

Meeting Summary

Core Quality Measures Collaborative

HIV and Hepatitis C Workgroup: Measure Selection Approach and Evaluation Meeting

The National Quality Forum (NQF) convened a closed session web meeting for the HIV and Hepatitis C Workgroup on February 13, 2019.

Welcome and Review of Web Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff read the antitrust statement and reminded the Workgroup of the voluntary nature of the CQMC and the obligation of all participants to comply with all applicable laws. NQF staff reviewed the following meeting objectives:

- Review the CQMC decision making process
- Discuss current measures in the core set
- Evaluate new measures for addition to the core set

Decision making process

Voting and Quorum

NQF staff gave an overview of quorum and voting process. The Workgroup was informed that voting and non-voting participants could take part in discussion, but only voting participants would participate in the voting process. Quorum is defined as representation from at least one health insurance provider representative, at least one medical association representative, and at least one representative from the remaining voting participant categories (i.e., consumers, purchasers, regional collaboratives).

NQF staff advised that the Workgroup will thoroughly discuss each item and all views will be heard. Items for which the co-chairs determine that a general consensus and quorum has been reached may be approved or disapproved by a voice vote. Items for which voting participants express dissenting opinions or when a quorum has not been reached, the Workgroup co-chairs will subject the applicable item(s) to an electronic vote. In the event that reaching consensus is not possible, the measure will be presented to the Collaborative for additional discussion. The Collaborative will be responsible for the final decision to approve a core measure set.

Principles for measures included in the CQMC core measure sets

1. Advance health and healthcare improvement goals and align with stakeholder priorities.
 - a. Address a high-impact aspect of healthcare where a variation in clinical care and opportunity for improvement exist.
2. Are unlikely to promote unintended adverse consequences.

3. Are scientifically sound (e.g., NQF-endorsed or otherwise proven to be evidence-based, reliable, and valid in diverse populations).
 - a. The source of the evidence used to form the basis of the measure is clearly defined.
 - b. There is high quality, quantity, and consistency of evidence.
 - c. Measure specifications are clearly defined.
4. Represent a meaningful balance between measurement burden and innovation.
 - a. Minimize data collection and reporting burden, while maintaining clinical credibility (i.e., measures that fit into existing workflows, are feasible, and do not duplicate efforts).
 - b. Are ambitious, yet providers being measured can meaningfully influence the outcome and are implemented at the intended level of attribution.
 - c. Are appropriately risk adjusted and account for factors beyond control of providers, as necessary.

Principles for the CQMC core measure sets

1. Provide a person-centered and holistic view of quality, including consideration of Social Determinants of Health (SDOH) and experience of care.
2. Provide meaningful and usable information to all stakeholders.
3. Promote parsimony, alignment, and efficiency of measurement (i.e., minimum number of measures and the least burdensome measures).
4. Include an appropriate mix of measure types while emphasizing outcome measures and measures that address cross-cutting domains of quality.
5. Promote the use of innovative measures (e.g., eMeasures, measures intended to address disparities in care, or patient-reported outcome performance measures, or PRO-PMs).
6. Include measures relevant to the medical condition of focus (i.e., “specialty-specific measures”).

Discussion on Current Measures in Core Set

Current measures in HIV Core Set

NQF#	Measure	Steward	Level of Analysis	Endorsement Status	Performance Data	Use
0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	NCQA	Clinician	Endorsed	PQRS data provided during last endorsement review: 75.8% compliance (2010)	MIPS, Ryan White Core Measures
0409	HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis	NCQA	Clinician	Endorsed	PQRS data provided during last endorsement review: chlamydia and gonorrhea performance rate =32.4%; syphilis performance rate=50.3%	MIPS, NYS DOH HIV/AIDS Value-Based Payment Quality Measure Set
2082	HIV viral load suppression	HRSA - HIV/AIDS Bureau	Clinician	Endorsed	2010-2014 performance gap data from the Ryan White	MIPS, Ryan White Core Measures,

					HIV/AIDS Program Services Report showed 65 percent viral load suppression among the 10th percentile of providers, and 94 percent among the 90th percentile	Medicaid Adult Core Set, NYS DOH HIV/AIDS Value-Based Payment Quality Measure Set
2079	HIV medical visit frequency	HRSA - HIV/AIDS Bureau	Clinician		During the last endorsement review, the developer provided a rate of 73% compliance with this measure	MIPS, Ryan White Core Measures
0579	Annual cervical cancer screening or follow-up in high-risk women	Resolution Health, Inc.	Clinician	Endorsement Removed	During the endorsement review, the developer provided testing data showing a result of 78.5%	Not available
N/A PQRS #P22	HIV Screening of STI patients: Percentage of patients diagnosed with an acute STI who were tested for HIV	CDC	Clinician	Not Endorsed	N/A	Measure formerly used in PQRS

Measures Previously Considered but Not Included

NQF#	Measure	Previous Notes
0408	HIV/AIDS: Tuberculosis (TB) Screening	<ul style="list-style-type: none"> One-time, point-in-time measure Repeated testing could be more beneficial to at-risk populations; however, defining "at-risk" populations can be challenging.
1999	Late HIV diagnosis	<ul style="list-style-type: none"> Measure was not included as it is a population level measure (state). There was concern that this measure may be difficult to capture from claims data or public health records.
0404	HIV/AIDS: CD4 Cell Count or Percentage Performed	<ul style="list-style-type: none"> Workgroup felt it was more important to focus on viral load.
PQRS #P23 HIV	Ever Screened for HIV: Percentage of persons 15-65 ever screened for HIV	<ul style="list-style-type: none"> Concerns that high risk patients may need to be tested again, measure excludes people over 65, and there may be gaps in data when patients switch providers or plans.

		<ul style="list-style-type: none"> • Group agreed that cost of over testing is worth the risk of under testing. • CMS included this measure in PQRS: <ul style="list-style-type: none"> ○ Clinically sound and represents an important screening concept. ○ Reportable by a variety of specialists
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Previously Identified HIV Measure Gaps

- HIV RNA Level (revise NQF #0404 CD4 Cell Count or Percentage Performed to assess HIV RNA Level which is now recognized as the key metric)
- #0413 HIV/AIDS: Screening for High Risk Sexual Behaviors (NCQA) had endorsement removed in 2013
- #0573 HIV Screening: Members at High Risk of HIV (Health Benchmarks - IMS Health) had endorsement removed in 2014
- PQRS #P23 - HIV: Ever Screened for HIV: Percentage of persons 15-65 ever screened for HIV. Reconsider upon release of additional testing data likely in summer or fall of 2016. Less than 100% performance expected.
- Updated medical visit frequency measurement with virtual visits (#2079)
- Follow up for patients diagnosed with HIV and with low viral load
- HIV screening related to obstetrics
- Starting treatment and achieving suppression early
- PrEP use in high-risk individuals
- Recognition of HIV as a long-term, chronic condition with comorbidities

Current measures in Hepatitis C Core Set

NQF#	Measure	Measure Steward	Level of Analysis	Endorsement Status	Performance Data	Use
N/A	Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis	AGA	Clinician	Not Endorsed	N/A	MIPS
N/A	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	PCPI	Clinician	Not Endorsed	N/A	MIPS

Measures Previously Considered but Not Included

NQF#	Measure	Previous Notes
0393	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	<ul style="list-style-type: none"> • Removed from PQRS. Low bar measure. However, good clinical practice.
0395	Paired Measure: Hepatitis C Ribonucleic Acid (RNA) Testing Before Initiating Treatment	<ul style="list-style-type: none"> • “Topped out”
0396	Paired Measure: HCV Genotype Testing Prior to Treatment	<ul style="list-style-type: none"> • “Topped out”

0399	Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400)	<ul style="list-style-type: none"> Information on why measure was not selected not available.
0400	Paired Measure: Hepatitis C: Hepatitis B Vaccination (paired with 0399)	<ul style="list-style-type: none"> Information on why measure was not selected not available.
0398	Hepatitis C: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks after Initiation of Treatment	<ul style="list-style-type: none"> Need for potential changes to RNA testing/SVR measurement timeframe
PQRS #Y20	Discontinuation of Antiviral Therapy for Inadequate Viral Response (measure specific to Hepatitis C diagnosed patients)	<ul style="list-style-type: none"> May be difficult to operationalize

A Workgroup member asked about the working definition for “topped out”, as there was no recollection from previous CQMC deliberation that the term was used in decision-making. The Workgroup member shared that from recollection, measures #0393, #0395, and #0396 were thought to have been harder to put into practice, and the Workgroup had agreed to instead consider SVR measures in the future. A Workgroup member sought clarification for the term “low bar measure”. NQF staff shared that this likely referred to a measure that the Workgroup agreed did not drive the type of improvement desired (e.g., less closely linked to outcomes). NQF staff requested that Workgroup members who participated in previous CQMC meetings share any knowledge around the rationale for not including measures #0399, #0400 and #0398 in the core set.

Previously Identified Hepatitis C Measure Gaps

- #0393 Hepatitis C: Testing for Chronic Hepatitis C - Confirmation of Hepatitis C Viremia
- Testing of viral load 12 weeks post-end of treatment
- Increased ability to treat Hepatitis C

A Workgroup member who served in the previous CQMC shared that when measures for the current core set were being selected, newer direct-acting antivirals (DAAs) were in development and coming to market.

Evaluation of new measures

NQF staff shared that for the environmental scan they reviewed NQF-endorsed measures and measures in MIPS and other federal programs. NQF staff highlighted that they did not review measures on the CMS Measures Under Consideration (MUC) list. NQF staff shared a crosswalk comprised of findings from the environmental scan.

Review of Potential HIV Measures

Highlighted in the crosswalk were measures that were previously discussed, but will be reconsidered: HIV Screening (discussed as PQRS #P23), NQF #2080 Gap in HIV medical visits, NQF #2083 Prescription of HIV Antiretroviral Therapy, and NQF #3211e (an eMeasure version of #2083, not previously discussed). eMeasure versions of measures currently in the set (#3209e and #3210e) were also identified in the scan, as well as a measure not previously discussed – Adherence to Antiretrovirals (PDC-ARV).

HIV Screening

The Workgroup discussed that the measure follows CDC recommendations, but the Workgroup advised NQF to check with CDC to see if there are updates or if they are interested in submitting for endorsement. A Workgroup member noted that measure is based on a strong recommendation from the US Preventative Services Taskforce. A Workgroup member mentioned a new initiative that focuses on screening/testing of individuals to identify those not receiving care, noting the measure

would be important to the initiative, and offered to share indicators being used. The Workgroup is considering the measure for inclusion.

2080 Gap in HIV Medical Visits

A Workgroup member requested clarification on whether visits only referred to face-to-face consultations, concerned the measure is not considering telehealth encounters. A Workgroup member stated there was some vagueness to the term “visit”, but that it is meant to include a consultation with a provider that has prescribing ability. The Workgroup member will clarify and share information with NQF staff. The Workgroup is considering the measure for inclusion.

2083/3211e Prescription of HIV Antiretroviral Therapy

A Workgroup member suggested the measure would be more valuable if it assessed how quickly an individual diagnosed with HIV is prescribed antiretroviral therapy. A Workgroup member advised that a potential challenge with such an approach would be the feasibility and the operationalization (e.g., date of diagnosis versus date of script). It was discussed that antiretroviral adherence would potentially be better, but that viral load suppression is the optimal choice. The Workgroup agreed to remove the measure(s) from the list for consideration for inclusion in the core set.

3209e HIV Medical Visit Frequency, 3210e HIV Viral Load Suppression (and eMeasures in general)

Workgroup members shared that they generally support eMeasure inclusion as many providers are using eMeasures, but also noted challenges in reporting data to private payers. A Workgroup member stated that harmonization of all measures types should be priority and suggested the Workgroup include eMeasures, but make them optional. The Workgroup members agreed to consider 3209e and 3210e for inclusion.

Adherence to Antiretrovirals (PDC-ARV)

This measure was developed as a health plan performance measure that uses administrative prescription claims data to assess adherence to antiretrovirals (PDC \geq 90%). There was some discussion around the implications and potential to test the measure at the clinician level. The Workgroup expressed some concern that certain factors may be out of a clinician’s control. The Workgroup agreed that viral suppression is the ideal outcome measure. The Workgroup agreed to remove the measure from consideration, but include this area as a gap to revisit in the future.

Review of Potential Hepatitis C Measures

The measure scan identified an eMeasure version of a measure currently in the core set: 3059e One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (eMeasure of PQRS #400). New measures for discussion include 3060e Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users, 3061e Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection, Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options, and Treatment of Chronic Hepatitis C: Completion of Therapy. #3059e, #3060, #3061e were previously approved for trial use and will be reviewed for full NQF endorsement this Spring (2019).

3059e One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk

A Workgroup agreed that if the measure and eMeasure specifications are harmonized (which they are) the eMeasures can be considered.

3060e Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users

This measure was not previously discussed, uses registry data, and is used in MIPS. A Workgroup member shared that it would be preferred if the measure also included men who have sex with men (MSM) and individuals with a history of heavy substance abuse. Also highlighted was the need to better understand how often individuals are screened for active injection drug use. Another

Workgroup member, however, stated that not all MSM are non-monogamous and not all heavy drug use involves injection drugs, thus potentially lowering their risk. The Workgroup requested the full specifications of the measure and decided to keep it for consideration for potential inclusion into the core set.

3061e: Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection

The Workgroup discussed that the measure was not included on the 2018 MUC list. The Workgroup expressed concerns around the two populations and specifications, especially the specificity of “referral to evaluation or treatment services”. There was discussion that the fragmentation of the system could result in an inability to capture referrals. There was an agreement from the Workgroup to continue to consider the measure for inclusion.

Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options

The measure is currently used in MIPS (#390). A Workgroup member stated that Hepatitis C treatment options have vastly improved since 2016, making this measure outdated. The Workgroup agreed this measure would be removed from consideration for inclusion in the core set.

Treatment of Chronic Hepatitis C: Completion of Therapy

This measure was tested at the health plan level of analysis. A Workgroup member advised that, similar to the HIV medication adherence measure, there are some concerns with this measure, especially at the clinician level. The Workgroup preferred to consider a measure focused on SVR. There was discussion that patients without 100% adherence have reported a 100% cure rate. The Workgroup decided that the measure would be removed from considered at this time, but welcomed additional future discussion with the developer around this focus area.

NQF staff advised they would review the SVR measure and introduce the measure for discussion during the next meeting. A Workgroup member also suggested the review of the Viral Hepatitis Action Plan to check the status of the development of a cure measure.

Next Steps

NQF staff shared that the focus of the next Workgroup meeting would be to vote on measures for addition to the core set, continuing discussions as needed, and to identify and discuss potential measures for removal. The Workgroup was advised that its recommendations would be presented to the full Collaborative for approval after the Workgroup vote. NQF staff requested members who did not have access to the CQMC SharePoint to email CQMC@qualityforum.org for assistance.