



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 2712

Corresponding Measures:

De.2. Measure Title: Statin Use in Persons with Diabetes

Co.1.1. Measure Steward: Pharmacy Quality Alliance

De.3. Brief Description of Measure: The percentage of patients ages 40 to 75 years who were dispensed a medication for diabetes that receive a statin medication.

1b.1. Developer Rationale: The American College of Cardiology/American Heart Association (ACC/AHA) guidelines recommend moderate- to high-intensity statin therapy for primary prevention for persons aged 40-75 years with diabetes (class I recommendation).

Guideline: 2013 ACC/AHA Guideline on Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: a Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. (1)

The measure reflects this new clinical guideline and will promote appropriate treatment of patients with diabetes (age 40-75) to reduce their risk of cardiovascular disease and complications.

Prescription claims data are used as a proxy for diabetes diagnosis in this measure as well as other PQA and HEDIS measures. Medical data used in testing confirmed that the denominator criteria of two prescription claims for a hypoglycemic agent identified a population where a great majority had a diagnosis of diabetes during the measurement year. These criteria also included very few persons with select conditions (i.e., polycystic ovarian syndrome, gestational diabetes or diabetes secondary to another condition) that were considered for exclusion from the measure.

This measure uses only prescription claims as a source of data resulting in the inability to identify individuals with contraindications to statin therapy or other medical exceptions. Therefore the performance rate goal for this measure is not intended to reach 100%.

1. Stone NJ, Robinson J, Lichtenstein AH, Bairey Merz CN, Blum CB, Eckel RH, Goldberg AC, Gordon D, Levy D, Lloyd-Jones DM, McBride P, Schwartz JS, Shero ST, Smith SC Jr, Watson K, Wilson PWF. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation*. 2013;00:000–000. Accessed 2/3/2014
<http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a.full.pdf>

S.4. Numerator Statement: The number of individuals from the denominator with 1 or more fills for a statin medication during the measurement year.

S.6. Denominator Statement: Individuals aged 40 years to 75 years as of the first day of the measurement year, meeting continuous enrollment criteria (the measurement year, with one allowable gap), and have 2 or more prescription claims for a diabetes medication during the measurement year. Individuals with a hospice indicator or ESRD diagnosis are excluded from the measure.

S.8. Denominator Exclusions: Individuals in hospice care or with end-stage renal disease.

De.1. Measure Type: Process

S.17. Data Source: Claims

S.20. Level of Analysis: Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Feb 19, 2016 **Most Recent Endorsement Date:** Feb 19, 2016

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[SUPD_Template_MeasSubm_Evidence_FINAL_062615.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), *SKIP this question and answer the composite questions.*

The American College of Cardiology/American Heart Association (ACC/AHA) guidelines recommend moderate- to high-intensity statin therapy for primary prevention for persons aged 40-75 years with diabetes (class I recommendation).

Guideline: 2013 ACC/AHA Guideline on Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: a Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. (1)

The measure reflects this new clinical guideline and will promote appropriate treatment of patients with diabetes (age 40-75) to reduce their risk of cardiovascular disease and complications.

Prescription claims data are used as a proxy for diabetes diagnosis in this measure as well as other PQA and HEDIS measures.

Medical data used in testing confirmed that the denominator criteria of two prescription claims for a hypoglycemic agent identified a population where a great majority had a diagnosis of diabetes during the measurement year. These criteria also included very few persons with select conditions (i.e., polycystic ovarian syndrome, gestational diabetes or diabetes secondary to another condition) that were considered for exclusion from the measure.

This measure uses only prescription claims as a source of data resulting in the inability to identify individuals with contraindications to statin therapy or other medical exceptions. Therefore the performance rate goal for this measure is not intended to reach 100%.

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<http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a.full.pdf>

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*
Testing results for this measure was performed on data for calendar years 2012 and 2013.

For the 2012 data, results were calculated for one Medicare plan (N=1,807,725), one Commercial plan (N=16,615,029) and one Medicaid plan (N=665,715). The measure rates ranged from 59.1% to 67.6%, with a mean of 62.8% and a standard deviation of 6.6%.

For the 2013 data, results were calculated for 736 Medicare Part D plans (N=23,185,246). The measure rates range from 66.1% to 100%, with a mean of 72.5% and a standard deviation of 8.3%. The Interquartile Range (IQR) is 6.2%.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

N/A

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

For calendar year 2012, the measure rates were calculated by three different insurance types. The rate for the Commercial insurance population is 60.4%. The rate for the Medicare population is 73.6%, and the rate for the Medicaid population is 59.1%.

Data from January-March 2015 for eight (8) Part D contracts show that the measure rate for the Low Income Subsidy (LIS) population is 67.3%, while the rate in the Non-LIS population is 67.1%.

Definition: Medicare Low Income Subsidy (LIS)

A subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

N/A

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Cardiovascular : Hyperlipidemia, Endocrine : Diabetes

De.6. Non-Condition Specific(check all the areas that apply):

Health and Functional Status : Change

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Populations at Risk, Populations at Risk : Dual eligible beneficiaries, Populations at Risk : Individuals with multiple chronic conditions

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

<https://www.pqaalliance.org/pqa-measures>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [PQA_ICD_Code_ESRD_July_2018_v2.xlsx](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

2018 Updates

Value Sets (S.2b): Updated value sets (PQA ICD Code ESRD July 2018)

- ICD-9 information was removed, as it no longer is needed due to mandatory ICD 10 compliance as of October 2015.

- Added ESRD exclusion information.

- Added hospice exclusion information.

Denominator (S.7): Updated medication table SUPD-A: Diabetes Medications to add new medications (ertugliflozin (+/- metformin, sitagliptin), semaglutide, dapagliflozin + saxagliptin). Removed glimepiride + rosiglitazone.

Denominator Exclusions (S.8 and S.9): Added the exclusion criteria for ESRD and hospice.

Stratification (S.10): Added stratification language (Commercial, Medicaid, Medicare (report each product line separately). For Medicare, report rates for low-income subsidy (LIS) and non-LIS populations separately. This is consistent with PQA plan-level measures.

Calculation Algorithm/Measure Logic (S.14): Updated to reflect addition of hospice and ESRD exclusions from S.8 and S.9

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The number of individuals from the denominator with 1 or more fills for a statin medication during the measurement year.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in

required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The number of individuals from the denominator with 1 or more fills for a statin medication (Table SUPD-B: Statin Medications) during the measurement year.

Table SUPD-B: Statin Medications

Atorvastatin (+/- amlodipine, ezetimibe)

Fluvastatin

Lovastatin (+/- niacin)

Pitavastatin

Pravastatin

Rosuvastatin

Simvastatin (+/- ezetimibe, niacin, sitagliptin)

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

Individuals aged 40 years to 75 years as of the first day of the measurement year, meeting continuous enrollment criteria (the measurement year, with one allowable gap), and have 2 or more prescription claims for a diabetes medication during the measurement year. Individuals with a hospice indicator or ESRD diagnosis are excluded from the measure.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The denominator includes individuals who are age 40 to 75 years as of the first day of the measurement year, meeting continuous enrollment criteria (the measurement year, with one allowable gap), and have 2 or more prescription claims for a diabetes medication during the measurement year (Table SUPD-A: Diabetes Medication). Individuals with a hospice indicator or ESRD diagnosis are excluded from the measure (PQA ICD Code ESRD July 2018).

One allowable gap in enrollment is permitted, defined as a gap in enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the member may not have more than 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Table SUPD-A: Diabetes Medication

Metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

Chlorpropamide

Glipizide (+/- metformin)

Glimepiride (+/- pioglitazone)

Glyburide (+/- metformin)

Tolazamide

Tolbutamide

Netaglinide

Repaglinide (+/- metformin)

Acarbose

Miglitol

Pioglitazone (+/- alogliptin, glimepiride, metformin)

Rosiglitazone (+/- metformin)

Albiglutide

Dulaglutide

Exenatide

Liraglutide (+/- insulin degludec)

Lixisenatide (+/- insulin glargine)

Semaglutide
 Pramlintide
 Alogliptin (+/- metformin, pioglitazone)
 Linagliptin (+/- empagliflozin, metformin)
 Saxagliptin (+/- dapagliflozin, metformin)
 Sitagliptin (+/- metformin, ertugliflozin, simvastatin)
 Insulin aspart (+/- insulin aspart protamine)
 Insulin degludec (+/- liraglutide)
 Insulin detemir
 Insulin glargine (+/- lixisenatide)
 Insulin glulisine
 Insulin isophane (+/- regular insulin)
 Insulin lispro (+/- insulin lispro protamine)
 Insulin regular (including inhalation powder)
 Canagliflozin (+/- metformin)
 Dapagliflozin (+/- metformin, saxagliptin)
 Empagliflozin (+/- linagliptin, metformin)
 Ertugliflozin (+/- sitagliptin, metformin)

Note: The active ingredients are limited to oral, inhalation and injectable formulations only (includes all dosage forms; excludes nutritional supplement/dietary management combination products).

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Individuals in hospice care or with end-stage renal disease.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Hospice exclusion: Individuals in hospice care at any time during the measurement year, identified with a hospice indicator from the enrollment database or place of service code 34 in claims database.

End-Stage Renal Disease exclusion: Identified by any of the following during the measurement year:

- PQA ICD Value Set, ESRD Exclusion.
- An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
- Medicare Data (if ICD codes not available): RxHCC 261 - Dialysis Status for Payment Years 2016 or 2017. Available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html>.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

Commercial, Medicaid, Medicare (report each product line separately). For Medicare, report rates for low-income subsidy (LIS) and non-LIS populations separately.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Denominator Calculation:

Step 1: Identify individuals aged 40 to 75 years as of the first day of the measurement year.

Step 2: Identify individuals meeting the continuous enrollment criteria.

Step 3: Identify individuals with 2 or more prescription claims for a diabetes medication (Table SUPD-A: Diabetes Medications) during the measurement year.

Step 4: Exclude individuals who met one or more of the following:

- Hospice: a hospice indicator at any time during the measurement year
- ESRD: An ESRD diagnosis at any time during the measurement year

The number of individuals identified in Step 4 is the denominator for the measure.

Numerator Calculation:

Step 5: The number of individuals from the denominator with 1 or more fills for a statin medication (Table SUPD-B: Statin Medications) during the measurement year.

The number of individuals identified by completing Step 5 represents the numerator for this measure.

Step 6: Divide the numerator by the denominator and then multiply by 100 to obtain the rate (as a percentage) for the measure.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Health plan (e.g., Medicare, Medicaid, other) prescription claims data.

Health Plan member enrollment information.

This measure is intended to be reported by prescription drug plans that only have prescription claims and enrollment data.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Health Plan

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Other

If other: The level of analysis for this measure is the prescription drug health plan, but it contains claims from multiple care settings, including ambulatory, skilled nursing facility, pharmacy, etc.

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

2. Validity – See attached Measure Testing Submission Form

[SUPD_measure_testing_attachment_93015.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Other

If other: [Prescription claims data](#)

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

[ALL data elements are in defined fields in electronic claims](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs

associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Prescription claims data is required for payment to health plans, so there is no extra burden or cost in the collection of the data. There have been no feasibility issues with the use of this measure.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

PQA develops and maintains numerous performance measures related to the medication use system. The Measures are the proprietary property of PQA, and it is in the interest of PQA to protect and promote the appropriate use of the Measures. PQA may approve an organization's use of the Measures; however, no organization may use the Measures without first obtaining permission from PQA prior to using the Measures. Certain uses of the Measures are only approved with a licensing agreement from PQA that specifies the terms of use and the licensing fee. PQA reserves the right to determine the conditions under which it will approve and/or license the Measures.

Licenses are granted on a year-to-year basis. PQA reserves the right to audit the licensee's use of the Measures and may revoke a license if it is determined that the licensee has used the Measures in a manner that is outside the scope of permitted use that was specified in the licensing agreement.

Licensees using PQA measures for commercial purposes are required to pay a fee. The licensing fee may be structured as a fixed annual amount or as a variable amount that is dependent on the volume of utilization of the Measures. As a benefit of membership, PQA members who use the Measures only for internal quality improvement initiatives (i.e., self-assessment) will not be assessed a licensing fee.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	Quality Improvement (Internal to the specific organization)
Regulatory and Accreditation Programs	Medicare Part D Patient Safety Report http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html?redirect=/PrescriptionDrugCovGenIn/06_PerformanceData.asp

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Name of program: Medicare Part D Patient Safety Reports

Purpose: Quality improvement and monitoring

Geographic area – National; nearly 700 health plan sponsor contracts

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

The measure is new (endorsed by PQA membership in November 2014) and is being further evaluated by Medicare Part D. It is currently being reported by CMS to all Medicare Part D health plan sponsors in the monthly Patient Safety Reports. The reports are based on 2015 prescription drug event (PDE) information.

URAC is planning to add this measure as an exploratory measure to their accreditation programs for Community Pharmacy, PBM, and Mail Service.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

CMS is considering this measure as a new 2017 display measure (using 2015 data) and as a possible 2018 Star Rating measure (using 2016 data).

Source: Memorandum April 2015: Announcement of Calendar Year 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Attachment VII: 2016 Call Letter Pg 111

<http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html>

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

PQA's measure development is a transparent, consensus-driven process to draft, test, refine, and endorse measures. The development process involves six steps: measure conceptualization, measure specification, stakeholder engagement, draft measure testing, measure endorsement, and finally measure use and update.

After specifications have been drafted for a measure concept, PQA selects partners to test the draft measure. These partners often are PQA member health plans or academic institutions with expertise in quality and performance measure testing that also have access to the data sources needed to calculate the measure rates. The testing partner implements the technical specifications within their existing datasets and provides a report to PQA that details testing results and any recommendations for modifications of the technical specifications. The Quality Metrics Expert Panel (QMEP) reviews the testing results and recommendations and determines final criteria for the measure based on the findings. The QMEP provides a final assessment of the feasibility and scientific acceptability of the draft measures.

PQA owns and maintains the performance measure, including updates to the specifications and all value sets to ensure accurate and consistent calculation of the measure. In addition to describing the steps to calculate our measures, the specifications provide information about how to interpret results (i.e. higher or lower rates are better). Various organizations license the measure specifications for performance evaluation. PQA provides technical assistance and support to licensees and to those with permission to use PQA measures.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

PQA owns and maintains the performance measure. PQA is not involved with providing results from the performance evaluation. As the measure steward, PQA provides technical assistance to support accurate implementation of the measure specifications.

PQA receives feedback from measure users via technical assistance email box or inquiries sent directly to staff. PQA staff responds to inquiries in a timely manner. Frequently asked questions and other recommendations are reviewed by PQA staff and brought to the Measure Update Panel (MUP) for further consideration, as appropriate.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

PQA receives feedback from measure users via technical assistance email box or inquiries sent directly to staff. PQA staff responds to inquiries in a timely manner. Frequently asked questions and other recommendations are reviewed by PQA staff and brought to the Measure Update Panel (MUP) for further consideration, as appropriate.

4a2.2.2. Summarize the feedback obtained from those being measured.

Health plans recommended individuals with end-stage renal disease (ESRD) be excluded from the measure.

4a2.2.3. Summarize the feedback obtained from other users

PQA's Patient and Caregiver Advisory Panel (PCAP) recommended the exclusion of individuals with hospice and end-stage renal disease from the measure.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

During measure development:

- Performance measures that are recommended by the QMEP for endorsement consideration by PQA membership are posted on the PQA web site for member review, written comments are requested, and a webinar for member organizations is held to address comments and questions. This process allows stakeholders to discuss their views on the measures in advance of the voting period. PQA member organizations vote on endorsement of performance measures.

For revisions:

- After endorsement, PQA leverages a multi-stakeholder advisory panel, the Measure Update Panel (MUP), to consider feedback for potential measure update consideration. The panel's objectives are to identify the need for measure updates based on current evidence, guidelines, and standards, ensure new medications are reflected in the NDC lists and measure specifications, and revise the measures to improve clarity, consistency, and harmonization. Material changes – those that affects the measure result – are also evaluated and approved by the QMEP. This process, which engages PQA stakeholders, ensures feedback is reviewed and applied based on consensus and evidence.

- Additionally, PQA provides both member and non-member organizations with individual technical assistance upon request. Frequently asked questions and other recommendations are reviewed by PQA staff and brought to the MUP for further consideration.

- Since the last update, the MUP considered adding criteria to exclude individuals in hospice or with ESRD from the measure. Both the MUP and QMEP voted in favor of making this change to the measure.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

N/A

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

No negative consequences were incurred by individuals or populations during the testing nor has any evidence of unintended negative consequences to individuals or populations been demonstrated.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

The following NQF endorsed measure was not included on the drop down above:

NQF Measure 0729: Optimal Diabetes Care- Cholesterol Statin Use Component

Measure Steward: MN Community Measurement

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

Differences between measures 0729 and 2712: The composite measure, 0729, addresses A1c, blood pressure, statin use, tobacco non-use and daily aspirin or anti-platelet use for patients with diagnosis of ischemic vascular disease. Measure 2712 addresses one specific aspect of appropriate medication use, statin medications in a population with diabetes age 40-75. The composite measure, 0729, is reported at the clinician level and uses data from the medical record. Measure 2712 is reported at the health plan level is based on prescription claims data. The composite measure 0729 includes diabetic patients 18-75 years, while measure 2712 only includes diabetic patients age 40-75 years. While the intent and basis of the measures are similar, there are some differences in the measure specification. These differences are due to the accessibility of clinical data for measure 0729 including LDL, allergies, diagnosis etc. Rationale: The rationales of the measures are similar as they address the same guideline but in different settings of care. Impact on interpretability: These measures will be interpreted differently since one (0729) is a composite measure of diabetes care used by clinicians in an ambulatory setting. The other measure (2712) is specific to statin use in a limited age group of diabetics and will be used by health plans and pharmacists. Data collection burden: There will be no additional level of burden as the data used in measure 2712 is prescription claims data and administrative data that are already collected by the health plan.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

N/A

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Pharmacy Quality Alliance
Co.2 Point of Contact: Lynn, Pezzullo, lpezzullo@pqaalliance.org, 515-554-6685-
Co.3 Measure Developer if different from Measure Steward: Pharmacy Quality Alliance
Co.4 Point of Contact: Lynn, Pezzullo, lpezzullo@pqaalliance.org, 703-347-7963-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

Role of the PQA Adherence Workgroup:

PQA is a consensus-based membership organization. PQA Workgroup members represent a diverse group of stakeholders with expertise in clinical, quality improvement and prescription drug data. This measure concept was developed by the PQA Adherence Workgroup in 2014.

The members of the PQA 2014 Adherence Workgroup include:

Ritchie Madeline Academy of Managed Care Pharmacy (AMCP)
 Bain Amanda Academy of Managed Care Pharmacy (AMCP)
 Biernacki Anne Marie ActualMeds Corporation
 CardenThomas Aetna
 Markevich Andy Ahold USA
 Patel Vaishali Allergan
 Mistry Trusha American Association of Colleges of Pharmacy (AACP)
 Haydon-Greatting Starlin American Pharmacists Association (APhA)
 Capehart Krista American Pharmacists Association (APhA)
 Gunter J. Ashley American Society of Health-System Pharmacists (ASHP)
 Delaney Evan Amerigroup
 Kounelis Peter John AmerisourceBergen Corporation
 Davis Carol Anthurium Solutions, Inc. / ASI Services LLC
 Kaur Ayesa Applied Research Works
 Stacy Jane Astellas Scientific and Medical Affairs, Inc.
 Legg Randy AstraZeneca LP
 Ayshford Robb Ateb
 Conner Suzy Blue Cross and Blue Shield of North Carolina
 Witkowski Nancy Boehringer-Ingelheim Pharmaceuticals
 Dezii Christopher Bristol-Myers Squibb

Palmieri James	California Northstate University College of Pharmacy
Omotayo Yemi	Capital Health Plan
Ey Mark	CARE Pharmacies Cooperative
Wolf Carolyne	Catamaran
Nguyen Michael	CenseoHealth
Lee-Martin Alice	Centers for Medicare and Medicaid Services (CMS)
Lambert Jennifer	Cigna-HealthSpring
Lizotte Margaret	CVS Health
Arnold Stephanie	Daiichi Sankyo
Serwetman Lea	Dovetail Health
Bauman Tina	Express Scripts, Inc.
Nowak Jeri	Fairview Medication Therapy Management
Matuszewski Karl	First Databank
McClelland Scott	Florida Blue
ToumadjAli	Gilead Sciences
Miner Paul	Gilead Sciences
LovelaceBelinda	GlaxoSmithKline
Civin Lynne	Gorman Health Group
LennartzCrystal	Health Mart Systems Inc.
Fortuna Laura	HealthPartners
Butteri Nicole	Highmark Health Services
Young Peinie	Humana
Pearce Heather	Humana
Frankfort Jim	IMS Health
Clelland Carmen	Indian Health Services
Kfuri Antoine	Inovalon, Inc.
Ziernicki Danielle	Johnson & Johnson
Makarem Abir	Kaiser Permanente
Hayes Kristin	LDM Group
Blank Dawn	Lilly USA
Lichucki Rebecca	MarkeTouch Media
Eyerly Sandy	MeadWestvaco
Whalley-Buono Elizabeth	MeadWestvaco
Logan Tripp	MedHere Today
LukoskieLynn	Medication Management Systems
Leslie Scott	MedImpact Healthcare Systems, Inc.
Hogue Susan	MedVantx, Inc.
Gerhart Julie	Merck & Co.
Nwachukwu Ugo	Mirixa Corporation
Rowell Crescent	National Alliance of State Pharmacy Associations (NASPA)
Masten Dale	National Association of Chain Drug Stores (NACDS)
Sapp Aaron	National Association of Chain Drug Stores (NACDS)
Dunklau Hank	National Community Pharmacists Association (NCPA)
Jester Laura	National Community Pharmacists Association (NCPA)
Persinger Gary	National Pharmaceutical Council
Westrich Kimberly	National Pharmaceutical Council
Wisniewski Tami	Novo Nordisk, Inc.
WindsheimerAndrea	Novo Nordisk, Inc.
Burich Molly	Otsuka America Pharmaceutical, Inc.
Hoopes Alex	OutcomesMTM
Barrett Barbara	Parata Systems
Friedman Steven	PDX, Inc.
Patel Binal	PerformRx
Gouveia-Pisano Julie Ann	Pfizer, Inc.
Searle David	Pfizer, Inc.

Lang	Kelsey	Pharmaceutical Research & Manufacturers of America (PhRMA)
Kelly	Jack	Pharmacist Partners
Scott	Amy	Pharmacy Quality Solutions
Conklin	Mark	Pharmacy Quality Solutions
Erxleben	Tori	PharmMD
Lee	Charles	Polyglot Systems, Inc.
Dauer	Stephanie	Prime Therapeutics
Scanlon	Katie	Publix Super Markets, Inc
Sistrunk	Robin	Publix Super Markets, Inc
Erensen	Jennifer	Purdue Pharma, L.P.
Kahlon	Summer	RelayHealth
McCullough	Jesse	Rite Aid
Bhosle	Monali	RxAnte
SenGupta	Ran	RxPREDICT
McCabe	James	Safeway, Inc.
Romo-LeTourneau	Victoria	Sanofi
Dao	Anthony	SCAN Health Plan
Werner	Shepin	SinfoníaRx
Kebodeaux	Clark	St. Louis College of Pharmacy
Wittbrodt	Eric	Takeda Pharmaceuticals America, Inc.
Losinski	Victoria	Target
Feltman	Matthew	The Kroger Co.
Kirby	James	The Kroger Co.
Lindholz	Colleen	The Kroger Co.
Chabot	Sandye	Therapeutic Research Center (home of Pharmacist's Letter and Prescriber's Letter)
Shipp	Roy	Tri State Distribution, Inc
Miceli	David	Tri State Distribution, Inc
Schilling	Craig	UnitedHealth Group
Hall	Anna	University of Florida College of Pharmacy
Holmes	Erin	University of Mississippi Center for Pharmaceutical Marketing & Management
Keast	Shellie	University of Oklahoma College of Pharmacy - Pharmacy Management Consultants
Daw	Jessica	UPMC Health Plan
Anderson	Janice	URAC
Vargulick	Adam	VoicePort
Garofalo	Tim	voiceTech Inc.
Chazaud	Sandrine	voiceTech Inc.
Medvedeff	David	VUCA Health
Rudkin	Kristi	Walgreen Co.
Marakas	John	Walmart

PQA QMEP members' role: The PQA Quality Metrics Expert Panel (QMEP) is charged with evaluating the measure concepts proposed by the PQA workgroups and prioritizing the measure concepts for specification and testing. The Panel reviews comments from PQA members on draft measures to determine whether modifications should be made or what variations should be considered during testing. The QMEP reviews the results of the pilot-testing of the draft measures and makes final recommendations to the PQA membership regarding endorsement of the draft measures. The Panel is comprised of persons who have clinical or other technical expertise related to quality measurement. The members are invited to serve on the QMEP by PQA's senior measurement development team. The composition of the QMEP reflects PQA's membership.

Members of the 2014 QMEP include:

Steven Burch	GSK
Catherine Coast	Highmark
Lynn Deguzman	Kaiser Perm
Chris Dezii	BMS
Chris DuPaul	CVS/Caremark

Karen Farris	U of Michigan/APhA
Pat Gleason	Prime Therapeutics
Mary Ann Kliethermes	Midwestern University/APhA
Terri Moore	formerly URAC – historic consultant in 2014
David Nau	PQS
Bimal Patel	MedImpact
Chris Powers	CMS
Kent Summers	Astellas
Mitzi Wasik	Coventry
Jenny Weber	Humana
Keith Widmer	Express Scripts
Gary Young	Northeastern University
Measure Developer/Steward Updates and Ongoing Maintenance	
Ad.2 Year the measure was first released: 2014	
Ad.3 Month and Year of most recent revision: 11, 2014	
Ad.4 What is your frequency for review/update of this measure? Annually	
Ad.5 When is the next scheduled review/update for this measure? 06, 2016	
Ad.6 Copyright statement: Rights retained by PQA, Inc. 2015	
Ad.7 Disclaimers: N/A	
Ad.8 Additional Information/Comments: N/A	