Meeting Summary

Implementation Workgroup Web Meeting 1, Option Year 2

The National Quality Forum (NQF) convened a web meeting for the Implementation Workgroup on February 24, 2021.

Welcome and Review of Web Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff reviewed the meeting objectives:

- Recap of last year's work
- Goal and scope for this year
- Identification and prioritization of topics

Recap of last year's work

NQF staff began with a recap of last year's work (Option Year one). The Workgroup was reminded that a total of four meetings were convened during which the Workgroup helped develop content that informed development of the draft Implementation Guide. The Guide underwent public comment prior to its finalization and being published on the CQMC website. It was further noted that despite the Implementation Guide's primary audience being health plans seeking to implement and/or evolve value-based payment programs, it is relevant to a broad audience.

The Implementation Guide highlighted four key elements of success for value-based payment programs:

- Leadership and Planning
- Stakeholder Engagement and Partnership
- Measure Alignment
- Data and Quality Improvement Support

Also included in the Implementation Guide are technical considerations for implementation, i.e., benchmarking/performance targets, patient attribution, and addressing small numbers and measure reliability. The Implementation Guide also provided recommendations for moving forward such as greater data capabilities and infrastructure to facilitate bolder measurement. The Implementation Guide noted difficulties in making a use case for infrastructure when measures are not in use and/or implementation of measures in the absence of the necessary infrastructure. The Implementation Guide therefore recommended stakeholders to work together in moving measurement forward. A co-

chair echoed the recommendations of involving a broader audience i.e., multiple stakeholders e.g., EHR developers, ACO's, payers (private and public) in the discussion to ensure alignment.

Goal and scope for this year

NQF staff then transitioned to focusing on work for the current year (Option Year two). This work will include a refresh of the Implementation Guide. This refresh will address any content issues and include feedback from stakeholders; updating of tools and resource; and adding additional content and/or updating or one or two priority areas/topics. The work will take place over a two-month period with two Workgroup meetings, including this meeting.

The Workgroup was notified that CQMC would be refreshing the core sets and convene three new workgroups as follows:

1. Digital Measurement: this Workgroup will provide recommendations for a model for facilitating greater uptake of digital measures in the CQMC core sets and create a Roadmap for CQMC Digital Measurement.

2. Cross-cutting: this Workgroup will create a core set of cross cutting measures that address topics such as patient safety, diagnostic accuracy, patient-reported measures, care coordination, access to care, and SDOH.

3. Measure Model Alignment: this Workgroup will develop recommendations that address governance, structural, and operational models for payer and purchaser alignment around the collection, transmission, standardization, aggregation, and dissemination of data to support core set adoption and implementation.

The Implementation Workgroup was encouraged to join the Measure Model Alignment Workgroup as the work and content explored by the two groups overlap.

Identification and prioritization of topics

NQF staff shared that some potential topics they had identified for consideration are digital measures, patient-reported outcome performance measures (PRO-PMs), measures of health equity, specifically, overcoming trust issues around obtaining demographic information, and best practices for achieving alignment in measure specifications.

A co-chair suggested including the challenges of implementing the CQMC core sets without the involvement of EHR vendors, as there is need to have support for EHR measures to build in specifications for both the state and plan level. It was noted that measure alignment across programs supporting CQMC work e.g., CMS, CMMI, Medicaid, Medicare, commercial payers, purchasers etc. would aid in implementation of the core sets.

NQF staff inquired from the Workgroup on what the Implementation Guide should focus on to address the current bottlenecks in implementation. A public payer member acknowledged the

challenge of alignment at the state level and shared that efforts are underway to search for opportunities to have providers or states report data one time, e.g., via Health Information Exchanges (HIEs), and have the data used for multiple purposes at different levels to remove burden, fostering alignment and consistency in reporting. It was also shared that the challenge comes when specifications are not uniform across users because of the different populations being served by multiple public programs, e.g., Medicare does not have maternal and child health measures.

Also raised as a potential area of focus was the definition of digital measures, e.g., whether it is a measure that only uses claims data and does not require additional manual or chart review. Another suggestion was examining the roll-out of the measures at different levels of analysis which can cause a barrier to implementation. The Workgroup member used the example of a managed care plan using a measure at the provider level versus use at the state level results in multiple definitions as managed care organizations, county, state, and providers etc., all independently implement the "same" measure in their practices.

A Workgroup member shared challenges HIEs experienced due to the specification nuances at different levels of reporting, e.g., MIPS must report at provider/group level unlike other CMS programs which report at a plan level. This was noted as an opportunity for measure developers to consider the different levels of reporting, i.e., state, plan, or individual provider when developing measures.

A Workgroup member who focuses on high-need beneficiaries i.e., dual-eligible, with high negative impacts of SDOHs agreed that measure alignment is a challenge at the provider level, plan level, and beneficiary level. An example of the CAHPS survey is implemented was given as an example. Some states require different surveys for Medicaid than those used for Medicare and this would result in an individual completing two surveys over a short span of time. A suggestion was made to begin with simplifying such processes for the dual-eligible beneficiaries, who are already a primary focus point in terms of health equity, quality, and cost. A suggestion was made to include examples of use cases and/or best practices in the Implementation Guide.

A Workgroup member supported addressing issues with completeness and accuracy of eCQM data elements. It was noted that in hospitals, eCQM data varies in quality, and manual chart abstraction is frequently more accurate. This raises the question of whether effort is better spent on creating more eCQM measures or on further examining differences between manual chart abstraction and eCQM. A co-chair shared that many ACOs have moved back to manual chart abstraction because use of eCQMs resulted in inaccurate quality scores. Also noted were concerns about the quality of data mapping for most EHR vendors.

A Workgroup member highlighted the 2016 NQF report on Variation in Measure Specifications which discusses the challenges of mis-aligned measure specifications. NQF staff noted that the Implementation Guide included this report as a reference. NQF staff proposed that some of the solutions be included in the Guide during the refresher. A co-chair recommended that the Workgroup review a 2017 reported authored by David Nerenz et. al., titled Associations Between Community Sociodemographics and Performance in HEDIS Quality Measures: A Study of 22 Medical Centers in a

Primary Care Network.

NQF staff summed up the discussion by acknowledging that different levels of reporting represent a significant challenge to implementation and that during discussions last year there was a discussion on how to best collect data. One of the proposed solutions was centralized data infrastructure, e.g., through regional health collaboratives and shared reporting infrastructures. NQF staff inquired if including additional information about this in the Guide would be worthwhile, noting that NQF's interim CEO, Chris Queram, worked to develop a shared reporting infrastructure in Wisconsin. A co-chair shared that they have explored having their state HIEs as the master source from which plans could query all provider information at all levels but indicated that this is a lofty goal considering the HIEs current capabilities. A Workgroup member shared that long-term services and supports are often left out of HIE networks, and behavioral health information may be missing or difficult to locate. A co-chair shared that HIEs often connect hospitals or primary care clinics where the bulk of quality care data resides e.g., in the form of immunizations, colon cancer screenings etc. NQF staff echoed this by sharing discussions from NQF's Measures Applications Partnership (MAP) Long-Term Care/Post-Acute Care Committee regarding the interconnectedness of skilled nursing facilities and the availability of information electronically which is uneven across the continuum of care for patients.

NQF staff asked what additional interventions might help address quality measurement issues. A co-chair shared that in their state, both Medicare and Blue Cross Blue Shield share their claims files with ACOs, allowing them to fill in gaps based on the clinical records. The co-chair asked the workgroup if the process is similar in their ACOs or if electronic exchanges are used.

In response, a Workgroup member shared that they use a single measure set for all their ACOs nationwide with approximately 15 measures, which are updated once every 3-4 years. The member shared that to qualify for reporting providers must have 20 episodes and that reporting varies depending on the case counts, whereby some providers report as few as eight measures and others the entire suite of measures. The member indicated that they have over 268 ACOs which makes it operationally impossible to use different measure sets in each state. The member shared that reporting is done through claims, manual attestation, and formatted flat files from health settings and population health tools. The member cautioned that their current core set produces a fair amount of noise, and that providers still have a significant amount of burden. It was noted that they had been working on the core set for 4-5 years and have yet to reduce the noise enough to get significant buy-in from most stakeholders.

A Workgroup member inquired about alignment between the CQMC ACO core set and Medicare Advantage (MA) STARS program, stating there be interest in reviewing measures that align across ACOs and MA. A co-chair responded that ACOs would be interested because they have to report on MA, primary care, and Medicare Shared Savings Program which are similar but also slightly different from each other.

A co-chair shared that their health plan's commercial side of business has a measure set that comprises of 17 measures which are categorized into two domains, evidence-based medicine (EBM)

and patient experience. Measures in the core set are periodically updated (every 3-4 years) but updates can take place sooner if there is a substantial reason. The co-chair shared that their ACOs had requested that their core set generally align with HEDIS denominators and other HEDIS specifications, for ease of operationalization. Their health plan set uses both the CQMC ACO core set and HEDIS for alignment. The co-chair shared a list of retired measures that had either become topped-out, caused confusion in reporting, or were difficult to capture comprehensively and accurately. It was shared that the patient experience domain was generally difficult to implement as it includes surveys and regular patient experience scores. The co-chair indicated that aligning measure sets helps reduce noise and encourage buy-in from stakeholders such as health plans and EHR vendors.

A Workgroup member questioned HEDIS' role in core measures used by health plans; whether it is helpful or potentially a barrier to meaningful quality reporting/alignment. Another Workgroup member questioned why low-value measures and retired measures are operationally challenging. In response, the co-chair shared that primary care physicians (PCPs) indicated that they had little control over some of the care and found it hard to influence whether patients go to urgent care or managed care via telehealth, who by the time they are seen by their PCP are 5-7 days into their illness. It was shared that PCPs feel that they have minimal influence over such measures and therefore are reluctant to includes these areas in their accountability. Other examples provided were those of manual lab stations, which if checked off manually can become too cumbersome to manage; medication management used in depression measurement when there is no attempt to use other first-line interventions like cognitive therapy which could be effective. The co-chair highlighted that the goal should be to reduce burden on providers so that they have a better focus and higher success capturing and impacting the measures.

A Workgroup member shared that physicians agree that the measures are important, but some do not work very well e.g., bronchitis measures which are very gameable as providers may decide to assign a different diagnosis or prescribe other antibiotics not commonly used to treat the infection i.e., amoxicillin. Another Workgroup member asked if the measures in the health plan core set used the same specifications as the MA STARS program. In response the co-chair advised that they worked in the commercial side of the business and were not familiar with the MA STARS program specification details.

NQF staff inquired if a centralized infrastructure is necessary to implement measures at a large scale, noting that many collaborative efforts take place at a state level. Staff noted that, for instance, the optimal diabetes care composite is captured via collaborative effort in Minnesota and in Wisconsin, but not in other states. A Workgroup member shared that composite measures are problematic to operationalize. A co-chair shared that the American Academy of Family Physicians did not support composite measures as they were in essence four measures and that they did not give a true indication of population health. Composite measures were also noted as being difficult to implement and were generally a burden to the providers. Another Workgroup member inquired if the health plan updates their cores set measures in alignment with HEDIS measures. It was noted that there was a recent HEDIS update that merged adolescent and well-child measures. The co-chair advised that their response to NCQA has been to potentially limit frequent measure specification changes, as it poses a challenge in implementation and when comparing providers year over year. Also highlighted

was the inclusion of the measures in provider contracts which may require updating the contracts if measures change which is burdensome to the health plans and providers.

A co-chair representing ACOs shared their organization has 11 core set measures in the categories of adult, pediatrics, prenatal, and behavioral health. The core set was initially a collaborative effort among the State University School of Public Health, the chief medical officers (CMOs) for the state ACOs, and public and private payers. It was noted that creating the adult set was relatively straight forward and that it aligned with Blue Cross Blue Shield. The prenatal core set was reported as having no alignment but was considered by physicians as important to measure. A behavioral health measure (NQF #2152 *Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling*) was included in the core set due to the high incidence of alcohol misuse in the state. The co-chair shared that the ACOs were a combination of different types of physicians, all attempting to determine how to best cover an entire population. The core set will be undergoing some updates, including a review of some of the HEDIS updates and adolescent depression and anxiety screening measures due to the rise in cases reported in the wake of the COVID-19 public health emergency. It was reported that the core set was getting traction from the Medicaid MCOs and the next step will be to include employers. The co-chair highlighted that despite many plans not including prenatal in their core set, pregnancy is the category of highest spending for women ages 20-40. A member of the Workgroup representing Medicaid shared that the opportunity for improvement in childhood and well-child checks for CMS align with NCQA specifications, noting that these are subset measures. CMS will collect data simultaneously for both 0-15 months and 16-20 months as a part of the larger measure.

NQF staff asked the Workgroup to consider how realistic it was to align goals, or if the current state is the most alignment that is feasible. A Workgroup member who represents a public payer indicated that the Quality Rating System (QRS) has a few Pharmacy Quality Alliance (PQA) measures but mostly contains NCQA measures. An example of measure misalignment was hemoglobin A1c, with commercial payers picking one A1c value and CMS, because of their population, choosing a different value. The member stated that there is an aim to strive for alignment and in the case that there is no alignment there should be a justification.

It was reported that NCQA has the conversion of some of their measures to electronic reporting currently out for public comment. It was stated that big health plans may not have a challenge in implementing such changes, but rural health plans cannot completely shift to electronic reporting due to ongoing technology and resource challenges. A co-chair shared that most ACOs cannot report eCQMs accurately and upgrading their systems would be expensive (approximately $500k-$1 million). NQF staff asked if Workgroup members were aware of any groups that had successfully navigated this reporting change or are getting the infrastructure in place, so that they can be highlighted as an example in the Implementation Guide. A co-chair recommended that the Workgroup considers using Minnesota Community Measurement as an example.

A regional collaborative member of the Workgroup shared that their core set is used by purchasers, payers, providers, policy makers, and consumers. The core set was noted to be undergoing some updating in 2021 and has strong participation from its members. The member echoed that the

biggest challenge their employer members face is getting data for their own beneficiaries. It was reported however, that through the collaborative process the employers have become more knowledgeable in working with their third-party administrators and health plans, e.g., know what to ask for and measure what is important to them.

NQF staff and co-chairs requested Workgroup members to share examples of what their respective organizations or states have as their core sets and how they have been implemented to help inform the Implementation Guide refresh.

Next Steps

NQF staff closed by requesting members to share their state core sets, additional information, tools, and recommended updates to the Implementation Guide before the end of March. The Workgroup was informed that the next meeting would be on May 12, 2:00-4:00 pm ET.