Measurement Year 2017 (MY 2017) Measure Set and Summary of Changes

This document highlights any changes from Measurement Year (MY) 2016 and includes specifications for any testing measures that have already been identified.

Program and Policy Updates

- *None at this time.*

MY 2017 VBP4P Measure Adoptions

The following measures will be added to the MY 2017 Commercial VBP4P measure set for payment and public reporting.

Statin Therapy for Patients With Cardiovascular Disease (SPC)

SPC measures statin receipt and adherence for patients with cardiovascular disease and was tested in MY 2015. Based on MY 2015 testing results, the *SPC* measure will be added to the MY 2017 measure set. The first rate – *Received Statin Therapy* – will be recommended for payment and public reporting; the second rate for information only.

1. *Received Statin Therapy*. Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

The *SPC* measure was included as a testing measure in MY 2015 and was specifically developed to reflect new clinical guidance around cholesterol and replace the retired cholesterol measures.

The current specification for this measure can be found on page 51 of the MY 2016 VBP4P Manual.

IHA aligns with measure specification updates from measure stewards when possible; updated specifications will be included in the MY 2017 VBP4P Manual December 1, 2017.

Statin Therapy for Patients With Diabetes (SPD)

SPD measures statin receipt and adherence for patients diabetes and was tested in MY 2015. Based on MY 2015 testing results, the *SPD* measure will be added to the MY 2017 measure set. The first rate – *Received Statin Therapy* – will be used for payment and public reporting; the second rate for information only.

1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

The *SPD* measure was tested in MY 2015 and was specifically developed to reflect new clinical guidance around cholesterol and replace the retired cholesterol measures.

The current specification for this measure can be found on page 71 of the MY 2016 VBP4P Manual.

IHA aligns with measure specification updates from measure stewards when possible; updated specifications will be included in the MY 2017 VBP4P Manual December 1, 2017.

MY 2017 Medicare Stars Measure Changes

High Risk Medication (HRM)

The VBP4P program intends to align with the Medicare Stars 2018 version of *HRM*; specifications will be updated accordingly in the draft MY 2017 manual, released September 1, 2017.

MY 2017 VBP4P Measure Removals

The following measures will be removed from the MY 2017 Commercial VBP4P measure set.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

The *URI* measure will be retired based on consistently high performance across all POs participating in VBP4P. This measure has topped out and will be retired from the measure set beginning in MY 2017.

The current specification for this measure can be found on page 118 of the MY 2016 VBP4P Manual.

Human Papillomavirus Vaccine for Adolescents (HPV)

The *Human Papillomavirus Vaccine for Adolescents (HPV)* measure was added to the *Immunizations for Adolescents (IMA)* measure in MY 2016 to align with HEDIS. In conjunction with the change, the standalone *HPV* measure will be retired in MY 2017; the antigen will continue to be collected as part of the *IMA* measure.

The current specification for this measure can be found on page 94 of the MY 2016 VBP4P Manual.

Generic Prescribing (GRX)

The generic prescribing rate – *Anxiety/sedation—sleep aids* will be retired from the measure set beginning in MY 2017 as it is also included in the overall generic prescribing rate recommended for payment.

The current specification for this measure can be found on page 176 of the MY 2016 VBP4P Manual.

MY 2017 VBP4P Testing Measures

Pending successful preliminary testing by Truven, the following measure will be added to the MY 2017 Value Based P4P Manual for testing. The measure specification will be adapted for reporting by POs and health plans for the VBP4P program.

Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer

The VBP4P committees recommend testing *Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer* in MY 2017 pending internal testing completed by IHA and Truven in MY 2016. This PQA measure examines multi-provider and/or high dosage opioid use among individuals 18 years and older without cancer.

Three rates are included the measure:

- Rate 1 (Opioid High Dosage): The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.
- Rate 2 (Multiple Prescribers and Multiple Pharmacies): The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.
- Rate 3 (Multi-Provider, High Dosage): The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.

The current PQA measure specification is included in **Appendix A**.

Commercial P4P Advancing Care Information Domain Changes

- *None at this time.*

Medicare Stars Potential Testing Measures

- *None at this time.*

Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer

Description

We describe 3 measures that examine multi-provider, high dosage opioid use among individuals 18 years and older without cancer. Patients in hospice also are excluded. The denominator includes individuals with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is ≥ 15 during the 12-month measurement year.

Three measures are described herein that examine the quality of opioid use. Each of the following numerators will be considered:

Measure 1 (Opioid High Dosage): The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.

Measure 2 (Multiple Prescribers and Multiple Pharmacies): The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.

Measure 3 (Multi-Provider, High Dosage): The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.

Definitions

Measurement Period:	Twelve-month measurement year.
Opioid:	Also include tramadol and tapentadol (See Table Opioid-A)
Morphine Equivalent Dose (MED):	The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic (See Appendix A for conversions – separate attachment)

Rationale

The purpose of quality measurement is to improve quality, inform consumers, reduce risk to patients and influence payment. At this time, the goal is to develop measure concepts that are indicative of potential improvements in or to our healthcare system so that evidence-based patient care can be provided and patient outcomes can be achieved, in consideration of costs and, ultimately, value.

Towards this end, we propose 3 measures related to opioid use that are indicative of the quality of care for these medications. We propose these measures to examine the quality of use related to the dose of the medications over time, access to the medications and the combination of both of these criteria.

Claims data from commercially insured patients indicate that approximately 8% of opioid prescriptions for acute pain and 12% for chronic pain specify a daily dosage of 120 MED or more.[1] The proportion of patients being treated at this dosage for more than 90 days has not been described. However, one study of veterans treated with 180 MED/day or more for 90+ days[2] found that this group was characterized by high rates of psychiatric and substance abuse disorders and frequently did not receive care consistent with clinical guidelines. Other studies

have suggested the people at high opioid dosage are at greater risk of overdoses and fractures.[3,4,5] The Washington State Agency Medical Directors Group has suggested 120 MED as a dosage level that should not be exceeded without special consideration.[6]

Prescription drug monitoring programs, which track the use of multiple providers by patients, indicate that such use is typically found among a small proportion of patients, with the proportion declining as the number of providers increases. In Massachusetts in 2006, considering only Schedule II opioids, 0.5% of patients saw 4+ prescribers and 4+ pharmacies.[7] A national study found that 13% of patients had overlapping prescriptions from two or more different prescribers during an 18-month period. Of these, 0.5% used 4+ prescribers and 4+ pharmacies.[8] People who see multiple prescribers or use multiple pharmacies are more likely to die of drug overdoses.[4] Data from the California PDMP indicates that people with higher daily dosages are more likely to see multiple prescribers or go to multiple pharmacies.[9]

The data above suggest that prevention of opioid overdose deaths should focus on strategies that target (1) high-dose opioid users as well as (2) persons who seek care from multiple doctors and pharmacies. The data suggest that these criteria can be considered separately, as measures related to prescribed opioids for legitimate uses versus diverted uses. Thus, we propose 3 measures: one for each criteria and one that is the intersection of both criteria. This approach will also assist health plans in managing the number of patients who meet the measure criteria and planning their respective interventions, so that a balance of identification and intervention can be determined.

Eligible Population

Ages: 19 years and older as of the last day of the measurement period.

Continuous enrollment ***…using enrollment data***	Subjects should be continuously enrolled during the measurement period.
Allowable Gap for Medicaid	In cases where Medicaid enrollment is verified monthly, the enrollee is considered continuously enrolled if there is no more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).
Measurement Period	The patient's measurement period begins on the date of the first fill of the target medication (i.e., index date) and extends through the last day of the measurement year or until death or disenrollment.
Benefit	Pharmacy.
Stratification	Commercial, Medicaid, Medicare (report each product line separately). Low income subsidy (LIS) population (report rates for LIS population and non-LIS population separately.)

Administrative Specification

Intended Use: Health Plans

Data Source: Medical claims, Pharmacy claims, Prescription Drug Hierarchical Condition Categories (RxHCCs)

Measure 1

Denominator: Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is ≥ 15.
Numerator: Any member in the denominator with greater than 120mg MED for ≥ 90 consecutive days*

Rate: The rate is to be reported as a proportion: XX out of 1,000 enrollees.

Measure 2

Denominator: Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is ≥ 15.

Numerator: Any member in the denominator who received opioids from 4 or more prescribers AND 4 or more pharmacies.

Rate: The rate is to be reported as a proportion: XX out of 1,000 enrollees.

Measure 3 (intersection of 1 & 2)

Denominator: Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is ≥ 15.

Numerator: Any member in the denominator with greater than 120mg MED for ≥ 90 consecutive days* AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies.

Rate: The rate is to be reported as a proportion: XX out of 1,000 enrollees.

***Identifying members with prescription opioids that exceeded the MED threshold:**

To identify members with prescription opioids that exceeded the MED threshold, each claim is to be converted into the MED using the appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MED for each day's claims then are summed to determine the total MED for that day.

For each member in the denominator:

1. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations:
   - # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply)
   - MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor)
2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member.
3. Identify the days where the MED threshold is exceeded.
4. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator.

Exclusions:

Denominator exclusion: Any member with Prescription Drug Hierarchical Condition Categories (RxHCCs) 8, 9, 10, 11 for Payment Year 2015; or RxHCCs 15, 16, 17, 18, 19 for Payment Year 2016; or a hospice indicator from the enrollment database. (See Appendix B for RxHCC lists and associated diagnoses.)

Payment Year 2015

RxHCC 8	Chronic Myeloid Leukemia
RxHCC 9	Multiple Myeloma and Other Neoplastic Disorders
RxHCC 10	Breast, Lung, and Other Cancers and Tumors
RxHCC 11	Prostate and Other Cancers and Tumors

Payment Year 2016

RxHCC 15	Chronic Myeloid Leukemia
RxHCC 16	Multiple Myeloma and Other Neoplastic Disorders
RxHCC 17	Secondary Cancers of Bone, Lung, Brain and Other Specified Sites; Liver Cancer
RxHCC 18	Lung, Kidney, and Other Cancers
RxHCC 19	Breast and Other Cancers and Tumors

http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Advance2014.pdf
https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

Table Opioid-A: Opioid Medications**

Opioid Medications			
buprenorphine	hydrocodone	morphine	oxymorphone
butorphanol	hydromorphone	opium	pentazocine
codeine	levorphanol	oxycodone	tapentadol
dihydrocodeine	meperidine		tramadol
fentanyl	methadone		

**Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., BunavailTM, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys® (fentanyl transdermal patch) is also excluded as it is only for inpatient use; It is also only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)