CQMC Core Quality Measures Collaborative

Meeting Summary

Accountable Care Organization (ACO)/Patient-Centered Medical Home (PCMH)/Primary Care Workgroup Web Meeting 2

The National Quality Forum (NQF) convened a web meeting for the Accountable Care Organization (ACO)/Patient Centered Medical Home (PCMH)/Primary Care Workgroup on September 7, 2022.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants to the meeting and introduced the co-chairs of the ACO/PCMH/Primary Care Workgroup (provider co-chair Dr. Karen Johnson and payer co-chair Dr. Martha Walsh). The co-chairs provided welcoming remarks to the Workgroup. NQF staff reviewed the antitrust statement, as well as acknowledging that CQMC is a member-funded effort with additional support from the Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).

NQF staff facilitated roll call and reminded the group that the roster includes both voting and non-voting members; while both types of members can participate in discussion, only voting members will be asked to cast votes on any changes to the core set. NQF staff reviewed the meeting objectives:

- Continue discussion of potential changes to the ACO/PCMH/Primary Care Core Set as part of the yearly maintenance process
- Discuss future work for the ACO/PCMH/Primary Care Workgroup, including development of an organizing framework, preferred characteristics for core sets, and health equity considerations

Measure Maintenance

NQF staff briefly reviewed the outcomes from the last meeting held in July. The Workgroup decided that *#3568 Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)* and *#3541 Annual Monitoring for Persons on Long-Term Opioid Therapy* will move forward to voting for potential addition. *#3597 Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System* will not be considered further for addition to the core set.

Potential Removals from the Core Set

0421/0421e: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

The first measure discussed for removal was *#0421/0421e: Preventive Care and Screening: Bobby Mass Index (BMI) Screening and Follow-Up Plan.* This measure was identified by a Workgroup member based on its potential for unintended consequences. NQF staff shared that this measure focuses on the percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months, and with a BMI >= 18.5 and < 25 kg/m2, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. This measure excludes palliative care patients, pregnant patients, patients who refuse measurement or follow-up, patients with a documented reason for not completing BMI follow-up, and patients with a

documented medical reason (e.g., elderly patients for whom weight reduction or weight gain could complicate underlying health conditions).

A Workgroup member noted that this measure is potentially inappropriate for older patients and can lead to unnecessary and harmful weight loss plans for adults 65 years and older. This Workgroup member noted that study findings indicate that BMI ranges are not necessarily appropriate for older patients and such patients may be excluded from the denominator if it is not appropriate to put them on a weight loss follow up plan. However, they noted reports of a healthcare system being required to enforce the metric and labeling older adults with a BMI in the range of 25 to 30 kg/m2 as obese and following up with weight loss referrals. These referrals are not indicated and may be harmful and burdensome to older patients and practices that provide care to older patients. The Workgroup member also referenced a study in which higher BMI classification may be protective for older adults in terms of mortality. This Workgroup member shared this potential harm is of particular concern to geriatric health professionals and smaller practices whose resources depend on quality metrics.

This measure is no longer NQF endorsed but the steward is maintaining it outside of the NQF endorsement process. This measure was last discussed in June 2021; at that time, the group recognized the measure had high performance based on Medicare Part B claims data, but high performance was not consistent when this measure was reported as an eCQM or based on Merit-Based Incentive Payment System (MIPS) Clinical Quality Measure (CQM) data. There were differences in performance data based on whether this measure was reported electronically or via claims. In 2021, the group noted that the variations in performance may be more indicative of a data gap than an activity gap. The Workgroup decided this measure should remain in the core set.

NQF staff proposed an option to include a note in the core set presentation that would recognize the concern about potential use in older adults, highlighting that this population should be excluded. One of the co-chairs noted that measure *#0421/0421e: Preventive Care and Screening: Body Mass Index (BMI)* is no longer endorsed by NQF, not because it lost endorsement but because the measure steward is no longer pursuing endorsement. A Workgroup member commented that they support the idea of adding a note for this measure highlighting the exclusions, rather than removing the measure from the set. The measure steward specified this measure has a denominator exception for this population. A patient would be denominator eligible and come through for the quality action assessment; however, the patient would end up being ineligible for the purposes of performance rating. It would be at the clinician's discretion to document that the patient is elderly and does not meet measure criteria. A Workgroup member asked the measure steward if there were specific diagnoses that would remove these patients from the measure. The steward clarified there are currently no medical conditions within the elderly patient exception, but if weight reduction or weight gain would complicate other underlying health conditions, such as illness, physical disability, mental illness, dementia, confusion, and nutritional deficiencies these patients would be removed from the performance rate. A co-chair shared that most measures include diagnoses which would remove patients from the measure rather than requiring clinician documentation of the problem. The co-chair shared concern about the potential unintended consequences. The Workgroup decided to move forward with adding a note for the measure in the core set.

Comparison of #0097 Medication Reconciliation Post-Discharge and Transitions of Care Measure

NQF staff introduced a comparison of measure *#0097: Medication Reconciliation Post-Discharge* and the Transitions of Care measure. #0097 is no longer used alone by the steward and was integrated into the National Committee for Quality Assurance (NCQA) Transitions of Care measure in 2018. Measure #0097 is in the ACO/PCMH/PC core set and remains NQF endorsed. In April 2020, the Workgroup members

discussed measure #0097, noting the importance of patient safety but expressing concerns about it potentially being a low bar or “checkbox” measure with high performance. However, other members shared their experiences of low performance, emphasizing there is still an opportunity for improvement. Additionally, a few organizations reported success in implementing the measure.

NQF staff shared a side-by-side comparison of both measures and described measure #0097, which focuses on patients 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge. The Transitions of Care measure reports four rates: notification of inpatient admission, receipt of discharge information, patient engagement after discharge, and medication reconciliation post-discharge. NQF staff noted that measure #0097 and the Transitions of Care measure are process measures that are not risk adjusted. A co-chair clarified that two components of the measure require data from the medical record, while claims data is used for the other two components. A Workgroup member who is also the measure steward expressed the importance of all four components of the Transitions of Care measure because they are key steps to support quality transitions. A member asked why measure #0097 is endorsed but the Transitions of Care measure is not. The steward representative responded that the difference is due to timing of NQF endorsement cycles and when the measures are tested and ready for submission. A co-chair asked the Workgroup to provide comments on whether to substitute the Transitions of Care measure for #0097. A Workgroup member reiterated the importance of high-quality care for people with disabilities who are transitioning between a variety of care settings. Another member commented that measure #0097 was retired from the Medicare Star Rating program in favor of the Transitions of Care measure. NQF staff and the co-chair thanked the group for their discussion and summarized that the Transitions of Care measure will be included in the voting survey as a replacement for #0097.

Potential Additions to the Core Set

3568: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

NQF staff provided an overview of #3568, which was discussed during previous Workgroup meetings. NQF noted that although this measure was already discussed, Workgroup members expressed the need to revisit this discussion before moving this measure to a formal vote. NQF highlighted that the Workgroup noted that measure #3568 is a patient-reported measure that assesses the perception of primary care, separate from clinical outcomes. Workgroup members also discussed that the denominator includes patients who have only one encounter in the past year, and at least one Workgroup member questioned the relevance of questions for acute injuries. This measure evaluates patients’ overall primary care relationship, while Consumer Assessment of Healthcare Providers and Systems (CAHPS) is encounter-specific and can be used in specialties. Additionally, the measure developer and steward developed a platform that supports the implementation of this measure.

A co-chair invited the measure developer and steward (American Board of Family Medicine [ABFM]) to share additional comments regarding measure implementation, the number of patients who had one visit per year, and how the measure compares to the CAHPS measure. The developer shared that National Research Survey (NRC), a widely used platform for fielding patient-reported surveys, has implemented the measure in their platform and various other organizations have begun to field it. Additionally, the developer shared that CAHPS is primarily patient experience focused and transaction based, while PCPCM is meant to assess overall primary care, aligning with the National Academies of Sciences, Engineering, and Medicine (NASEM) report qualifications. The developer highlighted that the PCPCM PRO-PM measure is not specified to be fielded in relation to a specific visit; it focuses more broadly. The developer shared that based on data from 2022, 37% of respondents had a single visit with

the physician during the past year, and PCPCM scores remained consistent. This suggests that patients who having just one visit with their physician during the measurement period is not a detriment to a physician's PCPCM score.

A co-chair opened the floor for discussion of this measure. A Workgroup member expressed strong support for the PCPCM PRO-PM measure and shared that Meaningful Measures 2.0 prioritizes person-centered outcome measures. #3568 will be included in the voting survey for potential addition to the core set.

3617: Measuring the Value-Functions of Primary Care: Provider Level Continuity of Care Measure
NQF staff provided an overview of #3617. This measure is a process measure that uses claims data. It evaluates primary care physicians; for each physician, their denominator is all patients they saw during the evaluation period who had at least two primary care provider (PCP) visits (could include visits to other PCPs), and the numerator is the number of those patients whose Bice-Boxerman Continuity of Care Index is >= 0.7. #3617 was recently endorsed as part of the CDP Spring 2021 cycle. NQF noted that this measure addresses the gap area of continuity of care and was recommended for discussion by a Workgroup member.

A co-chair invited the measure steward ABFM to provide additional information on #3617. The ABFM representative shared that several years ago the Workgroup identified continuity of care as a high-priority gap area. The ABFM representative also shared that measure #3617 is a cognitive care measure that is a part of their primary care initiative, which aims to simplify and improve the measurement of primary care. The steward emphasized that continuous relationships between doctors and patients are key because they support improved health and lead to lower costs. Sustained relationships also lead to greater patient satisfaction and trust in healthcare. The steward shared that the numerator cutoff was established based on published literature and the index itself is well studied. The measure is used in the PRIME Registry, which is the largest registry for primary care physicians. During the pandemic (when reporting was not required), about 600 clinicians reported the measure in MIPS along with 250 groups. In 2019, approximately 2400 clinicians and 800 groups reported the measure.

A co-chair emphasized that this measure aligns with a gap area identified by the Workgorup and noted it is low burden since it is claims based. A co-chair asked if the measure is meant to be used at an individual clincian level. The steward confirmed it is specified at the individual clincian level but can be rolled up for group reporting. The steward also clarified that if a patient sees a nurse practitioner or physician assistant, those encounters are excluded from the measure calculation; this measure only includes primary care physicians. A Workgroup member asked how the measure identifies if a physician is a primary care physician. The steward responded that the code set included in the measure allows for this identification. Based on their analysis, the required fields are regularly populated in claims. No members were opposed to bringing this measure to a vote. This measure will be included in the voting survey for potential addition to the core set.

Additional Measure Updates

NQF staff shared a few additional updates and measures that the group could potentially discuss in the future. The four measures up for potential future discussion include:

- MUC21-125: Psoriasis – Improvement in Patient-Reported Itch Severity
- MUC21-135: Dermatitis – Improvement in Patient-Reported Itch Severity
- MUC21-136: Screening for Social Drivers of Health
- MUC21-134: Screen Positive Rate for Social Drivers of Health

These measures were brought forward to prompt initial reactions to whether these measures or topic areas are of interest to the group to consider in the future. These measures went through the Measure Applications Partnership in 2021 and received conditional support for use in their respective programs contingent upon NQF endorsement. A co-chair mentioned the importance of including patient reported measures in the core set. The co-chair suggested the group look at a set of patient-reported measures and select ones that align with the measure selection principles rather than looking at each measure individually. Workgroup members supported using this type of approach when considering measures in the future.

NQF staff noted the Health Equity Workgroup is discussing the Social Drivers of Health measures and potential paths forward as part of their work. A Workgroup member noted that NCQA has measures related to social determinants of health and social drivers, which should be discussed in the future with this Workgroup. A Workgroup member also suggested that it would be beneficial to have CMS representatives speak to these measures and their approach to health equity measurement during next year's meeting. A co-chair asked the group if anyone had any reasons not to discuss these measures in the future. Hearing no objections to discussing these measures in the future, the co-chairs recommended the Workgroup discuss them during next year's maintenance cycle.

Next, NQF staff discussed newly developed measures *#3665: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood* and *#3666: Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain*. These measures went through the NQF endorsement process in fall 2021 and were also raised by a Workgroup member as addressing a core set gap areas related to patient reported measures, advanced illness, and hospice/ palliative care. A co-chair commented that there is focus on primary palliative care right now; some people do not have access to palliative care physicians so they are seeing primary care physicians instead. These measures will be brought forward for further discussion next year.

NQF staff shared specification updates for measure *#1885: Depression Response at Twelve Months-Progress Towards Remission* which is in the core set. This measure has been redesigned with several changes. The age range for this measure now includes adolescent patients. The steward added the PHQ-9M tool as appropriate based on the expanded age range. They also expanded the follow-up window from plus or minus 30 days to 60 days, added exclusions for schizophrenia and pervasive developmental disorder, and removed the requirement that a major depression diagnosis is in the primary position.

NQF staff then asked the group about the current "Notes" in the core set and whether they remain accurate or relevant or require updates. The purpose of the notes section is to inform core set users of information that would be helpful to aid in implementation. A co-chair asked the group if the note section goes far enough to thoroughly inform core set implementers and outline how the measures should be used. A Workgroup member suggested a separate column in the core set presentation to more prominently indicate the level of analysis for which a measure is tested and specified. NQF staff informed the group that this year's updates will include a column on level of analysis rather than using symbols. NQF also plans to include clarifying language at the beginning of the core set presentations explaining more about how measures should be used based on their level of analysis.

Future Work

The CQMC has received feedback from members on the need to consider the specific mix of subtopics represented in each core set in addition to the measure selection principles. Some of this feedback included looking more broadly at the core sets, addressing priority topics that are missing, and

considering whether the current areas covered in the core sets reflect the areas the group wants to prioritize for measurement in value-based care models. NQF staff asked the group for their input on whether the current core set addresses the topics that are most important and if there are any topics that are left out. A co-chair noted there are no pediatric measures in the core set and asked if this is because the scope of the ACO/PCMH/PC core set focuses on adults. NQF staff informed the Workgroup about the separate Pediatrics core set and shared that traditionally this Workgroup has focused more on the adult population. The Workgroup suggested there may be value in aligning with the measure recommendations of the Pediatrics Workgroup or referencing their core set. The co-chairs suggested the group email any comments on measurement gaps areas or health equity considerations for the core set.

Next Steps

NQF shared that a summary of the Workgroup meeting would be posted on the CQMC SharePoint page. NQF staff will share a voting survey for the measures discussed for potential addition. NQF staff and the co-chairs thanked Workgroup members for their participation during the meeting.