



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 #: 0553

Corresponding Measures:

De.2. Measure Title: Care for Older Adults (COA) – Medication Review

Co.1.1. Measure Steward: National Committee for Quality Assurance

De.3. Brief Description of Measure: Percentage of adults 65 years and older who had a medication review during the measurement year. A medication review is a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.

1b.1. Developer Rationale: Medication review can be a useful tool to reduce medication related problems (Christensen & Lundh 2012). The process of reviewing a patient's medication list reduces the risk of adverse drug interactions being overlooked and helps physicians minimize the duplication and complexity of the patient's medication regimen (Kallio et al. 2018). This in turn may increase patient adherence to the medication regimen and reduce hospital readmission rates. A recent systematic review found that medication review resulted in a decrease in the number of drug-related problems among patients (Huiskes et al. 2017).

Christensen, M., & Lundh, A. (2016). Medication review in hospitalised patients to reduce morbidity and mortality. Cochrane Database of Systematic Reviews, (2).

Huiskes, V. J. B., Burger, D. M., van den Ende, C. H. M., & van den Bemt, B. J. F. (2017). Effectiveness of medication review: a systematic review and meta-analysis of randomized controlled trials. BMC family practice, 18(1), 1-15.

Kallio, S. E., Kiiski, A., Airaksinen, M. S., Mäntylä, A. T., Kumpusalo-Vauhkonen, A. E., Järvensivu, T. P., & Pohjanoksa-Mäntylä, M. K. (2018). Community Pharmacists' Contribution to Medication Reviews for Older Adults: A Systematic Review. Journal of the American Geriatrics Society, 66(8), 1613-1620.

Knight, E.L., J. Avorn. Quality indicators for appropriate medication use in vulnerable elders. Ann. Intern. Med. 2001. 703-10.

S.4. Numerator Statement: At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.

S.6. Denominator Statement: All patients 66 years and older as of the end (e.g., December 31) of the measurement year.

S.8. Denominator Exclusions: Exclude members who use hospice services.

De.1. Measure Type: Process

S.17. Data Source: Claims, Electronic Health Records, Paper Medical Records

S.20. Level of Analysis: Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Aug 05, 2009 **Most Recent Endorsement Date:** Jun 11, 2019

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

[0553_-_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.

Medication review can be a useful tool to reduce medication related problems (Christensen & Lundh 2012). The process of reviewing a patient's medication list reduces the risk of adverse drug interactions being overlooked and helps physicians minimize the duplication and complexity of the patient's medication regimen (Kallio et al. 2018). This in turn may increase patient adherence to the medication regimen and reduce hospital readmission rates. A recent systematic review found that medication review resulted in a decrease in the number of drug-related problems among patients (Huiskes et al. 2017).

Christensen, M., & Lundh, A. (2016). Medication review in hospitalised patients to reduce morbidity and mortality. Cochrane Database of Systematic Reviews, (2).

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Knight, E.L., J. Avorn. Quality indicators for appropriate medication use in vulnerable elders. Ann. Intern. Med. 2001. 703-10.

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.*

The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure.

Performance data is summarized at the health plan level and summarized by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at 10th, 25th, 50th, 75th, and 90th percentile. Data is stratified by year.

Medicare

Measurement Year: 2016; 2015; 2014

Number of Health Plans: 504; 427; 404

Mean: 88.0; 84.1; 87.2

STDEV: 16.1; 18.8; 14.0 MIN: 0.1; 0.0; 0.0

MAX: 100.0; 100.0; 100.0

P10: 71.3; 57.9; 73.5

P25: 86.5; 80.3; 82.0

P50: 93.2; 91.0; 90.7

P75: 97.5; 96.6; 95.8

P90: 99.5; 98.9; 98.6

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. The HEDIS Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines 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.

Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

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 studies have identified disparities in medication prescribing practices (CMS and RAND 2017; Hall-Lipsy 2010) and rates of medication adherence (Lewey 2013), to our knowledge no studies have found disparities in rates of medication review (the focus of this measure) by race/ethnicity, gender, age, insurance status, socioeconomic status and/or disability. As one example, a recent study that examined medication review found no differences by race (Trivedi et al. 2018).

CMS Office of Minority Health and RAND Corporation. Gender Disparities in Health Care in Medicare Advantage. Baltimore, MD. 2017.

Hall-Lipsy EA, Chisholm-Burns MA. Pharmacotherapeutic disparities: racial, ethnic, and sex variations in medication treatment. Am J Health Syst Pharm. 2010 Mar 15;67(6):462-8.

Lewey J, Shrank WH, Bowry AD, Kilabuk E, Brennan TA, Choudhry NK. Gender and racial disparities in adherence to statin therapy: a meta-analysis. Am Heart J. 2013 May;165(5):665-78, 678.e1.

Trivedi M, Fung V, Kharbanda EO, Larkin EK, Butler MG, Horan K, Lieu TA, Wu AC. Racial disparities in family-provider interactions for pediatric asthma care. J Asthma. 2018 Apr;55(4):424-429.

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):

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

Care Coordination

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

Elderly, 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)

Attachment Attachment: 0553_COA_Med_Review_Value_Sets.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.

No significant changes.

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).

At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.

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).

This measure can be met using the administrative specification (using administrative claims codes) or the hybrid specification (using administrative claims codes and medical record review).

Administrative: Either of the following meet criteria:

- Both of the following during the same visit during the measurement year where the provider type is a prescribing practitioner or clinical pharmacist:
 - o At least one medication review (Medication Review Value Set).
 - o The presence of a medication list in the medical record (Medication List Value Set).

- Transitional care management services (Transitional Care Management Services Value Set).

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

(See corresponding Excel document for the value sets referenced above.)

Hybrid: Documentation must come from the same medical record and must include one of the following:

- A medication list in the medical record, and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
- Notation that the member is not taking any medication and the date when it was noted.

A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Do not include medication lists or medication reviews performed in an acute inpatient setting.

Prescribing practitioner is defined as a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

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

All patients 66 years and older as of the end (e.g., December 31) of the measurement year.

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).

Use administrative data to identify all patients 66 years and older as of the end of the measurement year.

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

Exclude members who use hospice services.

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.)*

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

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 = 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.)

Step 1. Determine the eligible population: All patients 66 years and older as of the end (e.g., December 31) of the measurement year.

Step 2: Identify the denominator: Exclude any patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

The remainder is the eligible population

Step 3: Identify the numerator: Individuals in the denominator who have documentation of at least one medication review conducted by a prescribing practitioner or clinical pharmacist and have a medication list in their medical record.

Step 4: Calculate the rate: Numerator/Denominator

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 – This measure is not based on a survey or instrument.

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

If other, please describe in S.18.

Claims, Electronic Health Records, Paper Medical Records

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 and medical record documentation 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 plans 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. 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[nqf_testing_attachment_7.1_COA.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.

Yes

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.

Yes

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.

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 by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information \(e.g., DRG, ICD-9 codes on claims\), Abstracted from a record by someone other than person obtaining original information \(e.g., chart abstraction for quality measure or registry\)](#)

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**.

[Some data elements are in defined fields in 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).

[To allow for widespread reporting across health plans, this measure is collected through multiple data sources \(administrative data, electronic health data, and paper records\). We anticipate as electronic health records become more widespread the reliance on paper record review will decrease.](#)

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 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 stakeholders 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 informs both annual updates to the measures as well as routine re-evaluation of measures. These processes include updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence.

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, without modification, are encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Modifications to, and/or commercial use of, a measure requires the prior written consent of NCQA and is subject to a license at the discretion 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)
	Public Reporting CMS Star Ratings for Medicare Advantage Plans and Prescription Drug Plans https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html Payment Program CMS Star Ratings for Medicare Advantage Plans and Prescription Drug Plans https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html Quality Improvement (external benchmarking to organizations) Healthcare Effectiveness Data and Information Set https://www.ncqa.org/hedis/

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

CMS STAR RATINGS FOR MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS: This measure is included in the composite Medicare Advantage Star Rating. CMS calculates a Star Rating (1-5) for all Medicare Advantage health plans based on 48 performance measures. Medicare beneficiaries can view the star rating and individual measure scores on the CMS Plan Compare website. The Star Rating is also used to calculate bonus payments to health plans with excellent performance. The accountable entity is the health plan, and the service assessed in this measure can take place in any health care setting except acute inpatient care. Medicare Advantage covers 33% of all Medicare beneficiaries (19 million members) across 49 states.

The HEALTHCARE EFFECTIVENESS AND DATA INFORMATION SET (HEDIS) is one of health care's most widely used performance measurement and improvement tools. It includes measures for physicians, PPOs, and other organizations. Individual HEDIS measures are used in numerous public reporting, payment, accreditation, and quality improvement programs. 184 million individuals are enrolled in health plans or other organizations that report HEDIS measures (approximately 56% of the total U.S. population).

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.

Special Needs health plans that report HEDIS calculate their rates and know their performance when submitting results. CMS publicly reports rates for these plans to help Medicare Managed Care Organizations understand how they perform relative to others.

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.

CMS publicly reports average performance rates on this measure annually.

(See <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/2016-HEDIS-Report.pdf> for a recent example.)

NCQA also presents data at various conferences and webinars annually. 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. In addition, NCQA regularly provides technical assistance on measures through its Policy Clarification Support System, as described in Section 3c.1.

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 using a consensus-based process to consider input from multiple stakeholders, including but not limited to entities being measured. 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.

Questions received through the Policy Clarification Support system have generally centered around clarification on whether certain notation in medical record documentation is sufficient to meet measure criteria. Other questions have sought clarification about who can perform the care that meets the measure numerator.

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

This measure has been deemed a priority measure by CMS, as illustrated by its use in accountability programs such as the Medicare Advantage Star Ratings 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 update, feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure to exclude patients on hospice to eliminate undue burden on these patients. We also revised the measure to focus medication reviews on members in ambulatory care. The intent of this measure is to review the medications that an individual regularly takes in community settings (rather than medications prescribed and monitored in acute care).

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.

Over the past three years, this measure has shown slight improvement across health plans (see section 1b.2 for summary of data from health plans). These data are nationally representative and indicate that a higher percentage of individuals enrolled in these health plans are receiving high quality care compared when compared with scores prior to the past 3 years.

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 have been no identified unintended findings for this measure during testing or since implementation.

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

There have been no identified unexpected benefits for this measure during testing or since implementation.

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)

0097 : Medication Reconciliation Post-Discharge

0419 : Documentation of Current Medications in the Medical Record

2456 : Medication Reconciliation: Number of Unintentional Medication Discrepancies per Medication Per Patient

2988 : Medication Reconciliation for Patients Receiving Care at Dialysis Facilities

3317 : Medication Reconciliation on Admission

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

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?

Yes

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

See response in 5b.1 (response would not fit in this text box).

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.)

ANSWER TO 5A.1:

NCQA is committed to harmonization across measures and reducing unnecessary burden in measurement. However, it is important to note that the numerator (the specific health care service) being reported in this measure (Measure 0553) differs from many of

the other related measures.

Measures 0097, 2456, 3317, and 2988 address MEDICATION RECONCILIATION, which is a care service that includes compiling a list of medications the patient is currently taking and comparing it against a second list (generally a physician's admission, transfer, and/or discharge orders) in order to reconcile discrepancies between the two lists and make sure the patient is prescribed the appropriate medications and to decrease the likelihood of adverse medication interactions.

This care service is different from a MEDICATION REVIEW, which is the focus of this submission (Measure 0553). In a medication review, the goal is a critical examination of all the medications a patient is taking with the objective of reaching an agreement with the patient about treatment, optimizing the impact of medicine, and minimizing medication-related problems.

A medication review is also different from a simple documentation of current medications in the medical record (the focus of Measure 0419e), because this measure involves a review of medications in addition to a documentation of the patient's medications in the medical record.

Additional differences among the measures include level of accountability and target population, as demonstrated below:

0053: Care for Older Adults – Medication Review

Level of accountability: Health plan

Target population: Older adults (age 65 years and older)

0097: Medication Reconciliation Post Discharge

Level of accountability: Health plan

Target population: Adults 18+ discharged from hospital

0419e: Documentation of Current Medications in the Medical Record

Level of accountability: Individual clinician

Target population: Adults 18+

2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Level of accountability: Facility (hospital)

Target population: Adults 18+ discharged from hospital

3317: Medication Reconciliation on Admission

Level of accountability: Facility (hospital)

Target population: Adults 18+ admitted to hospital

2988: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities

Level of accountability: Facility (dialysis facility)

Target population: Adults permanently assigned to a dialysis facility

Evidence of performance gap and relation to risk of adverse events:

- Many medication errors occur during times of transition, when patients receive medications from different prescribers who lack access to patients' comprehensive medication list. Conducting medication reconciliation at major care transitions (eg, upon admission, upon discharge) may improve patients' ability to manage their medication regimen properly and reduce the number of medication errors (Measures #0097, 2456, 3317, 2988).

- Older adults are a vulnerable population and are more likely to have multiple comorbid conditions and thus be receiving multiple medications. This places them at higher risk of an adverse medication event, even without a care transition. This supports an annual medication review targeted specifically to older adults (Measure #0053). This measure is more specifically targeted to a vulnerable population and less burdensome to providers than a medication list documented at every medical visit (Measure #0419e).

ANSWER TO 5b.1:

While the other measures generally address a similar focus (medications), no other NQF-endorsed measures address both the same measure focus AND the same target population.

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.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance

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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.

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Patricia?Bomba,?MD, MACP, Excellus BlueCross BlueShield?

Jennie Chin Hansen, RN, American Geriatrics Society (Retired)?

Joyce?Dubow, MUP,?Public Member?

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 Laurie Spoll, Aetna

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2010

Ad.3 Month and Year of most recent revision: 07, 2018

Ad.4 What is your frequency for review/update of this measure? This measure is reviewed approximately every 3 years, and sooner if clinical guidelines or evidence

Ad.5 When is the next scheduled review/update for this measure? 12, 2019

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