NATIONAL QUALITY FORUM

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 #: 0022   **Corresponding Measures:**   **De.2. Measure Title:** Use of High-Risk Medications in Older Adults (DAE)   **Co.1.1. Measure Steward:** National Committee for Quality Assurance   **De.3. Brief Description of Measure:** The percentage of patients 65 years of age and older who received at least two dispensing events for the same high-risk medication. A lower rate represents better performance.   **1b.1. Developer Rationale:** Lowering the use of high-risk medications in the older adult population should decrease morbidity and mortality associated with adverse drug reactions.
S.4. Numerator Statement: Patients who received at least two dispensing events for the same high-risk medication during the measurement year.   **S.6. Denominator Statement:** All patients 65 years of age and older.   **S.8. Denominator Exclusions:** Patients who were enrolled in hospice care at any time during the measurement year.
De.1. Measure Type: Process   **S.17. Data Source:** Claims   **S.20. Level of Analysis:** Health Plan
IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Jan 26, 2017
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
Final_DAE_nqf_evidence_attachment_7.1.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.
Yes

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.
Lowering the use of high-risk medications in the older adult population should decrease morbidity and mortality associated with adverse drug reactions.

1b.2. Provide performance scores on the measure as specified (<u>current and over time</u>) 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.*
The following data are extracted from HEDIS data collection for Medicare Advantage Health Plans (including all HMO and PPO plans). Performance data is summarized at the health plan level and summarized by mean, standard deviation, and performance at the 10th, 25th, 50th, 75th and 90th percentile. Data is stratified by year.

At least 2 different high-risk medications
YEAR| N | MEAN | ST DEV | MIN | 10TH (Better) | 25TH | 50TH | 75TH | 90TH (Worse) | MAX
2016^ | 485 | 9.1% | 3.4% | 0.0% | 5.9% | 7.0% | 8.5% | 10.7% | 13.7% | 30.1%
2017 | 482 | 9.9% | 4.1% | 0.0% | 6.1% | 7.3% | 9.0% | 11.9% | 15.4% | 35.5%
2018*| 502 | 9.6% | 3.9% | 0.0% | 5.8% | 7.1% | 8.6% | 11.4% | 14.9% | 27.4%
*For 2018 the average eligible population was 28,463, with a standard deviation of 70,665
^Note: These results are based on a previous specification of the HEDIS measure in which the numerator was based on multiple prescribing events of different high-risk medications instead of the current specification which looks at multiple prescribing events for the same high-risk medication.

The data referenced are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2018, HEDIS measures covered more than 21 million Medicare enrollees. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the median and mean eligible population-which is the same as the denominator-for the measure across health plans.

YEAR | N Plans | Median Denominator Size per plan | Mean Denominator Size per plan
2016 | 485 | 6,212 | 25,642
2017 | 482 | 6,476 | 27,903
2018 | 502 | 5,893 | 28,463

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.*
HEDIS data are stratified by type of insurance (e.g., Commercial, Medicaid, Medicare). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities, if the data are available to a plan. NCQA is actively engaged with partners including the CMS Office of Minority Health in identifying feasible methods to further integrate social risk factors into health plan quality measures, with a focus on stratification. Our work is aligned with recent recommendations from MedPAC and ASPE on optimal methods for addressing social risk in quality measurement and programs.[1,2] This is an NCQA wide initiative. Our intent is to implement methods to bridge data concerns in the future.

HEDIS includes two measures that can be used as tools for assessing race/ethnicity and language needs of a plan's population: Race/Ethnicity Diversity of Membership and the Language Diversity of Membership. These measures promote standardized methods for collecting these data and follow Office of Management and Budget and National Academy of Medicine guidance for collecting and categorizing race/ethnicity and language data. In addition, NCQA's Multicultural Health Care Distinction Program outlines standards for collecting, storing, and using race/ethnicity and language data to assess health care disparities.

1. Medicare Payment Advisory Commission. (2020). The Medicare Advantage program: Status report. In Report to the Congress: Medicare Payment Policy (p. 397). http://medpac.gov/docs/default-source/reports/mar20_medpac_ch13_sec.pdf
2. Office of the Assistant Secretary for Planning and Evaluation, & U.S. Department of Health & Human Services. (2020). Second Report to Congress on Social Risk and Medicare's Value-Based Purchasing Programs. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-basedpurchasing-programs

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
While disparities for this measure have not been well studied, there is some evidence to suggest differences in the use of potentially inappropriate medications by gender, race, and income status. A cross-sectional study examining the prevalence of potentially inappropriate medications in community-dwelling Medicare beneficiaries in California found that use was significantly higher in women, White beneficiaries, and low-income beneficiaries (Patel et al., 2018). A retrospective cohort study of 966,000 men and women treated by the Veteran's Health Administration showed that women were more likely than men to receive medications that may have harmful interactions with chronic conditions as described by the Beers Criteria (Bierman et al., 2007). In a different study, a retrospective database analysis of HEDIS data from the Department of Veterans Affairs found that Hispanics and those with no copayments had higher rates of medications listed as potentially harmful than Whites or those with required copayments (Pugh, 2011).
Bierman, A.S., M.J.V. Pugh, I. Dhalla, M. Amuan, B.G. Fincke, A. Rosen, D.R. Berlowitz. 2007. "Sex differences in inappropriate prescribing among elderly veterans." The American Journal of Geriatric Pharmacotherapy, 5(2):147-161.
Patel, R., L. Zhu, D. Sohal, E. Lenkova, N. Koshki, J. Woelfel, ... and E.L. Rogan. 2018. "Use of 2015 Beers Criteria Medications by Older Medicare Beneficiaries." The Consultant Pharmacist 33(1), 48–54.
Pugh, Mary Jo V., et al. "Exposure to Potentially Harmful Drug–Disease Interactions in Older Community-Dwelling Veterans Based on the Healthcare Effectiveness Data and Information Set Quality Measure: Who Is at Risk?." Journal of the American Geriatrics Society 59.9 (2011): 1673-1678.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, <u>as specified</u>, 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):*

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

De.7. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*
Elderly, 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.)
N/A

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)*
No data dictionary **Attachment:**

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.
Since the last endorsement, the measure name was revised to replace the term "elderly" with "older adults" to align with the language used in the American Geriatrics Society (AGS) Beers Criteria. The first rate (former Numerator 1) for members who received at least one dispensing event for a high-risk medication was retired. The remaining rate is a better assessment of the riskier, more long-term use of high-risk medications among older adults. It also allows organizations to address potentially inappropriate medication use after one dispensing event and work to prevent further dispensing, to improve on the remaining rate. The list of medications used in this measure has been updated to reflect the most current recommendations included in the AGS 2019 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.

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).
Patients who received at least two dispensing events for the same high-risk 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).
Patients who had at least two dispensing events for the same high-risk medication during the measurement year.
Follow the steps below to identify numerator compliance. Include patients who meet criteria in more than one step only once in the numerator. Do not include denied claims.

Step 1: Identify patients with two or more dispensing events (any days supply) on different dates of service during the measurement year for a medication in Table DAE-A. The dispensing events must be for the same drug as identified by the Drug ID in the NDC list. These patients are numerator compliant.

Step 2: For each patient, identify all dispensing events during the measurement year for medications in Table DAE-B. Identify

patients with two or more dispensing events on different dates of service for medications in the same medication class (as defined by the AGS Beers Criteria Table 2 and class title below). For example, a prescription for zolpidem and a prescription for zaleplon are considered two dispensing events for medications in the same medication class (these drugs share the same class title or description: Nonbenzodiazepine hypnotics). Sum the days supply for prescriptions in the same medication class. Identify patients with two or more dispensing events for medications of the same medication class where the summed days supply exceeds the days supply criteria listed for the medication. These patients are numerator compliant. For medications dispensed during the measurement year sum the days supply and include any days supply that extends beyond December 31 of the measurement year. For example, a prescription of a 90-days supply dispensed on December 1 of the measurement year counts as a 90-days supply.
- Note: The intent is to identify all patients who had multiple dispensing events where the summed days supply exceeds the days supply criteria; there is no requirement that each dispensing event exceed the days supply criteria.

Step 3: For each patient, identify all dispensing events during the measurement year for medications in Table DAE-C where average daily dose exceeds the average daily dose criteria listed for the medication. Identify patients with two or more dispensing events on different dates of service that exceed the average daily dose criteria for the same drug as identified by the Drug ID in the NDC list. These patients are numerator compliant. To calculate average daily dose for each dispensing event, multiply the quantity of pills dispensed by the dose of each pill and divide by the days supply. For example, a prescription for a 30-days supply of digoxin containing 15 pills, .250 mg each pill, has an average daily dose of 0.125 mg. To calculate average daily dose for elixirs and concentrates, multiply the volume dispensed by daily dose and divide by the days supply. Do not round when calculating average daily dose.

HIGH-RISK MEDICATIONS (Table DAE-A)
Anticholinergics, First-generation antihistamines---
Brompheniramine, Carbinoxamine, Chlorpheniramine, Clemastine, Cyproheptadine, Dexbrompheniramine, Dexchlorpheniramine, Diphenhydramine (oral), Dimenhydrinate, Doxylamine, Hydroxyzine, Meclizine, Promethazine, Pyrilamine, Triprolidine

Anticholinergics, anti-Parkinson agents---
Benztropine (oral), Trihexyphenidyl

Antispasmodics---
Atropine (exclude ophthalmic), Bellandonna alkaloids, Clidinium-Chlordiazepoxide, Dicyclomine, Hyoscyamine, Methscopolamine, Propantheline, Scopolamine

Antithrombotics---
Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)

Cardiovascular, alpha agonists, central---
Guanabenz, Guanfacine, Methyldopa

Cardiovascular, other---
Disopyramide, Nifedipine (immediate release)

Central nervous system, antidepressants---
Amitriptyline, Clomipramine, Imipramine, Trimipramine, Amoxapine, Desipramine, Nortiptyline, Paroxetine, Protriptyline

Central nervous system, barbiturates---
Amobarbital, Butabarbital, Butalbital, Mephobarbital, Pentobarbital, Phenobarbital, Secobarbital

Central nervous system, vasodilators---
Ergot mesylates, Isoxsuprine

Central nervous system, other---
Meprobamate

Endocrine system, estrogens with or without progestins; include only oral and topical patch products---
Conjugated estrogen, Esterified estrogen, Estradiol, Estropipate

Endocrine system, sulfonylureas, long-duration---
Chlorpropamide, Glimepiride, Glyburide

Endocrine system, other---
Desiccated thyroid, Megestrol

Pain medications, skeletal muscle relaxants---
Carisoprodol, Chlorzoxazone, Cyclobenzaprine, Metaxalone, Methocarbamol, Orphenadrine

Pain medications, other---
Indomethacin, Ketorolac (includes parenteral), Meperidine

HIGH-RISK MEDICATIONS WITH DAYS SUPPLY CRITERIA (Table DAE-B)

Anti-infectives, other (greater than 90 days supply, days supply criteria)---
Nitrofurantoin, Nitrofurantoin macrocrystals, Nitrofurantoin macrocrystals-monohydrate

Nonbenzodiazepine hypnotics (greater than 90 days supply, days supply criteria)---
Eszopiclone, Zolpidem, Zaleplon

HIGH-RISK MEDICATIONS WITH AVERAGE DAILY DOSE CRITERIA (Table DAE-C)
Alpha agonists, central (greater than 0.1 mg/day, average daily dose criteria)---
Reserpine

Cardiovascular, other (greater than 0.125 mg/day, average daily dose criteria)---
Digoxin

Tertiary TCAs (as single agent or as part of combination products), (greater than 6 mg/day, average daily dose criteria)---
Doxepin

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2020. For medications in Table DAE-A and DAE-C, identify different drugs using the Drug ID field located in the NDC list on NCQA's Web site (www.ncqa.org), posted by November 2020.

S.6. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
All patients 65 years of age and older.

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.)*
<u>IF an OUTCOME MEASURE</u>, *describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*
All patients that are 66 years of age and older as of December 31 of the measurement year.

S.8. **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*
Patients who were enrolled in hospice care at any time during the measurement year.

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.)*

N/A

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.*)
N/A

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 = Lower 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.*)
Step 1. Determine the denominator: All patients 66 years of age and older as of the end (i.e., December 31) of the measurement year.

Step 2: Identify the numerator: Individuals in the denominator who have dispensed at least two prescriptions for the same high-risk medication (see definition of high-risk medication in section S.6) during the measurement year.

Step 3: Divide Step 2 (numerator) by Step 1 (denominator) to calculate the rate.

Note: For this measure, a lower rate indicates better performance.

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.
This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

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)*
Outpatient Services
If other:

S.22. <u>COMPOSITE Performance Measure</u> - 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
DAE_0022_Testing_Form-637396680504932134.docx

2.1 <u>For maintenance of endorsement</u>
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.
Yes

2.2 <u>For maintenance of endorsement</u>
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.
Yes

2.3 <u>For maintenance of endorsement</u>
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.
No - This measure is not risk-adjusted

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.
Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score)
If other:

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 a combination of electronic sources

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).
N/A

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.

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO´s ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.
The HEDIS Compliance Audit addresses the following functions:
1) information practices and control procedures
2) sampling methods and procedures
3) data integrity
4) compliance with HEDIS specifications
5) analytic file production
6) reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the 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)*.
Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that

is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

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)

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

HEALTH PLAN RATINGS/REPORT CARDS: This measure is used to calculate health plan ratings which are reported on the NCQA website. These ratings are based on performance on HEDIS measures among other factors. In 2019, a total of 255 Medicare health plans, 515 commercial health plans and 188 Medicaid health plans across 50 states were included in the ratings.

STATE OF HEALTH CARE ANNUAL REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2019, the report included results from calendar year 2018 for health plans covering a record 136 million people, or 43 percent of the U.S. population.

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of Medicare Advantage Health Plans. In 2019, a total of 247 Medicare Advantage health plans were accredited using this measure among others. Health plans are scored based on performance compared to benchmarks.

NCQA PATIENT-CENTERED MEDICAL HOME (PCMH): This measure is used in the Patient Centered Medical Home Recognition program, which identifies medical practices that have invested in a model of care that puts patients at the forefront and where continuous quality improvement is a priority.

CMS QUALITY PAYMENT PROGRAM: This measure is used in the Quality Payment Program (QPP) which is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

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?*)
N/A

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.*)
N/A

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.
Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

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.**
NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System, as described in Section 3c1.

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.
NCQA measures are evaluated regularly. During this "reevaluation" process, we seek broad input on the measure, including input on performance and implementation experience. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

4a2.2.2. **Summarize the feedback obtained from those being measured.**
In general, health plans have not reported significant barriers to implementing this measure, as it uses the administrative data collection method. Questions received through the Policy Clarification Support system have generally centered around minor clarification of the specifications, such as confirmation that information in claims meets the measure intent and satisfies the measure numerator and questions about the supporting guidelines for the measure. NCQA responded to all questions to ensure consistent implementation of the specifications. During a recent public comment period, a majority of comments from measured entities supported updates to the measure to align with the latest clinical recommendations.

4a2.2.3. **Summarize the feedback obtained from other users**
This measure has been deemed a priority measure by NCQA and other entities such as the Centers for Medicare and Medicaid Services as illustrated by its use in the Quality Payment Program.

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 the measure's last major update, feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure specification to include clarifying text and additional examples to further support determining numerator compliance.

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.

The 2016 to 2018 data shows relatively stable performance and room for improvement across Medicare Plans (see section 1b.2 for summary of data from health plans). In 2018, the average performance was 9.6%. There was a 9 percentage point difference between plans at the 10th and 90th percentiles. This large difference in performance represents a persistent gap in care and room for improvement in medication safety for older adults, particularly given the substantially large average denominator size of all plans reporting on this measure and therefore the great number of older adults at risk for adverse drug events. Although overall rates aren't changing, there have been an increase in the number of plans reporting from 2016 (n=485) to 2018 (n=502). Many of the new plans reporting have larger denominator sizes, as demonstrated by the increasing mean denominator size over the three years of data.

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.

There were no identified unintended consequences for this measure during testing or since implementation. If this measure were to be implemented poorly, there is concern that it could lead to reduced access to medications. There will always be individual cases that will warrant the use of a potentially harmful medication and clinicians should weigh the risks and benefits of using these medications for their individual patients.

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

There were no identified unexpected findings during testing or since implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria <u>and</u> 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)
2993 : Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.
Pharmacy Quality Alliance: Use of High-Risk Medications in Older Adults

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.**

The Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) measure and NQF 0022 have a similar focus (measuring potentially inappropriate medication use in older adults) and reporting level (health plan), however they have different target populations. The DDE measure targets patients with a specific condition or disease that can experience adverse effects when combined with certain medications that are recommended to be avoided for that condition. This measure (NQF 0022) targets a larger population of all older adults and assesses use of high-risk medications that have been recommended to be avoided in all older adults. The DDE measure (NQF 2993) is being submitted for NQF re-endorsement during this current Patient Safety project as well. Together these measures cover a significant portion of the AGS Beers Criteria recommendations for population-level medication safety assessment. This measure (NQF 0022) is harmonized with PQA's Use of High-Risk Medications in the Elderly (HRM) measure. The HRM measure is also based on the AGS Beers Criteria Table 2 and targets the same population of older adults. However, CMS will retire this display measure for 2021 and no longer reports this measure in the Patient Safety reports for the 2019 measurement year. Commenters supported retiring this measure.

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:**

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Co.1 **Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance
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Additional Information

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

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Measure Developer/Steward Updates and Ongoing Maintenance
Ad.2 Year the measure was first released: 2006
Ad.3 Month and Year of most recent revision: 07, 2019
Ad.4 What is your frequency for review/update of this measure? Approximately every 3 years, sooner if the clinical guidelines have changed significantly.
Ad.5 When is the next scheduled review/update for this measure? 12, 2021

Ad.6 Copyright statement: ©2020 by the National Committee for Quality Assurance
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Ad.8 Additional Information/Comments: NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written