plans.⁴ The QBPs were created in the Affordable Care Act but will be implemented in a modified form through a 3-year demonstration project. In the demonstration, Medicare Advantage plans that achieve at least 3 stars will be able to participate in the QBP program. Each eligible plan will receive an increase in its payment rates based on the number of stars (ie, 3-star plans receive 3%, 4-star plans receive 4%, and 5-star plans receive 5%). Considering that the base payments for Medicare Advantage plans are not expected to increase in the future, the QBPs represent a primary opportunity to keep pace with inflation and maintain profitability. The average difference in payment for a 3-star plan versus a 5-star plan is approximately \$16 per member per month. For a Medicare Ad-

vantage plan with 1 million lives, moving from 3 stars to 5 stars would equate to nearly \$200 million per year in additional revenue.⁶

Pharmacist Engagement in Quality Initiatives

The medication safety and adherence measures used by CMS were developed, tested, and endorsed by the Pharmacy Quality Alliance (PQA), a nonprofit alliance of more than 70 health care organizations.⁷ The members of PQA include professional societies such as the American Pharmacists Association, American College of Clinical Pharmacy, Academy of Managed Care Pharmacy, and American Association of Colleges of Pharmacy, as well as numerous health plans, pharmacy benefit managers, pharmaceutical manufacturers, chain pharmacy corporations, and consumer advocacy groups. PQA was formed in April 2006 at the urging of then CMS Administrator Mark McClellan. The initial purpose of the alliance was to identify ways to measure the quality of prescription drug plans and pharmacy services. PQA's mission has broadened in recent years and not only develops measures of pharmacy quality, but also identifies best practices for improving the quality of medication use. It also provides education to pharmacists about quality improvement and provides linkage between pharmacy and broader health care quality initiatives.

Although public reports and financial incentives are necessary steps in promoting better value for Medicare Parts C/D, these efforts will only be successful if they can stimulate change in the way medications are prescribed, dispensed, monitored, and consumed. Medicare plans and their pharmacy benefit managers are reexamining their policies related to drug management and are likely to align the financial incentives for physicians and pharmacies with improvement of the plan's star ratings. For physicians, this may mean expansion of pay-for-performance programs and perhaps more prior authorization requirements for high-risk or high-cost medications. Pharmacies will likely see more preferred networks wherein pharmacies that score best on quality measures will be able to attain higher payments for drugs being dispensed or for clinical services being provided. This may also include incentives for patients to visit the preferred pharmacies or to participate in medication therapy management programs.

Pharmacists should view the increased attention to medication-related quality as an opportunity to reinforce their role in promoting appropriate medication use. Health plans and physicians should be more receptive than ever to collaboration of pharmacists in helping them improve their quality scores and maximizing quality-based payments. These collaborations may come in many forms and may connect pharmacists to emerging models for the primary-care medical home or accountable care organizations.

However, the increased responsibility for medication quality will also come with increased accountability through public reports on pharmacy quality or payment that is dependent on quality scores. The transparency and accountability may be well received by pharmacies and pharmacists that score well on measures of quality, but will likely meet resistance from pharmacies that do not fare well in a quality-driven reward system. This also places a significant obligation on organizations such as PQA to identify valid measures of quality and obligates payers to implement fair and reasonable systems for quality-based payments.

Pharmacists should become more engaged in the rapidly evolving efforts to identify appropriate measures of medication-related quality. PQA membership is open to all health care organizations, as well as educational institutions, and individual pharmacists can also participate through professional societies. Aside from PQA, there are many other organizations that will affect medication quality measures, including The Joint Commission, NCQA, the National Quality Forum, Patient-Centered Primary Care Collaborative, and federal agencies such as the Agency for Healthcare Research & Quality, Health Services Resources Administration, and CMS. Each state also has a federally funded Quality Improvement Organization (QIO) that is charged with supporting quality improvement efforts of health care organizations. These QIOs have a new “scope of work” that includes objectives to reduce adverse drug-related events; many QIOs have been looking for pharmacists to assist with these objectives.⁸

As the health care system searches for effective ways to improve quality while containing costs, there will be increased attention to the quality of medication use. This includes more public reports on quality of Medicare drug plans and more financial consequences related to quality of the medication use system. I hope that pharmacists will view these changes as an opportunity to establish their role as clinicians who play a vital role in a high-quality, high-value, health care system.

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References

1. Congressional Budget Office. Medicare baseline 2010. <http://www.cbo.gov/budget/factsheets/2010d/MedicareAugust2010FactSheet.pdf> (accessed 2011 Sept 9).
2. Nau DP, Kirking DM. Why is medication use less than appropriate? In: Fulda TR, Wertheimer AI, eds. *Pharmaceutical public policy*. New York: Haworth Press, 2007:477-98.
3. Johnson JA, Bootman JL. Drug-related morbidity and mortality: a cost-of-illness model. *Ann Intern Med* 1995;155:1949-56.
4. Centers for Medicare & Medicaid Services. Proposed changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for contract year 2012 and demonstration on quality bonus payments. November 10, 2010. <http://www.cms.gov/apps/docs/Fact-Sheet-2011-Landscape-for-MAe-and-Part-D-FINAL111010.pdf> (accessed 2011 Sept 9).
5. Centers for Medicare & Medicaid Services. Medicare health & drug plan quality and performance ratings, 2012 Part C & Part D technical notes. http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp#TopOfPage (accessed 2011 Sept 10).
6. Nau DP. Medicare Part D plan ratings. Implications for plans and pharmacies. Presentation at the PQA annual meeting, June 6, 2011. www.PQAalliance.org (accessed 2011 Sept 10).
7. Pharmacy Quality Alliance. www.PQAalliance.org (accessed 2011 Oct 28).
8. Centers for Medicare & Medicaid Services. Quality improvement organizations. http://www.cms.gov/QualityImprovementOrgs/01_Overview.asp#TopOfPage (accessed 2011 Sept 24).