Meeting Summary

CQMC Virtual Full Collaborative Meeting

The National Quality Forum (NQF) convened an all-day virtual full collaborative meeting for the Core Quality Measures Collaborative (CQMC) on April 13, 2021.

Welcome, Introductions, and Review of Meeting Objectives

Chris Queram (NQF), Danielle Lloyd (AHIP), and Michelle Schreiber (CMS) welcomed participants to the meeting, reviewed the agenda for the meeting, and emphasized the importance of the CQMC's work towards alignment and implementation of the core sets. NQF staff read the antitrust statement and reminded participants to refrain from discussing or exchanging competitively sensitive information. Ms. Lloyd shared the following meeting objectives with the group:

- Discuss progress and vision of the CQMC
- Develop the path forward to greater adoption of the CQMC core sets
- Develop the path forward to higher bar measures
- Strategize future directions for CQMC and the core sets

Review Current Scope and Goals

Ms. Lloyd provided an overview of the CQMC's activities to date. Ms. Lloyd shared that the overall goals of the CQMC are to align measures across public and private payers; identify high-value, high-impact, evidence-based measures; improve health outcomes; reduce the burden of measurement; and provide consumers with actionable information. The CQMC brings together over 70 member organizations, including payers, providers, consumers, employers/purchasers, and regional quality collaboratives. These members discuss and develop core sets of measures, traditionally around physician specialty areas.

Ms. Lloyd expressed sincere appreciation to the participants for their contributions to the CQMC. To date, the CQMC has developed (and updated) ten core sets on ACO/PCMH/Primary Care, Behavioral Health, Cardiology, Gastroenterology, HIV/Hepatitis C, Medical Oncology, Neurology, Obstetrics & Gynecology, Orthopedics, and Pediatrics. The Collaborative has also released guidance on future core set prioritization, gap areas, and suggestions for implementation. The CQMC will continue to advance these areas by performing ad-hoc core set maintenance, continuing to identify measure gaps and foster measure development in priority areas (via the Speaker Series meetings), and convening three new workgroups (Measure Model Alignment, Digital Measurement, and Cross-Cutting Workgroup). AHIP welcomed any suggestions for concept areas or measure developers to feature in the upcoming Speaker Series meetings.

Dr. Schreiber also provided a brief presentation on CMS' current efforts on measure alignment. Dr. Schreiber shared that CMS' vision is to use impactful quality measures to improve health outcomes and deliver value by empowering patients to make informed care decisions while reducing burden to clinicians, and that CMS has developed a Quality Measurement Action Plan with five goals to work towards this vision. The two most relevant goals to the Full Collaborative's discussion during the meeting are #1 (Use Meaningful Measures to Streamline and Align Quality measurement) and #3 (Improve Quality Measures Efficiency by a Transition to Digital Measures and Use of Advanced Data Analytics); the other goals are #2 (Leverage Measures to Drive Improvement Through Public Reporting and Payment Programs), #4 (Empower Consumers to Make Best Healthcare Choices Through Patient-Directed Quality Measures and Public Transparency), and #5 (Leverage Quality Measures to Promote Equity and Close Gaps in Care). Dr. Schreiber shared that Meaningful Measures 2.0 will work towards a true north of value for patients and will include eight domains: person-centered care, equity, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health. CMS shared that its internal plan to align measures in its programs is to start by considering each Meaningful Measures domain, agree on important conditions within the domain, identify the most important measure standards for the condition, then identify the best measures available to assess the domains. While there are valid reasons why not all measure specifications will align perfectly (e.g., measures intended to be applied to different populations), CMS shared that aligning on these concepts can help reduce measurement burden.

Overview of the Cross-Cutting Workgroup

Teresa Brown (NQF) provided the background for the Cross-Cutting Workgroup, an area of focus that was selected after the Collaborative agreed that there were overarching gaps across the Workgroups. The Cross-Cutting measures would be a shift from condition-specific measures which are only relevant to a specific clinical condition (e.g., hemoglobin A1c control measures for diabetic treatment).

Ms. Brown shared that the goal of the Cross-Cutting Workgroup is to develop a core set of cross-cutting measures in previously identified and overarching gap areas such as patient safety, diagnostic accuracy, patient-reported measures, access to care, care coordination, and social determinants of health (SDOH). The Workgroup will also identify and discuss specific gaps, barriers, and solutions to implementation. It was noted that in NQF's initial review, cross-cutting measures were retrieved from NQF Quality Positioning System (QPS), CMS Measure Inventory Tool (CMIT) and other related NQF frameworks (e.g., Roadmap to Promoting Health Equity and Eliminating Disparities, 2020 Improving Diagnostic Quality and Safety report, ongoing PRO-PM project). A total of 42 measures in different topic areas (e.g., access to care, screening, care coordination, patient safety, medication safety, immunizations, patient reported outcomes, functional status, and pain management) will be brought forth during the Workgroup's initial review. Maria Durham (CMS) solicited input from the full Collaborative regarding overarching frameworks, other topic areas and measure sources that should be considered. NQF staff also asked the full Collaborative how CQMC should address topics such as access to care and SDOH, where there are few fully developed and tested measures. NQF staff also inquired if the cross-cutting measures should be incorporated into the existing condition-specific sets, or if they should have a standalone set.

A Workgroup member recommended a review of the 2016 Council of Medical Specialty Societies (CMSS) Alignment Report. The full Collaborative was asked to consider the meaning of variation across measures (i.e., how much of the variation is intentional in a digital strategy framework) when addressing access and SDOH. The member recommended using already existing measures and tools, versus building new measures. It was noted that most health systems/health plans already have access measures and SDOH measures/instruments. Optum was noted as having a new SDOH tool that will enter a testing phase that the Workgroup can review. A CQMC member referenced the book, Cass Sunstein's *Too Much Information* to assist in the discussion. The book suggests a different perspective, related to information that should be disclosed during testing (i.e., revealing too much information and being overly transparent reduces public good). Additionally, from the same book, the themes to consider the following when selecting measures suitable for public reporting include:

1. Personal utility and happiness – will the measure enhance consumer trust that they will access good quality healthcare?
2. Instrumental – does the measure aid in decision-making (e.g., selecting a provider)?
3. Economic trade off – what would an individual pay to access information or not to have access to information?

The CQMC member recommended a shift from a framework that solely examines outcomes from a clinical perspective to including outcomes from the perspective of users of the publicly reported data (e.g., patients or caregivers). Other CQMC members agreed with the approach but recommended that the Workgroup first considers defining cross-cutting, to determine if the measures will apply to everyone, and establish if there are overarching themes.

Another member highlighted the need to ensure proper comparison of measures (e.g., specialty groups may define access differently in terms of wait time and availability of other comparable care). It was noted that what is important within quality is often decided by individual practices and their patients; therefore, asking the right questions will aid in establishing nuances and will result in higher reliability and consistency in the same question across the measurement landscape.

Also stressed by another member was the need to have patient-centered measures in a clinical pathway, just as specialty societies focus on conditions, and the need to use appropriate clinical management. In response to the challenges faced in accessing data (e.g., SDOH data), the member recommended sourcing data from claims (e.g., using z code information when available). However, the member acknowledged that there are challenges that exist in retrieving information (e.g., accessing information on death is easier for Medicare because of its population and how enrollment is handled but is still problematic for some other commercial plans). The member suggested that by ensuring that electronic health records (EHR) information is available and flows between users, the challenges in accessing clinical outcome data could be resolved.

A member of the Collaborative highlighted the complexity that comes with structuring and stratifying measures of equity. In response, another member shared that there is a need to standardize the data elements that would go into any SDOH measures (e.g., assessments performed at different levels). For example, an assessment prior to discharge after an emergency room visit is different from an assessment prior to a discharge after a 29-day stay at a skilled nursing facility (SNF). Assessments are not standardized across settings and may vary between care settings. A member recommended that assessments be standardized by including a basic set of data elements which will assess the baseline data before holding providers accountable to making a difference in their patients' outcomes. Examples of data sets would include unmet nutritional needs, housing needs, and how to determine whether a patient has needs within these areas. A component could also be added to the EHR for referral to the community resources that address different needs (e.g., Meals on Wheels for a patient with nutritional challenges). The member recommended the use of a system for a referral for basic needs with basic categories, addressing how the needs are met. The member asked the Collaborative to share any knowledge they may have on standardized elements for SDOH, to examine if the elements can be used for risk adjustment of outcome measures.

Most Collaborative members expressed support for standardization of data and highlighted work being done by NCQA and HL7's Gravity Project as good resources to help determine the Collaborative's direction. A member expressed their support for SDOH stratification and risk adjustment for areas with low compliance, which can be comprised of people who are economically disadvantaged. A member recommended the use of the Economic Innovation Group (EIG) Distressed

Community Index but recommended that the measurement industry develops its own common definitions. The member indicted that they are using EIG definitions and index to examine their provider performance across zip codes. CMS indicated that they have examined barriers in computation methods in the marketplace quality programs, and they are still exploring methods to ensure that the data being captured is accurate. CMS stressed that the standardization of data collection is a priority of the new administration and highlighted the United States Core Data for Interoperability (USCDI)/ the Office of the National Coordinator for Health Information Technology (ONC) projects that aim to examine the standardization of elements required during the certification process. This work was noted as drawing from the Gravity project in determining what should be part of the certification process, definitions, and components of data sets. CMS shared that it is currently using imputation models which are relatively accurate and readily available.

On whether the core set should stand-alone or be incorporated into existing sets, one member commented that a separate set would make the measures more visible. Another member shared their experience with cross-cutting measure sets: assuming that every cross-cutting measure fits within every specialty set is not always appropriate. The member supported having a stand-alone core set that would be examined by each workgroup for their respective core sets. A recommendation was made for the Cross-Cutting Workgroup to create a shortlist of measures. The measures would then be examined by all the clinical workgroups to determine synergies, overlap, and considerations. A member expressed support for this approach indicating that measurement of outcomes and health should be done at the patient and population level and may vary depending on setting (e.g., clinical outcomes may range between providers or specialists). It was noted that some measures may require adapting to a specific setting or condition, which could be determined by those specific workgroups.

Overview of the Digital Workgroup

Nicolette Mehas (NQF) provided background for the Digital Workgroup's upcoming activities. Dr. Mehas shared that digital measures, which capture data created during the course of care and can be transmitted electronically, are becoming a more feasible option as healthcare data systems develop. In an ideal state, clinicians would provide routine care and the data generated when providing care would be captured in an electronic health record in a standardized format and exchanged electronically (adhering to USCDI and Fast Healthcare Interoperability Resources [FHIR] interoperability standards). Afterwards, the data would be used to calculate quality measures, and the results would be used to support value-based purchasing and alternative payment models, as well as shared with consumers to support their decision-making. However, digital measurement faces challenges including varying data standards, fragmented data systems, high investment costs for upgrading IT infrastructure, building support for analytics, etc. These challenges are especially difficult for independent and rural providers. The Digital Measurement Workgroup will explore opportunities including streamlining data reporting and aligning capturing and reporting; activities will build on existing initiatives from CMS, NCQA, and past NQF work. Ultimately, the Digital Measurement Workgroup will create a roadmap that uses recommendations for voluntary adoption of models that facilitate greater uptake of digital measures, including electronic data capture and transmission of the CQMC core sets.

Dr. Schreiber acknowledged that CMS has set an ambitious goal of moving towards fully digital measurement by 2025, and that this goal is meant to encourage quick movement towards implementation. Dr. Schreiber shared that ideally, data would be reported once and then used across multiple CMS quality measurement programs. Dr. Schreiber also noted that feedback mechanisms should be established that help guide decision-making and quality improvement efforts for providers. Dr. Schreiber opened discussion by asking Collaborative members to share barriers to implementation of digital measures and possible solutions.

The group discussed the role of registries in advancing digital measurement. A Collaborative member shared that their organization is working on the results of an updated registry survey and can share back to the CQMC membership. They shared that an increasing number of registries are using FHIR standards and that registries are a possible pathway to encouraging digital measures. The group also discussed that registries pose new opportunities for leveraging cloud-based computing and advanced analytics (e.g., artificial intelligence, machine learning, neural networks) to assess datasets from multiple sources (e.g., a dataset combining clinical data and census data). A member expressed that without registries, it will be difficult to pivot to specialty measures that go beyond claims data.

The group agreed that the technology for digital measures exists, but smaller groups (e.g., a group of 2-3 small family practice doctors or a Critical Access Hospital) may not have the technical training and support to code and report their quality data (versus a larger group that might have a dedicated department). A Collaborative member shared that it is important to incentivize development of IT infrastructure by emphasizing the possible returns (driving quality of care; developing a system that is transparent and actionable, where groups can calculate and interpret their own data). Another member noted that regional collaboratives could serve as a central party to aggregate data or could provide technical support and relieve burden from smaller providers.

The group also discussed current data standards and data sources, including the following main points:

- Providers often provide good patient care (e.g., clinically meet measure requirements), but the data used to calculate quality metrics is not automatically recognized and used in measure calculations.
- A major barrier to digital measurement is data standardization. Common data standards exist, but different standards are adopted by different systems.
- EHR systems should adopt a required standard (whether registries, portals, health information exchanges, etc.) – this is especially helpful for providers that use multiple EHR systems.
- Adoption of a common standard could be incentivized by emphasizing the value add of adoption (e.g., DaVinci’s example use cases on data exchange for quality measurement) and would benefit from more uniform guides and maps for implementation.
- Standard-setting organizations need to be involved in this process – for instance, if standards or technologies are not designed to meet CMS data submission requirements, this might lead to further fragmentation.
- CMS and the Joint Commission require discrete data fields for eCQMs, but discrete data fields do not always capture the nuances of care (e.g., ‘partial credit’ for beginning discussion or starting referrals to other services, even if not yet complete). Multiple Collaborative members also agreed that unstructured data fields contain additional important clinical data, and these should be captured and coded in some way.
- There are multiple sources where data can be collected; if data from two sources conflicts, there should be a process for determining the ultimate “source of truth.”
- A Collaborative member shared that supplemental data, such as marketing data or financial data, could be linked to an individual’s care to contextualize their healthcare decisions.

Finally, a Collaborative member reminded the group that the patient perspective will need to be at the forefront of the discussion. The group discussed that there will likely be pushback from consumers and personal device manufacturers (e.g., CPAP machines) if forced to record and report quality data. While patient-reported data and data from remote patient monitoring are important potential sources of data, patients are unlikely to agree to sharing their data unless there is a clear benefit.

Ms. Lloyd noted that the team has reached out to the Strategic Health Information Exchange Collaborative (SHIEC), American Joint Replacement Registry, Electronic Health Record Association, and others to provide some registry perspective in the Digital Workgroup. Ms. Lloyd shared the proposed guidelines for vendor participation in the Workgroup (must have quality measurement experience; must participate as a non-voting member; must focus on experience with measure use and implementation, not promoting products or services) and asked that Collaborative members share any additional suggestions they have. No comments were offered, thus Ms. Lloyd let members know they could follow up with additional suggestions offline.

Break Activity

Dr. Mehas introduced the following questions and invited members to provide feedback via a Google Jamboard sticky note session during a 15-minute break. Dr. Mehas noted that feedback would be collated and shared back during the afternoon presentation on "Maintaining the Core Sets."

- What worked well? What did not work well?
- Do you have any suggested improvements to the measure selection process, criteria for core set measures, meeting processes and logistics, etc.?
- Are there any new measures or areas that should be considered in the ad hoc maintenance this year, or in future rounds of maintenance?

Overview of the Measure Model Alignment Workgroup

Dr. Mehas (NQF) provided background by sharing that the Measure Model Alignment Workgroup will be exploring different measure implementation, aggregation, and reporting models, which can influence results and contribute to burden. It was noted that there are different measure models that are developed specific to organizations and patient needs, which may cause alignment challenges. Some of the alignment challenges may be addressed by developing best practices for the following:

- Data collection and transmission.
- Attribution methodology.
- How measures are aggregated into ratings (e.g., Star Ratings) or an overall performance output (e.g., how they are grouped, and weighted).
- How results are presented to consumers to inform decision making (e.g., via dashboards or reports).
- How information is shared with providers and the timeliness of the information to allow for efficient improvements.

Dr. Mehas shared that the Workgroup's goal is to develop best practices and policy recommendations that address governance, structural, and operational models for payer and purchaser alignment around the collection, transmission, standardization, aggregation, and dissemination of data. This information will support scaled core set adoption and implementation while reducing provider burden. The proposed approach for the Workgroup will involve reviewing an environmental scan of publicly available collaborative models that can serve as a guide for payers, purchasers, providers, and others. The Workgroup will convene to review the publicly available collaborative models to assess their respective strengths and weaknesses. The Workgroup will also discuss barriers and solutions towards alignment and greater standardization of measure data used to compare quality performance and drive improvement, including potential policy solutions. The findings from the Workgroup discussions will be used to guide the development of a comprehensive Measure Model Alignment Guide, which will support the existing Implementation Guide.

The models that will be reviewed by the Workgroup will serve as examples of how measures are used, reported, and scored. The Workgroup will also consider how performance results should be shared with providers, consumers, and other stakeholders. NQF shared examples of regional collaborative models proposed for review: Integrated Healthcare Association (IHA) – AMP Report Cards, Kentuckiana Health Collaborative (KHC) – Consolidated Measurement Reports, and Wisconsin Collaborative for Healthcare Quality (WCHQ) – Performance and Progress Reports. It was noted that models such as CMS' Care Compare and Star Ratings and other models will also be referenced during the Workgroup discussions.

Ms. Lloyd reminded the Collaborative of the CQMC antitrust policy, highlighting that the group is not seeking consensus over which specific model every member organization should use. The aim of the discussion and Workgroup will be to examine best practices. Respective member organizations would make their own decisions regarding implementing any of the best practices or recommendations.

The Collaborative discussed characteristics of an ideal model for measure alignment, including considerations for governance, structure, and type of data reporting. The following questions were posed.

- What are the key considerations as we begin this work?
- What are models we should look to as examples for this work?
- What existing dashboards would be a good model?
- Are there other aspects of how measures are used that should be addressed (e.g., intent, risk-adjustment)?

A member expressed that the attribution methodology is an important component of measurement that should be considered by the Workgroup. Where possible, common approaches and definitions should be adopted. There is also a need to establish an aggregation/weighting methodology (e.g., using composite measure) and best practices for developing overall ratings of quality. The member supported creating standard aggregation guidance for potential use across payers. A member suggested the Workgroup reference previous NQF work on attribution and measure sets and measurement systems. In response, Dr. Mehas acknowledged these projects would be important to reference and recognized several synergistic components (e.g., grouping, scoring, risk adjustment, examining data sources, timeframe for data collection, sample sizes). A member shared that concerns over small sample sizes could be potentially addressed by bringing data together from multiple sources in accordance with all antitrust laws. The regional collaborative groups were highlighted for their potential to aggregate data and overcome low case volume concerns.

A member inquired whether Collaborative members were aware of any organizations that are defining attribution as it relates to outcomes. The member supported creating attribution guidance for different providers for any outcome events that will be examined. Also noted was the need for greater transparency of the attribution method (e.g., was a patient with diabetes attributed to his primary care physician, endocrinologist, or both). A member also suggested discussing opportunities for greater standardization of how risk adjustment is applied. Another member agreed the topics would be good areas for Workgroup discussion but also noted that risk adjustment is usually measure specific. A member expressed the need for guiding principles to promote patient-centered care (e.g., team-based attribution, considering SDOH, and promoting care coordination).

Opportunities to Collaborate with Regional Efforts

Amy Moyer (NQF) introduced speakers from three regional collaboratives. The Integrated Health Association (IHA), Kentuckiana Health Collaborative (KHC), and the Wisconsin Collaborative for Healthcare Quality (WCHQ) each presented an overview of their organization and measurement model and then responded to questions from attendees.

Thien Nguyen from IHA shared that the organization is a non-profit based in Oakland, California. IHA's goal is to bring the healthcare community together to solve industry-wide challenges. It is a membership organization with about 14 health plan members and 200 providers across all business lines. It collects information from members to aggregate data, providing benchmarking and other information back to participants. IHA strives for a balanced perspective from payers, purchasers, and providers, hearing all opinions and concerns to move everyone toward an aligned measure set for benchmarking and reporting. IHA has three committees: a governance committee to oversee strategy and direction of all IHA programs; a technical measurement committee to help guide the measure set development, provide expertise in measurement development and guide strategy and annual maintenance of the core set; and a technical payment committee, to provide expertise about applicable value-based incentive models.

Stephanie Clouser from KHC shared that the organization is a non-profit purchaser-led multistakeholder coalition with three overarching priorities: improve access to high quality care, make healthcare more affordable, and build healthier communities, all with a health equity lens. KHC works with its stakeholders to solve shared problems within the community together, rather than as individual organizations. Member organizations include health systems, providers, hospitals, health plans, employers, public health and government, labor unions, consumer advocacy groups, pharmaceuticals, and others, totaling around 65 organizations. KHC works with members to gather data from health plans, including HEDIS indicators, to feed into their annual quality measurement reports. KHC has coordinated with the state Medicaid office to create a core measure set since 2017. Alignment between Medicaid and Medicare was a goal, with KHC including the private payers as well, to encourage alignment between both the private and public sectors. The KHC core measure set is seen as the first step to alignment, specifically designed with the needs of Kentucky in mind (e.g., focusing on issues such as tobacco or lung cancer, which have higher rates in their state). The goals are to improve the quality and value of care, reduce provider burden in reporting, and to align Kentucky's healthcare organizations. The current core set includes 38 primary care measures, within the areas of preventive care, behavioral health, pediatric measures, chronic and acute conditions, and cost utilization. KHC does not currently focus on value-based work with their core measures set.

Matt Gigot from WCHQ shared that the organization was founded in 2003, with an overarching goal to bring meaning to performance measurement information that improves the quality and affordability of health care in Wisconsin, in turn improving the health of individuals and communities. WCHQ is a membership organization made up of approximately 40 members: 35 health systems and providers from across the state, four dental practices, and payers. WCHQ has a multistakeholder board of directors, and is funded through membership dues, leading to decision making focused on the value proposition to its members. WCHQ's core competencies include developing, collecting, and publicly reporting quality information across the state. In addition to public reporting, WCHQ creates and disseminates quality improvement strategies, reports and information, and best practices across member organizations. WCHQ's improvement model is to start with measurement, work with members for best practices, disseminate these best practices, and to create or adopt new measures to measure and support improvement. Additionally, member organizations submit patient-level data, with WCHQ maintaining a clinical-level data set, and aggregating data to report back to organizations. WCHQ applies adopted quality measures to this data set. It publicly reports the results at the health system and clinic level, providing state-wide benchmarks. It also uses this data set within the research arena. Subcommittees of the board of directors provide guidance and oversight for WCHQ activities. A multistakeholder measurement advisory committee provides guidance, oversight, and continual review for WCHQ's measurement portfolio and reporting practices. An ambulatory care specifications committee translates the measurement specifications to clinical applications. WCHQ measures may be adopted and publicly reported in incentive programs but are designed primarily for transparency and quality improvement purposes. WCHQ member organizations look to NQF, CQMC, and NCQA for opportunities to align; however, they also consider regional aspects when reviewing national stewards' information.

Ms. Moyer then introduced discussion questions to the Collaborative. A participant asked for more information on each collaborative's reporting process to CMS, and if this reporting is an added value to practices. WCHQ shared that EHR vendors are increasingly taking on the roles of fulfilling CMS compliance for data submission, and that the real added value is the ability to benchmark. IHA responded in agreement relating to EHR vendors and added that a value-add for their members is data aggregation, giving health plans the ability to see how their network is performing, with results that provide visibility across lines of business. KHC stated that they only receive health plan data, not provider data, and that benchmarking was the value-add to the member organizations.

Dr. Schreiber asked each collaborative about measure alignment, stating that reporting of slightly different measures to several different entities contributes to provider burden. She questioned whether the CQMC and the collaboratives themselves are part of the problem with reporting burden. WCHQ responded that regional variation in specifications is certainly part of the problem and that the balance between needs of regional member organizations and a national direction is a difficult part of the process. WCHQ continued to share that alignment is a frequent discussion topic with these regional members but that the desire remains to have regional control. CMS shared that this is a consistent challenge within CMS itself, and introduced that systems may be choosing measures that would allow them to look more favorable. IHA stated that alignment should start at the regulator level and that there is an opportunity to align from the top down. This alignment with regulatory requirements would supersede regional changes and reduce some of the data collection burden. Kentuckiana shared that national measure programs are not going to go away, so local collaboratives should collect and report measures for national priorities while focusing on selecting measures or areas that can provide the most opportunity for local improvement. Ms. Lloyd stated that these goals are aligned with the digital measurement workgroup, and that by collecting data once, incorporated as part of the workflow, and then reporting to multiple entities can increase value and simultaneously reduce reporting burden.

Measure Model Alignment Breakout Sessions

Ms. Lloyd introduced the following questions on measure model alignment for members to discuss in eight breakout groups:

- What is a potential ideal state for aligning how measures are used?
- What are the barriers to such collaboration?
- What strategies might CQMC employ to remove such barriers?
- How should CQMC prioritize the steps in this workstream?

Members reported back the following discussion (listed group by group below).

Group 1

This group discussed the following themes:

- Regarding the ideal state of measurement, the group questioned whether it is possible for the same measures to be used for quality improvement, transparency, and aligning payment incentives.
- Measurement models should aim to advance equity. This may require greater emphasis on performance rates for different populations rather than focusing only on average measure performance. A member emphasized that to get to improvement we need to understand those performing below average. Information by payer source may not be as helpful to target

disparities as understanding performance by other demographic characteristics.

- A first step to greater national alignment of measurement models is to agree on goals and priorities.
- Another goal should be to focus on aligning measure specifications. Can we accurately use measures for comparison if their specifications are different?
- A barrier to greater alignment is the varying priorities in different regions based on the needs of their population.
- Measurement models should reflect team-based models of care; however, from a network design/payment perspective the focus may be more on individual providers.
- National and regional carriers including CQMC measures in their incentive plan design would support greater alignment.
- CQMC should continue to focus on adoption strategies. Sharing data with regional groups and other stakeholders can also inform decisions about which measures to prioritize.

Group 2

This group discussed the following themes:

- The importance of keeping the intent of the measure in mind and ensuring the intent aligns with the program (e.g., misalignment of placing clinician-level measures in a program that focuses on hospital performance).
- A central data aggregator could reduce burden and guarantee alignment in the specifications and results reported.
- An ideal state would make it easy to capture all parts of the measure, even going as far as to eliminate all reporting burden.
- Barriers to achieving the ideal state of measurement include technological challenges; the different goals, motivations, and rules for stakeholders; and an unwillingness to compromise.
- The group noted that sometimes pay-for-performance program requirements can be too expensive and burdensome, so that it makes more sense to forego the financial benefit rather than to participate.
- Participants may push back on reporting requirements, and program stewards may need to modify the measure or data collection to maintain buy-in and participation in voluntary programs.
- The CQMC can help address these barriers by serving as a centralized place for questions and discussion of issues. CQMC could facilitate responses from measure stewards and help stewards understand who is using their measures and how.
- CQMC should celebrate and highlight organizations that have developed solutions to implementation challenges and help propagate that knowledge. Sharing best practices and ways to make it easier to use measures in the core sets can help increase measure uptake.

Group 3

This group discussed the following themes:

- Alignment of activities. Shared measure sets that have been streamlined, common streams for data collection and validation, and improved data flow would be helpful. Group members noted that common measure sets should prioritize measures that will be used for accountability, with more flexibility around individual institutions' quality improvement measures. Attribution does not necessarily need to be aligned and can be decided by individual institutions.
- Accountability. The group discussed that the "right" level of accountability may be the facility level instead of the individual provider level (due to statistical noise at the individual level). A group member expressed that the purpose of measurement is not to create a perfectly

objective system, but to encourage better care and outcomes for patients and populations. This goal is sometimes missed when providers focus on improving numbers for a required number of measures. Instead, an ideal state would encourage behavior change (e.g., reward improvements, eliminate incentives around gaming/coding measures, consider unintended consequences). More meaningful outcome measures should be developed. The group also discussed that reducing the number of measures that people can report on and establishing expectations that everyone reports on the same standards (e.g., CMS reducing the number of measures in MIPS) is helpful and discourages providers from only reporting measures on which they do well.

Group 4

This group discussed the following themes:

- Barriers to alignment. The group noted that digital measures should be able to be collected seamlessly and quickly, but there is still significant fragmentation. Digital measures have advanced, so incentives for their collection may also need to be updated. The group discussed that eCQMs have evolved and are capable of storing more detailed information that can be used for measurement. One member shared that third party systems can make it more difficult to report and that each entity may prefer the source they are already using (versus standardizing). There is a need to prioritize testing and certification to better conform to key aspects of eCQMs. Certain programs are not built for quality reporting, and there is a need for data mapping. Another idea raised was the use of a universal system so all reporting can be submitted in the same way. Group members desired greater transparency and data accessibility. The group suggested that systems that are catered to users may reduce potential for interoperability and that there is also a need for more analytical expertise at systems to be able to use and report digital measures.
- Strategies to removing alignment barriers. Many of the digital measurement barriers may be beyond the CQMC's purview. The group discussed that there is a need for infrastructure investment and leadership by ONC and CMS, alongside entities working on data standards. The CQMC could, however, promote digital measures and advance a collaborative conversation on their use. Members raised that there is a need for greater communication between federal partners and entities that report to them.

Group 5

This group discussed the following themes:

- Alignment of activities. There are different levels of analysis in the core set. A suggestion was made that, ideally, specifications could be calculated at various levels. There is a need for a manageable list of measures which are all calculated the same way. Measure users should be open to having areas of low performance and working on improving those areas versus being incentivized to report measures they are likely to perform well on. Measures that are high performing should be removed from the core sets, and the sets should be maintained periodically so they remain current. There is also the need for greater alignment of payment incentives used. One member expressed that the sets should include cross-cutting and high-impact measures and consider if measures can be used by rural providers (who are often not included in certain programs due to small volume issues).
- Barriers to alignment. Barriers recognized include varying measurement purposes, priorities, levels of analysis, and resources available for measurement. The group discussed the need to define what alignment means and establish that not everything can be aligned. Members expressed that the field should consider new ways of extracting measure information outside of building or updating EHRs (e.g., mining artificial intelligence).
- Strategies to removing alignment barriers. One strategy suggested was to directly ask clinicians and patients what they value and align with areas they find meaningful. For

example, a diabetes measure for continuity of care may be more meaningful than hemoglobin A1c. Other ideas were to search literature to identify innovative ideas for measurement and to obtain a broader perspective on priorities from stakeholders outside of the CQMC.
- Prioritizing steps in this workstream. The group suggested that the CQMC should establish common definitions for alignment, determine what can be aligned, and then then create a path to get there.

Group 6

This group discussed the following themes:

- Goals of measurement. A group member shared that quality improvement efforts should focus on progress towards evidence-based clinical goals, rather than focusing on comparing plans to plans.
- Alignment of activities. While different entities are measuring concepts at different levels, measurement of different entities should all support a common goal (e.g., providers might report on unnecessary C-section rate, while payers might provide information on support programs that help providers reduce unnecessary C-sections). The data collected at these different levels should "flow" freely between levels. Regional collaboratives may be a helpful starting point for discussing possibilities for alignment.
- Presentation of data. Data from measures can be used by members/consumers for healthcare decision-making; providers for quality improvement and contracting; purchasers and employers for performance-based guarantees; and for regulatory bodies. The group discussed that data needed to be presented and translated differently for each of these user groups (e.g., consumers might need additional guidance on the most important aspects of measures and how to interpret, displays of benchmarking data should be constrained based on the options available to individual consumers).
- Barriers to alignment. Group members shared barriers to alignment including lack of in-house expertise for data collection and analysis for some groups, inconsistent data definitions, and lack of buy-in due to unique program needs. It may be useful to identify groups that are not involved in alignment discussion to understand why they are unable or uninterested in involvement. A group member also shared that measures' exclusion and inclusion criteria do not always allow for patient choices to count (e.g., delaying vaccination for a child).
- Role of CQMC. The group discussed helpful products that CQMC could produce to support alignment. These included a flow map identifying areas that should and should not be aligned; a geographic map identifying regional collaboratives that can support local work; and a portal or white paper identifying examples of best practices for model alignment.

Group 7

This group discussed the following themes:

- Potential ideal state. The group discussed the need for greater standardization across measures and how data is captured in a clinical workflow to reduce burden. The group discussed the need for standardizing data collection across EHR platforms and ensuring that measures enable a fair comparison across entities. Other opportunities include achieving a set that people are generally satisfied with and that is balanced between achievable and ideal measures; limiting unnecessary variation in specifications; seamless data reporting (e.g., EMR data connected to HIE); and establishing a timely feedback loop.
- Barriers to alignment. There is a need to evolve from relying on claims-based measures to using digital measures. Better risk adjustment methods are needed. CQMC should move away from aligning around the lowest common denominator measures and focus on measures that

needle in quality. There is also a tension between preventing variation and promoting alignment; specific populations or small denominators may cause some organizations to modify a measure. Another opportunity is to establish an appropriate time frame for reporting, aiming for less lag and more real time data.
- Strategies to remove alignment barriers. The CQMC could promote greater collaboration between payers and medical record companies (e.g., EHRs and other vendors). The CQMC should serve as the "source of truth" for measures in the core sets and could provide education on the importance of not modifying measure specifications (e.g., user agreements for sets). The CQMC could also identify how measures are implemented (and when different specifications are being used).

Group 8

This group discussed the following themes:

- Potential ideal state. The group discussed the focus on health and health equity, as well as the balance the CQMC must recognize between aspirational and realistic approaches.
- Barriers to alignment. The group agreed with previous challenges presented by one of the regional collaboratives, IHA. It was shared that removing barriers starting at the regulatory or federal level would be necessary due to regional differences. Other barriers include a lack of transparency within organizational choice (i.e., organizations may tend to choose measures that may be favorable) and that shifting measure specifications may need additional context and explanation from the stewards.
- Role of CQMC. The group discussed the role of the CQMC within the larger competing priorities (e.g., COVID) and examining quality of the larger health system and accountability during unconventional healthcare scenarios.

Maintaining the Core Sets

Dr. Mehas shared major themes from the sticky note session by question. Members shared that they appreciated the diverse membership and that meeting summaries were detailed and helpful. A member of the Medical Oncology workgroup also shared that the co-chairs did a good job facilitating discussion. However, members shared that it was difficult for first-time attendees to participate and ask questions; group size sometimes limited discussion; and not all voting members are well-prepared to discuss the measures, or in some cases members do not attend calls or do not participate in discussion. Members also shared that discussion of measure burden was limited, discussion was not always patient-centered, and the workgroups were limited to discussing best-available measures that are sometimes out of date. A member also commented that future rounds of discussion should consider whether measures are appropriate for digital measurement (do not require hand-abstracted data). Members suggested improvements including establishing a more meaningful organizational framework for the core sets (e.g., patient journey or major clinical conditions); more frequent but less detailed review (e.g., consider addition of new measures every year but comprehensive review of set every three years); splitting workgroups into smaller discussion groups; improving consistency of criteria for inclusion, especially around NQF endorsement; and improving the process to remove measures from core sets. Finally, members suggested that the new Person-Centered Primary Care PRO-PM and measures addressing the effectiveness of team-based care be considered.

Erin O'Rourke (AHIP) shared with the Collaborative the principles for measures for the CQMC core measure sets. Steps undertaken during core set review and development process for each topic area were highlighted as follows:

1. Identify existing measures and potential inputs through an environmental scan conducted by NQF staff. Measures identified in the scan are usually NQF-endorsed measures, measures used in public programs with specifications available, and other strong candidate measures by the Workgroup.

2. Perform environmental scan and gather measure information.
3. Discuss measures and reach consensus on whether to include in electronic voting. This is typically 2-4 meetings, depending on the number of measures available for each topic area.
4. Vote on whether to add measures to core set. This is typically over a 4-week voting period. For a measure to be added, it must achieve a 60% affirmative vote overall and at least one affirmative vote from each voting category.
5. Identify remaining gaps and strategies to fill the gaps, including measures under development.
6. Discuss how to present and disseminate the core set.

Core sets approved by respective workgroups are presented to the Steering Committee and the Full Collaborative for a final vote of approval; again, this is typically over another 4-week voting period.

It was noted that this year the core sets will undergo the ad-hoc maintenance process for the first time (as opposed to the full review and maintenance process of last year). The Collaborative was advised that the goals of ad-hoc maintenance are:

- Ensure the core sets reflect best practices and current evidence.
- Provide opportunity to revise core sets as needed (i.e., add newly available measures in high-priority areas and remove measures no longer appropriate for the set).

Ms. O'Rourke shared that the ad-hoc maintenance process will be similar to previous workgroup meetings, where CQMC identifies measures, the Workgroup provides input, and voting members cast their votes on the measures following all voting procedures. During ad-hoc maintenance, NQF will still flag potential revisions to sets based on major changes (endorsement, changes in evidence, high performance, newly available measures that address priority gap areas, suggestions from Workgroup members) but will limit the scan to fully developed measures that fill gap areas. The Workgroups will also meet less frequently (e.g., 1-2 meetings instead of 4 meetings) during the ad-hoc maintenance year.

Ms. O'Rourke highlighted the lessons learned from Workgroup and Steering Committee discussions to date:

- Ensure we have the right stakeholders engaged and present at meetings.
- Consider including additional data sources for measure scan and performance.
- Consider if the core sets could benefit from an organizing framework (e.g., Meaningful Measures 2.0, person-centered episode of care, clarification of scope of specialty).
- Potentially broaden sources of measures.
- Foster development in priority areas (i.e., moving away from retrospective alignment towards prospective alignment).

The following questions were posed to the Collaborative to gain additional input on the vision and framework of the CQMC:

- Do the core sets address the most important aspects of healthcare and healthcare quality for that condition?
- Is specialty-specific model still preferred, or should another organizational method be considered?
- Are additional specialty areas needed?
- Have we adequately reflected dissenting opinions in the display of the sets?
- Have we adequately reflected caveats (e.g., best for larger groups)?

Ms. O'Rourke noted that the idea of using a different organizational framework was raised earlier in the meeting (e.g., creating patient-centered measure sets that track across the patient's journey) and sought input on how the sets should be organized. A member shared that the specialty-specific model should remain, but it might be helpful to consider the addition of cross-specialty groups (e.g., equity/SDOH workgroup; perioperative care; pain management; care transitions). Another member shared that the specialty-specific model might not be the best framework for patients with complex health status, and that cross-cutting, person-centered, goals-centered, or patient journey would be more relevant frameworks appropriate for these populations; another member shared support for this idea and noted that it would be easier to identify meaningful gaps using this framework. A member also shared that categorizing measures by stages of prevention could also be useful (primary prevention, or disease/illness prevention; secondary prevention, or optimization of disease treatment; and tertiary prevention, or addressing complications and preventing worsening of condition).

A member shared the challenge of having measures in core sets that are being used at a different level of analysis than the one they were tested for (e.g., a measure that was tested at the health plan level may not be appropriate at the physician/group practice level). The member expressed support for using measures at their intended level of analysis and noted that if a measure has not been tested at that level, this should be acknowledged clearly in the core sets. Another member agreed that additional clarity should be established around measures that are at a different level of analysis, and added that the CQMC should be clear on the level of analysis being recommended for each measure (e.g., if a hospital-level measure is included in the core sets, is the CQMC recommending that the measure be used at the clinician level or at the hospital level?)

Another member made a recommendation to consider transparent scoring of each metric from various parameters (e.g., patient-centered, specialty focused, large/small group applicability), where each parameter would be rated on a scale from 1-5 and the measures would need to meet a minimum score threshold to be included in the core set. A member expressed support for this recommendation and further noted that reliability may be reduced for measures at a lower level of analysis due to the smaller sample size of patients; another member agreed and added that reliability at the plan level does not necessarily indicate reliability at a provider or any other level. CMS echoed similar challenges around alignment, sharing as an example that the QRS program uses plan level measures while MIPS uses clinician level measures. CMS also acknowledged that developing an algorithm to help guide decision-making could be helpful – for example, a scoring approach could help promote the use of outcome measures, digital measures, and other innovative measures by a certain time frame. CMS also emphasized that the CQMC sets need to address issues of equity (e.g., use measures that allow for disaggregation of patient populations by race, ethnicity, gender).

A member shared that they agreed with the previously mentioned lesson of getting the right stakeholders to participate in meetings in order to encourage participation. Ms. O'Rourke asked the Collaborative for any suggestions for encouraging participation, keeping in mind the tension between the sizes of each Workgroup and the ability to participate in discussion. One member suggested that a possible solution might be an introductory 'quality measurement bootcamp' for CQMC participants, where participants discuss different characteristics of measures and importance of level of analysis, level of testing, denominator size, etc. The member also suggested that additional guidance could be provided for the Workgroup chairs to help them redirect conversation back to the principles for measure selection and keep the group's conversation grounded. Another member agreed with these suggestions.

Next, Ms. O'Rourke asked members to provide feedback on CQMC processes, including the following:

- How do we evolve the core sets without creating a moving target?
- Is every other year the right cadence for a full review?

- Are there any adjustments that should be made to the first two maintenance meetings?

A member shared that it is important to review measures that have come out of the NQF endorsement processes on a yearly basis, at minimum. The member flagged that NQF has recently endorsed measures that address vaccination, person-centered care, etc. and these should at least be considered on an annual basis. Another member agreed with this comment. Ms. Lloyd clarified that it may be necessary for some groups to meet at slightly different cadences based on availability of measures going forward (e.g., in-depth review every 3 years instead of every other year), but a general cadence of every other year is expected.

A member noted that the Workgroups are not responsible for creating or updating the measures and are instead focused on updating the measures selected for inclusion in the specialty sets. However, the measure developers and stewards are ultimately responsible for creating and updating the measures. The group discussed that developers are not always present for discussion; while NQF shares the information they have available on the measure, discussion sometimes needs to pause when more detailed questions on testing, methodology, etc. come up. The group discussed that it might be helpful to reach out to measure developers and ask if they are able to join meetings. A representative from NCQA shared that they would be willing to join discussion and provide technical clarifications for CQMC as they do for the review of the Medicaid core sets.

Members also discussed possible avenues for advancing measurement around equity and SDOH. A member shared that the aspiration for CQMC should go beyond “not increasing disparities,” and the CQMC model should aim to eliminate existing disparities. A member shared that providers may want measures to be adjusted based on SDOH based on fear of being penalized for working with a population with lower compliance, but from the patient perspective, care standards should be the same regardless of group; if the CQMC decides to address equity, these two opposing perspectives need to be considered. A member shared that even if organizations are discouraged by equity discussions, care systems need to address social drivers of health to help patients. A member shared that an equity-focused workgroup could be helpful; the group could focus on identifying tools that people are already using to assess SDOH, then sharing these tools and resources with the other workgroups for informational purposes (e.g., tools assessing access to care). Another member added that it might be helpful to discuss different ways that groups are attempting to assess the presence of social determinants and health inequities. Members shared that access is one of the most important aspects to consider for equity, and even though access measures are possibly more useful for measuring large systems rather than individual providers, it is important to track this information to understand how well the system is working. Members shared that when considering equity, it is important for the group to be explicit about the specific populations they need to consider (e.g., LGBTQ+ populations, injecting drug users, rural populations, populations using telehealth/virtual visits). Members also discussed that while an equity committee would be helpful for providing guidance, equity needs to be directly incorporated in all workgroups (e.g., specifically considering equity/SDOH as part of the regular review process, or intentionally including measures in areas of care where there are known gaps in equity). A member also shared that the equity committee would need to be directly connected back to the broader measurement endeavor to help drive conversation.

Finally, Ms. O’Rourke asked for feedback on the measure lifecycle and CQMC core sets, including the following questions:

- How should the CQMC approach measure concepts or measures that need testing?
- Would it help to change the removal approval process to make it easier to remove measures?

A member commented that it is a difficult balance between keeping the core sets stable over time and being responsive to changes in priorities. A member shared that since the workgroups include subject matter experts in their respective fields, they will rely on their expert knowledge to decide whether a measure is ready to be removed. Ms. Lloyd clarified that multiple Workgroup members had provided feedback that it is easier to gain consensus on measure additions, but difficult to gain consensus on measure removals. A member suggested that the voting for measure removal be reframed (i.e., a 60% affirmative vote is required to keep a measure in the core set, vs. a 60% affirmative vote is required to remove a measure from the core set). CMS also shared that as part of the next Measure Applications Partnership (MAP) cycle, NQF will be developing a removal process for measures in CMS programs. CMS noted that this process could be helpful for the CQMC to consider when it has been finalized. A member agreed with this and shared that aligning processes will help align the conclusions of different groups. Another member shared that CQMC could consider the Joint Commission's approach to measure removal.

A member also shared that it could be helpful to ask for specialty-specific feedback on the approach to measure concepts, then compare responses from different specialty groups. The member shared that colleagues in Pediatrics often share helpful perspective on addressing issues of SDOH, and other colleagues in internal medicine or family medicine might also offer a different perspective.

Closing Remarks and Next Steps

Ms. Lloyd thanked the participants for joining the meeting and shared upcoming Workgroup meeting dates, as well as encouraging participants (especially providers) to reach out if they are interested in filling any open co-chair spots. Dr. Schreiber also thanked attendees for their engagement and emphasized that the greater alignment can be achieved across organizations through clearly defined and parsimonious measure sets, the better the quality measurement ecosystem will be. Finally, Sheri Winsper (NQF) thanked all the participants for their discussion, acknowledged AHIP and CMS' partnership, and expressed excitement for the direction of this upcoming year of work with the CQMC.