A first move toward pharmacy performance measures was scheduled to be taken on November 20, when the full membership of the Pharmacy Quality Alliance (PQA) planned to meet for the first time. The PQA has flown under the radar since it was established last spring by the Centers for Medicare & Medicaid Services (CMS). But even though it might have low visibility at the moment, it could very well have a large impact in the future.

The PQA is a collaboration among drug industry groups and health insurance trade groups; membership has now expanded to 52 participants. The aim is to develop strategies for defining and measuring pharmacy performance. When since-departed CMS Administrator Mark McClellan, MD, PhD, announced the establishment of the group, he emphasized that he hoped those strategies would turn into measurement yardsticks that could be used to develop new pharmacy-payment models for optimizing patient health outcomes.

Obviously, Medicare would like to keep down the costs of its new drug outpatient coverage program (the Part D plan). So the PQA may well be a vehicle for moving the pharmacy industry toward a pay-for-performance (P4P) model.

McClellan returned to that thought in September, when he appeared before the Senate Special Committee on Aging, which was exploring ways to keep elderly patients from falling into the “doughnut hole.” This is the gap in Part D under which Medicare recipients must pay for 100% of their outpatient drug costs after they and their Plan D company have jointly paid out $2,250. Patients pay 100% of prescription costs at this point until they have spent a total of $3,600 for out-of-pocket expenses for the year. At that point, the federal subsidy resumes, paying 95% of any additional expenses. Thus, that doughnut hole is $1,350 deep.

Many senior citizens started falling into the doughnut hole in September—hence the hearings. Dr. McClellan mentioned that the promotion of generic brands would probably be one of the measurement tools to be developed by the PQA. In fact, according to Laura Cranston, RPh, Executive Director of the PQA, the November 20 meeting was expected to result in the group’s entire membership endorsing between 24 and 30 initial performance measures in nine different areas. These have been developed by nine subgroups working under the PQA Quality Metrics Work Group, co-chaired by Colleen E. Brennan, RPh, Director of Professional and Educational Affairs at the National Community Pharmacists Association, and John Coster, RPh, PhD, Vice President of Policy and Programs of the National Association of Chain Drug Stores.

One measure, for example, would specify how many days within a month patients would have to forget or neglect to take their cholesterol-lowering medication to be characterized as “noncompliant.” These measures, after they are endorsed by the full PQA membership, would then be validated by an outside organization. The process would take a minimum of six months. After that, it is expected that Medicare would ask pharmacies to volunteer to participate in a demonstration project.

No one should be under any illusion, though, that the effort to develop pharmacy performance measures—much less a P4P strategy—will be easy. After all, physician groups have been at it since 2004 under the umbrella of the Ambulatory Care Quality Alliance (AQA), another CMS creation on which the PQA is patterned. Six pilot sites around the nation are using a starter set of 26 quality-of-care measures for physician office practices.

But any kind of national rollout of the physician measures seems very far from being “ready for prime time.” Even if it were prepared, the American Medical Association (AMA) has many reservations about accepting any P4P yardstick from Medicare.

At the end of the regular session of Congress in September, key lawmakers were trying to avert a cut in Medicare pay for doctors—based on Medicare’s fee formula—starting January 1, 2007. Some lawmakers wanted to trade an increase in fees for the AMA’s acceptance of an initial down payment on P4P. But there is far from unanimous support in Congress for physician performance pay, and the AMA is cool to the idea. So it is difficult to see pharmacy P4P taking root any time soon.