Meeting Summary

CQMC Extended 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 19, 2022.

Welcome and Review of Meeting Objectives

Danielle Lloyd, Senior Vice President of Private Market Innovations & Quality Initiatives at America's Health Insurance Plans (AHIP), Michelle Schreiber, Deputy Director at the Center for Clinical Standards and Quality at the Centers for Medicare & Medicaid Services (CMS), and Dana Gelb Safran, President and Chief Executive Officer at the National Quality Forum (NQF), welcomed participants and reviewed the agenda for the meeting. Ms. Lloyd shared the antitrust statement and reminded participants to refrain from discussing or exchanging competitively sensitive information. Ms. Lloyd reminded participants that the CQMC is a member-funded effort with additional support from CMS and AHIP. Ms. Lloyd shared the following meeting objectives with the Collaborative:

- Overarching Goal: Strategize future opportunities to drive even greater impact of the CQMC
- Review CQMC progress to date and align on vision and strategy for next phases of work
- Explore the CQMC's role in three key areas where alignment will support the success of performance measurement programs:
    - Health equity measurement
    - Movement to digital measures
    - Measurement models to support value-based payment
- Understand leading barriers to achieving the desired impact of the core sets and how these can be overcome

Current Scope and Aligned 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 and measurement initiatives.

Ms. Lloyd shared that the focus of the CQMC core sets is provider level ambulatory measures and provided a summary of the previous year's work. Last year, the CQMC updated nine of the core sets as part of the maintenance process: ACO/PCMH/Primary Care, Behavioral Health, Cardiology, Gastroenterology, HIV/Hepatitis C, Neurology, Obstetrics & Gynecology, Orthopedics, and Pediatrics. The Collaborative also updated guidance on future core set prioritization, measurement gap areas, and suggestions for best practices to implement the sets in value-based payment (VBP) programs. The CQMC also convened high priority topic area Workgroups (e.g., Measure Model Alignment, Digital Measurement, Cross-Cutting Measurement, and Implementation), further advancing the CQMC's work in these areas.

Ms. Lloyd shared that earlier this year, the CQMC convened the Health Equity Workgroup. This new Workgroup is meeting to review and prioritize health equity measurement domains for the CQMC, identify current CQMC measures that are disparities-sensitive, prioritize existing health equity measures, and recommend strategies to further health equity within the CQMC.

Dr. Schreiber provided a brief presentation on CMS' current quality strategy, with a focus on health equity. CMS has recently published several Requests for Information (RFI) on health equity, data collection and stratification, as well as the levers within VBP programs that can be used to advance this work. Dr. Schreiber shared the recently released FY 2023 Inpatient Prospective Payment Systems (IPPS) Proposed Rule that will aid in updating Medicare payment policies for hospitals and long term care hospitals. CMS proposed inclusion of three health equity-focused measures in the Inpatient Quality Reporting (IQR) program: a commitment to equity structural measure (requiring an attestation from hospitals), percentage of patients screened for five social determinants of health (SDOH) (i.e., food insecurity, housing instability, transportation needs, utility assistance needs, interpersonal safety), and positivity rate of those SDOH screenings. CMS also introduced two measures centered around maternal health: a measure of severe obstetric complications and an electronic clinical quality measure (eCQM) version of the Joint Commission's Caesarian Birth measure. CMS also proposed eCQMs addressing opioid safety and malnutrition.

Dr. Schreiber also shared CMS' new National Quality Strategy and discussed the eight goals of the strategy. These goals incorporate principles such as safe, timely, effective, efficient, equitable, and patient-centered care. They also include lessons from COVID-19 and focus on priorities such as resilience, workforce, community, and alignment. The goals are as follows:

1. Embed quality across the care journey
2. Advance health equity
3. Foster engagement with stakeholders focused on person and family-centered care
4. Promote safety to achieve zero preventable harm
5. Strengthen resiliency in the healthcare system
6. Embrace the digital age
7. Incentivize scientific innovation and technology
8. Increase alignment to promote seamless and coordinated healthcare

Advancing Health Equity as Part of Value-Based Care

Dr. Schreiber shared that health equity is a high priority for healthcare stakeholders to promote high-value care and optimize outcomes for patients. The newly convened CQMC Health Equity Workgroup has the following objectives:

- Review and prioritize health equity measurement domains for the CQMC
- Identify current CQMC measures that are disparities-sensitive
- Prioritize existing health equity measures across payers in value-based contracts
- Recommend strategies to implement and adopt CQMC measures that assess existing inequities
- Outline future opportunities for the CQMC to advance health equity measurement

CMS recognizes that there is a need for a standardized process for collecting data. An initiative launched by the Office of the National Coordinator for Health Information Technology (ONC) called United States Core Data for Interoperability+ (USCDI+) will aid in the advancement of interoperable datasets. Dr. Schreiber shared the key themes from the first Health Equity meeting. Those themes include key domains for health equity (e.g., quality, access, social needs/risks, culture of equity & cultural responsiveness), refinement of criteria that determine disparities-sensitive measures, providers' lack of resources to respond to identified social needs, and actionable disparities-sensitive measure data. Dr. Schreiber introduced Dr. Rebecca Whitaker, Assistant Research Director at the Duke Margolis Center for Health Policy, to share a case study of a multi-payer state-level effort around data collection.

Dr. Whitaker shared that the Duke Margolis Center for Health Policy is an interdisciplinary health policy research center whose mission is to improve health equity. North Carolina has a multi-stakeholder equity research program that develops evidence-based policies, performs empirical analysis, and includes a wide network including primary care providers, specialists, and community networks. Work is based on three tenets: having a unique equity policy window; recognition that systems are at different stages in the development of race, ethnicity, and language (REaL) data; and accountability of plans to advance and sustain equity. North Carolina has identified three stratification priorities – race, ethnicity, and language – which support the National Committee for Quality Assurance's (NCQA's) push to stratify measure data by 2024. North Carolina has also established an North Carolina Executive Roundtable to discuss measures promoting equity with a key target of aligning measures. Most recently, the Roundtable was able to employ stratification in monitoring COVID-19 vaccinations and use of monoclonal antibody treatment.

Next, Dr. Schreiber introduced Michelle Jester, Executive Director of Social Determinants of Health at AHIP, to share their work in developing updated demographic data standards with potential impact on future national standards. Ms. Jester shared that the current demographic data standards still have many inaccuracies. AHIP used an evidence-based and stakeholder-driven process with goals to standardize data definitions, aim for actionability, and align with national standards. In addition, they developed a coding crosswalk and data documentation to guide organizations on data collection, aiming to advance interoperability.

Dr. Schreiber introduced the next speaker of this session, Juan Lopera, Inaugural Chief Diversity, Equity, and Inclusion Officer at Beth Israel Lahey Health (BLH). Mr. Lopera shared BLH's diversity, equity, and inclusion (DEI) vision and goal to transform care by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain, and develop diverse talent. BLH developed an infrastructure that addresses health disparities by collecting patient demographic data to inform disparity research and intervention. Mr. Lopera shared the health equity framework which included data standardization and collection, research and analysis, interventions, and program outcomes and measurement. Mr. Lopera shared that 92% of patients self-reported their demographic data on REaL and sexual orientation and gender identity (SOGI). In addition, Mr. Lopera highlighted innovations such as developing an "equity composite score" and race distributions by diagnosis groups.

Health Equity Breakout Sessions

Dr. Schreiber introduced the following discussion questions on health equity for members to discuss in five breakout groups:

- What role should the CQMC play in advancing health equity measurement?
    - Seek to proactively align around data content and/or exchange standards?
    - Opine on the use of self-collected data versus imputed data?
    - Assess measures for the appropriateness of stratification?
    - Recommend which variables measures should be stratified by?
    - Seek to pilot test either stratified clinical measures or new equity measures?
    - Develop and publish a list of priority equity measure concepts?

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

Group 1

The group discussed the following observations and suggestions:

- Data availability remains a continuing pain point when trying to report on shared measures. Certain populations (e.g., patients with intellectual disabilities) are also not represented in data collection, and future efforts around data collection should include opportunities and support for these populations to communicate their needs and preferences.
- Standardization, interoperability, and streamlining of health equity relevant data (e.g., demographic data) is important to support shared documentation in the medical record that follows patients over time and across systems, so patients are not burdened with sharing the same screening data.
- The CQMC could potentially make recommendations to CMS and other groups on aligning data content and standards for equity measures, stratification by variables, etc. and provide guidance on pilot testing and priority equity concepts.
- A member suggested that CQMC not only focus on data standards and formats, but also on education and awareness.

Group 2

The group discussed the following observations and suggestions:

- Standardization of equity measures is essential to gather actionable data that can be combined and compared.

- Data should be collected from various sources into shared repositories; in the current state, data systems are often not interoperable, and different clinicians (e.g., therapists and physicians) may be entering important equity-related data into separate electronic records.
- Health equity is a universal issue that will require a collaborative effort from various stakeholders; CQMC can facilitate collaboration given its diverse stakeholder base.
- CQMC could facilitate or support pilot testing (e.g., testing systems to report shared equity measure data or piloting an incentive program for measure adoption).
- CQMC could provide guidance on appropriateness of stratification of available measures. This might include topics such as the most important measures to stratify, recommendations on feasibility and usability of equity measures, potential barriers and pitfalls of stratification (e.g., insufficient coding data, underlying algorithms that contribute to unintentional bias), and guidance on when risk adjustment vs. stratification is appropriate.

Group 3

The group discussed the following observations and suggestions:

- Alignment across efforts to advance equity measurement will be important to success. Members suggested aligning with the Measure Applications Partnership (MAP) Health Equity Workgroup and clarifying the objectives and goals of each effort.
- Patient-collected data sources represent the “gold standard” in equity measures compared to imputed data sources.
- Stratification is an important tool for measures to gather important demographic and social data
- A member suggested that there is a need for measure developers to either provide stratification specifications or for the CQMC to consider this when accepting and selecting future core measures.
- The CQMC should consider alternate measure prioritization approaches based on broader domains and concepts.
- The CQMC should consider piloting equity-sensitive measures through provider and payer groups.
- There is a need to align equity recommendations to promote concerted efforts between payers and providers.
- The CQMC should consider SDOH data standards from the Gravity Project and data classes and elements from USCDI+ in its health equity efforts.

Group 4

The group discussed the following observations and suggestions:

- Self-reported data is the “gold standard” of evaluating patient experience and social risk factors, but this data may be challenging to standardize, collect, and aggregate. Using both self-reported and imputed data is likely appropriate, especially early on in data collection and efforts to identify disparities. Measurement efforts should not disadvantage safety net

providers, who may care for populations with higher risks while having fewer resources for collecting and responding to the social needs of their patients.
- Transparency of health equity measurement approaches is important for consistency and to reduce the potential for incomplete information which could result in biases.
- Need to establish consensus on definitions of equity and SDOH to allow engagement and alignment.
- When pursuing health equity, an overarching goal should be to understand the needs and preferences of the population being served and to measure accountability and progress towards those needs.
- Pilot testing equity measures is a valuable starting point. To minimize provider burden, it may be useful to first identify priorities for testing equity measures.

Group 5

The group discussed the following observations and suggestions:

- Participants agreed that CQMC should be proactively involved with aligning equity measures and identifying standardized definitions and approaches for stratification.
- Standardization of equity measures should be a priority for CQMC in their unique role working with CMS and AHIP in private-public collaboration.
- While CQMC measures focus on the clinician/clinician group level of analysis, there is also interest in how systems can scale physician-based recommendations into actionable models for healthcare networks.

Digital Measurement Strategy and Role for the CQMC

Dr. Mehas introduced Dr. Elizabeth Drye, the Chief Scientific Officer of NQF, to provide context related to digital measurement and an overview of the CQMC's related work to date. Dr. Drye shared that the CQMC initially convened the Digital Measurement Workgroup in 2021 to discuss and draft a report characterizing the current environment related to digital measurement (e.g., common definitions, stakeholders, barriers to implementation, and future opportunities to promote digital measurement).

While digital measurement is an important direction for the future, the CQMC has seen limited adoption of digital measures from its core sets due to barriers including lack of standardized data, nonstandard approaches to data capture in clinical settings, lack of shared low-burden technology supporting data sharing and measure calculation, and lack of incentives to adopt digital measures. Dr. Drye emphasized that the goal of today's discussion was to define the CQMC's future priorities and potential role related to advancing adoption of digital measurement, data standardization, and interoperability; to inform the discussion, speakers from CMS and Health Level 7 International (HL7) would provide additional information on the current state of digital measurement and efforts to advance the field.

Dr. Schreiber remarked that digital measurement and interoperable data are important priorities to CMS, and that the importance of interoperable data was highlighted during the COVID-19 pandemic when common data systems were needed to collect and understand overall vaccination rates and regional progress. Dr. Schreiber shared that CMS has committed to transitioning to all digital measures in its programs within this decade, given the potential to set standards, collect and organize data more widely, and drive a learning health system that will help move healthcare forward. Dr. Schreiber introduced Dr. Joel Andress from CMS to share information on the Digital Quality Measurement Strategic Roadmap.

Dr. Andress shared that CMS' goal is to reduce the burden of electronic health record (EHR) data transfer by adopting the Fast Healthcare Interoperability Resources (FHIR) application programming interface (API) technology on a wide scale. CMS recently developed a strategic roadmap for advancing digital quality measurement based on four key domains of activity: improving data quality, advancing technology, optimizing data aggregation, and enabling measure alignment. Dr. Andress commented that most of today's discussion will focus on standardization of data and leverage of advancing technologies to utilize that data. Dr. Andress also highlighted that the Digital Quality Measurement Strategic Roadmap aligns with the wider goals of the National Healthcare Quality Strategy by removing silos and system requirements that create barriers to using data in a way that follows patients through the healthcare system; enabling collection of data that can help support health equity considerations; and embracing the digital age by setting up systems where data is readily available, easily accessible to relevant parties, and usable to provide better care for patients.

Dr. Andress shared that digital quality measures (dQMs) advance the traditional definition of quality measures by recognizing that tooling, systems, and interoperable standards are also needed for the measure to function as a dQM (allowing for flexible data access, information transfer, etc.), and that CMS' goal is that data produced during routine care is used for quality measurement, minimizing data collection burden. While implementation of eCQMs can be difficult now because of lack of standardization, wide-scale alignment with the FHIR standard would help streamline implementation and is encouraged based on FHIR's anticipated longevity, flexibility, capacity to incorporate information from multiple formats, and ability to interface with APIs. If existing data are rendered into predefined API endpoints, APIs can be used to access these endpoints and to obtain granular data elements to calculate meaningful metrics for stakeholders based on their needs. CMS is currently specifying eCQMs in FHIR, as well as collaborating with federal partners (e.g., ONC) to encourage data standardization, engage in ONC's USCDI initiative to standardize a set of health data classes and constituent data elements (e.g., vital signs, medication, laboratory, facility identifiers), and engage in ONC's USCDI+ initiative to standardize additional data elements for specific use cases (e.g., additional data that might be needed for quality measurement, public safety, care coordination).

Next, Dr. Drye introduced speakers Dr. Yan Heras (Optimum eHealth) and Ms. Linda Michaelsen (Optum) to provide an overview on the HL7 Da Vinci initiative. Ms. Michaelsen shared the American National Standards Institute antitrust policy before providing an overview of the Da Vinci initiative, a FHIR accelerator with membership from providers, EHRs, payers, vendors, and industry partners. Da Vinci is currently working on 13 implementation guides related to clinical data exchange; quality and risk; coverage, transparency, and burden reduction; and foundational assets; today's discussion focused on two guides related to quality and risk (Data Exchange for Quality Measures Including Gaps in Care and Risk Adjustment).

Ms. Michaelsen shared an overview of the FHIR ecosystem, which includes data cycling between clinical care, measurement and analytics, reporting, researcher/payer/public health surveillance, clinical practice guidelines, and clinical decision support, noting that most of the linkages within this ecosystem are starting to be addressed by existing implementation guides within FHIR. Data exchange related to quality measurement is addressed by implementation guides including the Quality Measure Implementation Guide, Data Exchange for Quality Measures Implementation guide, Making EHR Data More Available for Research and Public Health (MedMorph), etc., which share a framework for exchange of data between providers, measure authorities, payers, and other agencies/registries. Da Vinci has also created profiles within FHIR, which take specific resources and constrain, extend, or add elements to them, allowing for application with a specific use case. Ms. Michaelsen provided an example of a measure report, which can be profiled three different ways – first to be used as an individual patient-level report (Quality Reporting Document Architecture I, or QRDA I) and gaps in care reporting; second to be used as summary reporting for a specific group of patients over a specific period (QRDA III); and finally in data exchange between providers and measuring organizations (payers, registries, or other parties who collect measure data from provider organizations).

Dr. Heras provided additional information on two implementation guides, the Quality Measure Implementation Guide and the Quality Improvement Core (QI-Core) Implementation Guide. The Quality Measure Implementation Guide defines an overall structure and standard approach for representing eCQM content in any measure, including defining required metadata, use of Clinical Quality Language, terminology, etc. QI-Core is a data model standard and specifies profiles and extensions to be used in quality measures.

Dr. Heras shared that Clinical Reasoning FHIR Connectathon events have been running for more than five years, and two sessions are upcoming in the future. During the May 2022 HL7 FHIR Connectathon, the following CMS and Health Effectiveness Data and Information Set (HEDIS) measures will be tested:

Eligible Clinician (EC) Measures

- CMS122v10 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
- CMS124v10 Cervical Cancer Screening
- CMS125v10 Breast Cancer Screening (also, health plan level Breast Cancer Screening measure in HEDIS)
- CMS130v10 Colorectal Cancer Screening
- CMS190v10 Intensive Care Unit Venous Thromboembolism Prophylaxis
- CMS347v5 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- CMS74v11 Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists

Eligible Hospital (EH)/Critical Access Hospital (CAH) Measures

- CMS104v10 Discharged on Antithrombotic Therapy
- CMS529v2 Hybrid Hospital-Wide Readmission
- CMS506v4 Safe Use of Opioids - Concurrent Prescribing
- CMS844v2 Core Clinical Data Elements for the Hybrid Hospital-Wide (All-Condition, All-Procedure) Risk-Standardized Mortality Measure (HWM)

Pre-Rulemaking Measures

- CMS816v1 Hospital Harm - Severe Hypoglycemia
- CMS871v1 Hospital Harm - Severe Hyperglycemia

Dr. Heras shared a spreadsheet listing past measures that have been tested over time. The Implementation Guides continue to mature, and CMS is using FHIR in developing and tooling eCQMs; other measure authors are also creating FHIR measures (e.g., attendees at NCQA's Digital Quality Summit).

Dr. Drye thanked the speakers for their presentations and noted that much of the work being done by CMS and HL7 anticipates interoperable data, and the scope of interoperable data required for quality measurement is not yet mandated by CMS and ONC. The USCDI+ work will help identify and prioritize the additional data elements that need to be interoperable to support quality measurement, and CQMC can play a role in that prioritization. Dr. Drye opened the discussion for questions for the speakers; there were no questions from the Collaborative.

Digital Measurement Breakout Sessions

Dr. Drye introduced the following discussion questions on digital measurement for members to discuss in five breakout groups:

- Should the CQMC establish a measures-driven prioritization of data standards?
- If this is successful, what other barriers to use of digital measures from core sets would remain? What role might CQMC play in addressing these?
- How can the CQMC work proactively to encourage dQM development in gap areas?
- How can the CQMC collaborate work with other initiatives advancing digital measurement? With which stakeholders should CQMC work to support progress?
- Should the CQMC set a goal related to adoption of digital measures (e.g., X percent digital measures in the core sets by X date)?

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

Group 1

This group discussed the following observations and suggestions:

- Most measures in the industry (and in CQMC's core sets) are claims-based, and data availability remains a challenge for many measures.

- Group members envisioned the role of CQMC as prioritizing "what," not "how" (e.g., setting priority measures and topics where data availability and format should be standardized first) to move from claims-based measures to digital measures.
- Technology (e.g., standardizing codes and upgrading infrastructure) is only part of the shift to digital measurement. People, culture, and commitment also need to be addressed as part of the solution (e.g., building guidance around how and where to record information within the EHR, providing training on consistent data coding).
- Some measures are built on non-standardized data elements (e.g., clinical notes, free-text fields). CQMC may need to consider a middle ground, where we encourage movement towards measures that are not claims-based, but do not include measures that would require extensive support (e.g., measures dependent on natural language processing).

Group 2

This group discussed the following observations and suggestions:

- CQMC can help identify and address upstream barriers, and could work with other organizations (e.g., ONC) to help incentivize change in these areas:
  - Payers and providers both have challenges accessing EHR data
  - Smaller providers may not have robust or interconnected EHR systems
  - Varying degrees of access to data
  - Challenges with buy-in on building data standards from the vendor side
- Data aggregation past the Taxpayer Identification Number (TIN) level is complicated and can result in variation in measure results based on the aggregation method. CQMC could potentially provide guidance on differences in results based on aggregations, and how these differences should be fairly reflected in programs and public reporting.
- CQMC could help prioritize which measures should be transitioned to dQMs, focusing on measures that have the biggest impact (e.g., greatest burden, prevalence).
- It may be helpful to integrate discussion on digital measurement into the core set maintenance process and discuss for each individual measure considered for the sets instead of having a separate digital measurement group. This would allow for a nuanced approach, as it may be easier for some specialties to transition to digital measurement than others.

Group 3

This group discussed the following observations and suggestions:

- Readiness for digital quality measures is uneven across systems and providers (e.g., different requirements in current systems, available infrastructure varies widely across providers).
- CQMC may need to consider multiple strategies and tiers of strategies to encourage digital measurement:
  - Approaches to promote digital measurement may vary based on setting, stakeholder familiarity with dQMs, availability of technology, willingness to engage, etc.
  - Regulatory requirements for programs currently have gaps in data reporting and measurement requirements and do not lay out standardized expectations on data

requirements. Also, the current measures in programs (e.g., Home and Community-Based Services) do not necessarily address the full breadth of issues relevant to those providers and patients.
  - Some groups have fallen behind in implementation of dQMs due to uneven distribution of resources for building infrastructure, etc.; there needs to be a strategy for supporting these groups and bringing them 'in line' with others, and this may include strategies related to regulation, quality measurement programs, and data standards.
  - CQMC future activities will need to interface effectively with these multiple types of strategies.

Group 4

This group discussed the following observations and suggestions:

- CQMC's diverse membership places it in a unique position to move digital measurement forward within organizations that may not have the motivation internally (e.g., if there are internal legal concerns for certain stakeholders moving forward with dQMs, recommendations from CQMC could help reduce these concerns)
- CQMC should consider the following approaches to measures in the core sets:
  - Prioritize digital measures and measures close to being transitioned to dQMs
  - Re-review measures in the current core sets that have data sourcing challenges
  - Understand which measures in the sets are fully reported as dQMs, vs. measures that have the option to report as dQMs
- CQMC should work in parallel with other existing efforts (e.g., USCDI+) and align goals with existing goals (e.g., CMS and NCQA) in the field.

Group 5

This group discussed the following observations and suggestions:

- CQMC's diverse membership poses a unique opportunity to align on public and private sector priority measures, and agreement on priorities could help drive data standards with USCDI/USCDI+.
- Prioritization of the most important data to collect would be helpful, but the group recognizes that priorities and data needs may change over time.
- Data validity (e.g., accuracy and completeness) are also important when considering digital measures; sometimes after implementing an eCQM, the performance is extremely different than the claims-based version of the measure. CQMC may be able to engage with ONC on existing work around accessing and developing robust EHRs to understand if EHRs are collecting valid data and if there is a framework that could be built to help understand the information that needs to be assessed before a measure can be deemed ready to implement in accountability programs.

- Education and guidance are important to advance digital measurement, given the complexity of the topic; providers in small practices or rural areas have received little support in this shift.
- A better understanding of provider workflows is important in dQM development, so that new measures do not pose burden on physicians to develop new workflows. Even if the systems themselves become more interoperable, dQM use will not increase if physicians do not implement the measures due to workflow issues.

Dr. Drye thanked the groups for sharing their detailed input and shared that this discussion would inform future planning for the CQMC.

Measure Model Alignment Strategy and Role for the CQMC

Ms. Lloyd shared that during the last extended Full Collaborative meeting, the group discussed a potential process to pilot test measures and align on elements across the full measurement process, in addition to aligning on measures and measure specifications. However, payers, purchasers, and providers face data sharing challenges including logistics and legal barriers (e.g., antitrust concerns). Further alignment could be achieved through an entity with a governance structure designed to bring multiple parties together for measurement purposes, as well as an established technology model (how to transfer information between entities) and an operational model.

Ms. Lloyd shared that the Measure Model Alignment Workgroup focused on considerations for establishing an operational model during the past year's work. Ms. Lloyd provided examples of entities that might be involved in such a model, including regional collaboratives, registries, and health information exchanges (HIEs). Ms. Lloyd shared that regional collaboratives have engaged multiple payers and purchasers for measurement, but regional collaboratives are only available in certain states. Registries, such as CMS' Qualified Clinical Data Registries (QCDRs) may also play a role in alignment by compiling data across multiple payers, but not all payers and providers use these registries. Health information exchanges (HIE) tend to be regional, but there may be opportunities in the future to connect these HIEs given the recent publication of the Trusted Exchange Framework and Common Agreement (TEFCA). There is also a possibility of establishing a national third-party neutral convener that could help bring data together.

Ms. Lloyd noted that the Measure Model Alignment Workgroup was charged with developing best practices and potential policy recommendations addressing governance, structural, and operational models for payer and purchaser alignment. The group's discussion was focused on the collection, transmission, standardization, aggregation, and dissemination of data to support core set adoption and implementation and reduce provider burden. The Workgroup first focused on lessons learned from regional collaboratives across the nation. The Workgroup reviewed an environmental scan of publicly available collaborative models that permit payers and purchasers, providers, and others to collaborate on the quality measurement process, and then discussed barriers and solutions towards greater standardization of measurement that can be used to compare performance as well as drive improvement. The Workgroup also discussed opportunities and threats posed by aspects of such models for stakeholders and how to determine which policy challenges may impede alignment discussions. Lastly, the Workgroup drafted a Measure Model Alignment Guide which gives information about options for an operational model, including a list of model elements:

- Context (accountable entity, intended use, measurement periodicity, attribution)
- Measure selection (choosing and retiring measures, measures themselves, how measures reflect the goal)
- Data (information sources and collection methods, transmission, standardization, aggregation, dissemination)
- Measure grouping (how measures are aggregated or assigned to domains)
- Scoring approaches (methods by which overall performance is determined, reporting policies)
- Risk adjustment (approach to isolate quality differences by accounting for differences in patient mix across entities)

Ms. Lloyd shared that the CQMC is seeking additional input to help inform next steps for the Measure Model Alignment work, including which of the identified model elements groups should align around, future models or entities that should be considered, and barriers and solutions to scale up alignment work to the national level.

Measure Model Alignment Breakout Sessions

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

- Beyond core measure sets, additional aspects of measurement models are high leverage areas for alignment – where greater alignment could significantly advance the success of value-based purchasing?
- To date, regional models have taken hold in some markets, but not others. Why is that and what prevents these models from scaling nationally?
- Do you see physician registries or health information exchanges as potential means to scale multi-payer alignment on a national basis? If not, why? What barriers would need to be removed to make them feasible?
- On what criteria and in what order of priority should we assess a potential preferred approach?
    - Feasibly of governance structure?
    - Footprint (e.g., how large of a geography does it cover)?
    - Scope (e.g., minimum number of payers and provider participants)?
    - Data availability and/or acquisition requirements?
    - Particular measures or measure types supported?
    - Support of centralized calculations?
    - Support of common dashboards?
    - Ability to publicly report results?
- If we could wave a magic wand, what structure and functions would appear to achieve multi-payer alignment?

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

Group 1

This group discussed the following observations and suggestions:

- Aggregating data reduces provider burden from reporting to multiple entities and can also address potential small sample size issues when addressing uncommon conditions.
- Regional collaboratives and HIEs already exist across the country, and these can be leveraged in pilot testing to illustrate how burden can be reduced and to understand what elements should and should not be scaled to the national level.
- Technology may be scalable, but there may be difficulty building the trust and relationships to support wide-scale alignment, which is a large component of the success of these collaboratives.
- This group also discussed the potential involvement of Medicare and Medicaid, the potential to test measures within the Centers for Medicare & Medicaid Innovation (CMMI), and interest in bringing data together from multiple payers.

Group 2

This group discussed the following observations and suggestions:

- Reporting burden depends on both the number and type of measures that are being reported. Certain types of measures (such as PRO-PMs and eCQMs) may pose a higher burden during implementation, and alignment could help limit this burden.
- Building a network of networks (e.g., sharing and aggregating data across entities at the state, regional, and potentially national level) could be helpful as a common infrastructure for sharing and exchanging data. A network of HIEs could reduce provider burden (report data to one place using a single sign-on), reduce data processing burden (data is processed at multiple points before being rolled up on a larger scale), and support efforts such as improving patient indexing. This type of model may also provide an opportunity to spread trust across multiple groups while improving standardization. This approach has been attempted with stakeholders in Michigan up to the point of data aggregation, but individual payers will likely want to provide input on how the data is used in performance calculations.

Group 3

This group discussed the following observations and suggestions:

- Scaling to a national level is a challenge; the group discussed the example of a measurement model in California, and how it was tailored to the unique regulatory context in that state; if models are scaled up, these unique aspects may not apply on a wider scale.
- Additional guidance on risk adjustment and stratification would be helpful, but stakeholders need some flexibility. NQF could potentially seek more information on risk adjustment models and the way measures are used in models as part of the endorsement process, or the CQMC could acknowledge the need for additional guidelines or framing for these topics.

- It could be helpful to share empirical testing around risk adjustment and stratification (e.g., sharing information on disparities in certain settings, sharing testing data to date); a common place to share these learnings could help accelerate measure and model development.

Group 4

This group discussed the following observations and suggestions:

- There are clinical guidelines with strong recommendations and evidence that do not have endorsed measures, since a developer has to volunteer to submit the measure and collect testing data for the endorsement process. Because of the lag time for measure endorsement, there is a delay in availability of relevant measures. The group discussed that an entity that could facilitate measure testing and dQM set-up, or some other mechanism to help multiple groups collaborate on measure testing and development, could be helpful in expediting this process.
- A member commented that the “Data” element is the most valuable element of measure models to align. A shared all-payer claims database could be a helpful tool for aggregating data.
- There are anti-trust concerns related to alignment around elements such as risk adjustment, as well as legal constraints for some parties (e.g., need to adhere to rulemaking procedures and federal statutes). However, equity and stratification considerations could be incorporated into measure selection, and groups could align on these topics.

Group 5

This group discussed the following observations and suggestions:

- The measurement model does not exist separate from the payment program model. Payment programs continue to proliferate, and there is variation in the goals of the programs. Multi-payer alignment efforts should consider the structure of these programs and what measures are being used for; as of right now, there is no strategic way to consider measure use across the programs and for stakeholders to provide input on the use of the measures.
- This group also noted technology continues to be a barrier, particularly EHR functionality (e.g., certain modules or screeners are expensive). If stakeholders cannot afford certain EHR modules, they may need to use workarounds such as collecting data on paper and then entering it manually into the EHR. HIEs may have leverage to address these EHR challenges, and there may be a role for TEFCA to help build a network of HIEs.

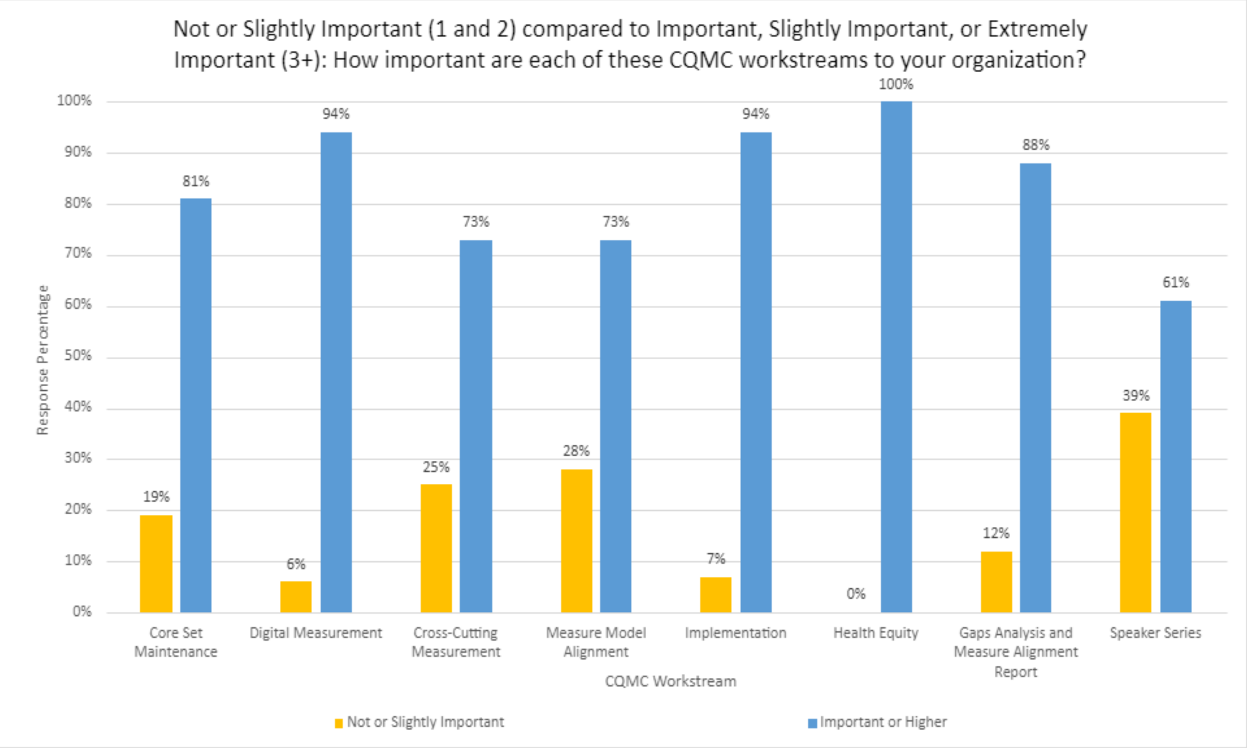
Prioritization Exercise for Future CQMC Work

Dr. Mehas and Ms. O’Rourke noted that today’s discussion will inform the next steps for three major areas of the CQMC’s work – health equity, digital measurement, and measure model alignment. Dr. Mehas asked for additional input from members regarding the full scope of the CQMC’s activities, asking the group for their thoughts on areas of the CQMC’s work that are most meaningful to their organization and where they believe CQMC can have the most impact. Dr. Mehas shared that this feedback will help the CQMC shape the scope of future work, focusing on the highest-priority areas to achieve greater adoption, alignment, and success among VBP programs.

First, NQF staff provided time for members to respond to a survey, rating the importance of the following CQMC workstreams to their organization on a scale of 1 (not important) to 5 (extremely important):

- Core Set Maintenance
- Digital Measurement
- Cross-Cutting Measurement
- Measure Model Alignment
- Implementation
- Health Equity
- Gaps Analysis and Measure Alignment Report
- Speaker Series

The results of this poll indicated that health equity and implementation work were the most important to Collaborative members. While other topic areas such as Cross-Cutting Measurement and the Speaker Series received a lower average score, there was not a vast difference between the work areas, validating that members generally find all CQMC work streams remain relevant and important.



Next, NQF staff provided additional time for members to provide open-ended input in a second survey containing the following questions:

- Is there any work we should stop doing?
- Are there any priority clinical areas to add core sets? (Note: prior suggestions include pulmonology, endocrinology, emergency care, geriatrics, and nephrology.)
- Has the speaker series with measure developers been effective? If so, what ideas do you have for future topics or speakers?
- Are there other priority work streams we should be considering?
- Are there any new types of members we need to recruit to support this work? Or are there collaborations we should seek with other organizations?

A CQMC member commented that an obstacle they encounter while reviewing the core sets is lack of clarity on the measure specifications being used. As developers update their measures over time, it can be difficult to keep track of small but important changes in the specifications. The member suggested that a streamlined process to highlight and consider specification changes could be helpful for CQMC discussions, as well as for providers trying to use the measures.

Ms. O'Rourke provided highlights from the survey responses received during the meeting. Ms. O'Rourke shared that emergency medicine, geriatrics (including long-term care settings), and diabetes (including endocrinology and nephrology) are areas where future core sets could be valuable. Diabetes care and nephrology were shared as priorities based on VBP models and the changing dynamics of dialysis settings and care standards. There were also comments suggesting a diagnostics core set like radiology, pathology, echocardiology, etc. Other areas of interest were opioids and substance abuse, maternal health, pulmonology, community resources and linkages, patient-reported outcome measures, functional assessments and care, incorporating non-physician specialties (e.g., social work), COVID-19 and pandemic response, and additional focus around disparities-sensitive measures and health equity being incorporated throughout the measure work. Interest in collaborating with other organizations, such as HL7 and NCQA, was emphasized by the survey, as well as expanded Speaker Series topics (e.g., payer presentations, health equity, post-acute care). There was desire for the CQMC to emphasize cost measurement in future work. Ms. Lloyd clarified that the CQMC assumes cost is being considered when measures are placed in a VBP program and to consider them within the Collaborative could be duplicative.

Closing Remarks and Next Steps

Ms. Lloyd thanked the Collaborative members for their input and encouraged participants to email NQF staff with any additional suggestions related to process improvements and participation. Ms. Lloyd also reminded the group to reach out to CQMC@qualityforum.org if interested in serving as a co-chair. Dr. Schreiber also thanked attendees for their full engagement throughout the meeting. Finally, Dr. Safran thanked all the participants for their participation, acknowledged AHIP and CMS' partnership, and expressed excitement for the direction of this upcoming year of work with the CQMC.