Meeting Summary

Core Quality Measures Collaborative Full Collaborative Meeting

Battelle convened the Core Quality Measures Collaborative (CQMC) Full Collaborative on Monday, November 6, 2023, to review and discuss updates from the Behavioral Health and Obstetrics and Gynecology (OB/GYN) Workgroups.

Welcome and Opening Remarks

Kate Buchanan, Battelle CQMC Lead, welcomed participants to the Full Collaborative meeting to discuss Behavioral Health and OB/GYN core set updates. Ms. Buchanan reviewed the anti-trust compliance statement and noted that CQMC is a membership-driven and -funded effort, with additional support from Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP). Ms. Buchanan gave an overview of the meeting agenda.

Ms. Buchanan introduced Danielle Lloyd, Steering Committee Chair and Senior Vice President of Private Market Innovations and Quality Relations at AHIP. Ms. Lloyd noted the objectives for the meeting were to prepare for the voting process for the Behavioral Health and OB/GYN Workgroups. Ms. Lloyd briefly reviewed the full collaborative voting and non-voting members. She provided updates on the future of CQMC and focus areas for 2024. This included continuing core set maintenance, alternating group reviews, guidance on adoption and implementation, stratification guidance, digital measurement, and demographic data.

Maternal Health

CMS Medical Officer, Dr. Tiffany Wiggins, MD, MPH, FACOG introduced the new "birthing friendly" designation that will be launched on CMS Care Compare. Dr. Wiggins said that this work is a milestone in the CMS Maternity Care Action Plan, which seeks to advance maternal care quality and safety and equity through addressing gaps in coverage and access. The Maternity Care Action Plan supports the implementation of the Biden-Harris Administration's Blueprint for Addressing the Maternal Health Crisis.

Dr. Wiggins focused on two gaps the plan seeks to fill: coverage and access to care, and quality of care. Regarding quality of care, Dr. Wiggins noted that CMS included two maternal health measures in last year's Hospital Inpatient Quality Reporting Program final rule. Both measures are electronic clinical quality measures (eCQMs), one focused on severe obstetric complications and the other focused on low-risk Cesarean births. Dr. Wiggins explained that the foundation for the birthing friendly designation is the Maternal Morbidity Structural Measure, an attestation measure that asks, "Does your hospital or health system participate in a Statewide and/or National Perinatal Quality Improvement Collaborative Program aimed at improving maternal outcomes during inpatient labor, delivery and post-partum care, and has implemented patient safety practices or bundles related to maternal morbidity to address complications,

including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis?" Hospitals that answer yes receive the birthing friendly designation. She noted that the logo of the designation will appear on the CMS Care Compare tool website and will be assigned to the hospitals, health systems, and insurance plans that meet the criteria.

Dr. Wiggins stressed that this is only the first step in assessing how maternity care quality is captured and in measuring the commitment of hospitals and health systems. Dr. Wiggins recognized the importance of the patient experience of care and patient-reported outcomes, noting that these aid in increasing patient respect and autonomy while reducing bias and discrimination. A member asked when the birthing friendly designation would become publicly available. Dr. Wiggins responded that it would be launched Wednesday, November 8, 2023. She added that the data for the designation can be found on the Provider Data Catalog. Ms. Lloyd said private payers would add information to their directories.

Review Core Set Maintenance Process, Review and Voting Process

Ms. Buchanan reviewed the measure selection principles and core set maintenance process:

- Annually, each core set goes through the maintenance process.
- As a part of the process, workgroups review proposed additions or removals from the core set.
- Following discussion, workgroups vote on the proposed changes.
- The CQMC Steering Committee reviews the vote and approves convening the Full Collaborative to discuss and finalize changes.
- The Full Collaborative reviews proposed changes and engages in discussion.
- Following the meeting, the Full Collaborative has four weeks to submit votes.
- As with the workgroups, the Full Collaborative follows a supermajority voting threshold. This means that at least 60% of participants cast an affirmative vote, and at least one affirmative vote is cast by a representative from each of the provider and payer voting participant categories.

OB/GYN Workgroup Update

Dr. Bauer provided an overview of the workgroup meeting in January 2023 to vote on measure CBE #0471e PC-02 Cesarean Birth. Dr. Bauer reminded participants the OB/GYN core set is made up of 19 measures in the domains of prevention and wellness, and maternal and perinatal health. The PC-02 measure is the eCQM version of the CBE #0471 PC-02 Cesarean Birth measure. He explained that this is an outcome measure at the facility level that looks at the number of nulliparous women with a term, singleton baby in a vertex position delivered by Cesarean birth. He stated that the workgroup discussion touched on the potential to reduce burden and allow providers to pull data electronically rather than from charts or claims data. However, the workgroup noted that some organizations would not be able to use the electronic version. Ms. Lloyd noted that from a broader perspective even with the introduction of an eCQM the CQMC tends to keep the claims-based measure in the respective core set since not all institutions can implement an electronic version. Dr. Bauer mentioned three measures in the core set, CBE# 0469/0469e PC-01 Elective Delivery, CBE#0471 PC-02 Cesarean Birth, and CBE# 0716 PC-06 Unexpected Complications in Term Newborns, should be kept together because that approach gives the facility a more comprehensive approach to what their rates are: PC-01 measures elected delivery before 39 weeks, PC-02 measures Cesarean delivery, and PC-06 measures unexpected complications in term newborns.

Dr. Bauer discussed the update on two measures the Workgroup was interested in: CBE #3682e Self-Identified Need for Contraception (SINC)-Based Contraceptive Care, Postpartum and CBE #3699e SINC-Based Contraceptive Care, Non-Postpartum. He explained that both are facility-level outcome measures that are currently being piloted. The workgroup also discussed pre-conception counseling. Dr. Bauer emphasized that reproductive health care work starts in pre-conception counseling. He noted that workgroup members shared strategic considerations on comprehensive reproductive care, using a health equity lens in future discussions, and potentially creating subsets within the workgroup, one for maternal health measures and one for other gynecological measures.

A member asked how the workgroup discussed #0471e PC-02 Cesarean Birth because there are not medical guidelines on the acceptable rate of Cesareans. She added that her own community struggled with the concept that lower rates of Cesarean births are not necessarily better. Dr. Bauer agreed, noting that this is a challenge to many hospitals and health centers. He stated that there are many ways to measure Cesarean births, which makes it difficult from a reporting standpoint. He recommended using a state-level view and comparing all birthing hospitals to see if Cesarean births are being determined consistently across health systems and whether facilities are engaging in prevention care.

A member asked if the workgroup considered the National Committee for Quality Assurance (NCQA) perinatal depression screening measure. Dr. Bauer replied that the workgroup did discuss it and agreed that the topic should be revisited again. Dr. Bauer noted that the measure should correlate with the recommendations from ACOG and other provider stakeholder groups.

Another member asked if the workgroup plans to focus on access to prenatal care after the overturning of Roe v. Wade. They noted that many labor and delivery units are closing because OB/GYNs are fleeing states with hostile abortion policies, creating maternity health care deserts. Dr. Bauer noted that he would include the topic in the agenda for the next workgroup meeting because the issue has a health equity component. Dr. Bauer acknowledged that maternity care deserts make it challenging to address other measures, like severe maternal morbidity.

A member commented that employer and payer programs are beginning to focus on women's health across the lifespan, with a special emphasis on menopause. The commenter was not sure which CQMC workgroup would address this lifespan issue. Ms. Lloyd responded that this is not typically a focus area and she would have to check if there were existing measures regarding menopause that could be included in the set. Dr. Bauer noted that this is worthy of inclusion in the gap area.

A member asked about patient-reported outcomes and patient experience measures. Dr. Bauer replied that these types of measures have, historically, not been included, but need to be incorporated into the core set.

Behavioral Health Workgroup Update

Dr. Vik Shah and Dr. Tom Smith, the Behavioral Health Workgroup co-chairs, lead the behavioral health discussion. Dr. Shah introduced measure CBE #1885 Depression Response at Twelve Months – Progress Towards Remission. Dr. Shah noted that the previous discussion around this measure focused on the

endorsement loss and conceptual questions about what progression without remission truly means at the 12-month mark. He noted that this measure was directed at patients who have not responded to treatments within 1 year and are likely to be diagnosed with chronic depression. He mentioned that this measure and CBE #1884: Depression Response at Six Months – Progress Towards Remission are the only two outcome measures in the Behavioral Health core set. The workgroup voted to retain both measures. Dr. Smith clarified that there were no new measures recommended for the workgroup in January; both measures were up for maintenance. Dr. Smith mentioned that CBE #1884 retained CBE endorsement, and the NCQA adopted the measure as part of their Healthcare Effectiveness Data and Information Set (HEDIS) electronic clinical data submission. Dr. Smith noted that the list of gap areas included access to care, coordinated care, and bi-directional integrated care. He stated that the workgroup discussed the importance of patient-reported measures in behavioral health.

A member questioned the level of analysis for both measures. The core set document lists both clinician and facility level of analysis. The measure developer clarified that the measures were tested at the group level. Ms. Lloyd stated that the language around facility level would be removed.

A member asked how Federally Qualified Health Centers (FQHCs) are classified within the measure. The developer replied FQHCs are categorized under medical groups and clinics.

Another member asked if any measures assess group modalities within clinical care settings. Dr. Smith noted that psychosocial rehabilitation resources are a known gap area, but access to individual and group psychotherapy and peer services is something the workgroup should consider more heavily. Dr. Smith said the workgroup should note the difference between access to a prescriber, access to therapy, and access to peer services.

Measuring the number of visits a patient has with a provider may give more insight into the patient-provider relationship. Dr. Smith noted that New York state reviewed a similar measure, but it failed to receive endorsement.

A member added that an important aspect of the patient perspective is cash-paid visits versus insurance-paid visits and the decline of in-network behavioral health providers.

Another member commented that historically, accessing behavioral health care in primary care has been a challenge and asked how the new Medicare policy, which allows Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) to enroll in Medicare Part B and bill for their services, will impact measures and if there are plans to pursue any measures looking specifically at this. Dr. Smith responded that it will be interesting to see if this new policy will impact existing measures. A member noted that behavioral health integration models showed challenges in billing. This new Medicare policy could potentially impact measures CBE #1884 and CBE #1885.

Future Directions

The Full Collaborative considered how the CQMC could promote maternal mental health. A member identified perinatal depression screening and follow-up plans as an area of collaboration for Behavioral

Health and OB/GYN Workgroups. Another member agreed and mentioned that a checklist has been developed for postpartum patients that includes mental health follow-up plans. The member also noted that Medicaid reimbursement is another area of discussion between Behavioral Health and OB/GYN Workgroups. Ms. Lloyd noted that CQMC has struggled with attributing access to providers since these issues are more reflective of community support systems. She questioned whether access issues should be in value-based arrangement component or quality improvement. A member replied that they believe the provider's role is to make assessments and forward that information into plans. The member added that there is still much to be done in terms of how providers and community-based resources communicate because no standard infrastructure exists. A member acknowledged that understanding and identifying barriers can aid in addressing and removing them. Ms. Lloyd noted the distinction between individual-needs measures and broader-access measures. Another member commented that screening for health-related social needs is not intended to create a burden for solving problems but, rather, informs the community on what is needed to improve equitable and accessible care.

Next Steps

Ms. Buchanan notified participants that emails were sent out in the middle of the meeting containing a link for voting, an attachment of the questions, and an instruction guide for the Voteer platform. Ms. Buchanan noted that voting is open for 4 weeks, starting November 6 and closing December 4 at 5 p.m. ET. Ms. Buchanan then shared her screen to review the Voteer platform. Ms. Buchanan reiterated that only one person per organization can vote. Ms. Buchanan encouraged participants to cast their votes sooner rather than later.

Ms. Buchanan restated that Battelle would begin this year's core set update process and to expect future emails from Battelle regarding CQMC communication. She provided the CQMC email and website. Ms. Lloyd noted that the 2024 calendar was still being finalized, thanked everyone, and adjourned the meeting.