

Meeting Summary

Accountable Care Organization (ACO)/Patient-Centered Medical Home/Primary Care Workgroup Web Meeting 1

The National Quality Forum (NQF) convened a web meeting for the ACO/PCMH/Primary Care Workgroup on June 29, 2021.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants to the meeting, as well as introducing the co-chairs of the ACO/PCMH/Primary Care Workgroup (continuing provider co-chair Dr. Amy Mullins and new payer co-chair Dr. Lisa LaCarrubba). The co-chairs provided welcoming remarks. 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:

- Review the CQMC's work from last year, including the 2020 ACO/PCMH/Primary Care Core Set
- Review and discuss how updates to the Medicare Shared Savings Program relate to the CQMC core sets
- Discuss potential additions and removals to the ACO/PCMH/Primary Care Core Set as part of ad hoc maintenance

Last Year's Work

NQF staff provided a brief overview of the CQMC's achievements in 2019-2020. During the past year, the CQMC workgroups reviewed and released updated versions of the eight original condition-specific core sets, including the ACO/PCMH/Primary Care, Cardiology, Gastroenterology, HIV/Hepatitis C, Medical Oncology, OB/GYN, Orthopedics, and Pediatrics core sets. The CQMC also created two new condition-specific core sets for Behavioral Health and Neurology. Finally, the CQMC released several guiding documents including an updated description of approaches for future core set prioritization, a compilation of measurement gap areas identified by the workgroups and opportunities for alignment, and an implementation guide intended for stakeholders looking to implement core sets as part of value-based payment programs. NQF staff shared that in 2021, the CQMC will build on prior work by developing new guides on measure model alignment and digital measurement, developing a new cross-cutting measure set, updating the Implementation Guide, and maintaining the current core sets.



NQF shared an overview of the ACO/PCMH/Primary Care Workgroup's updates to the core set last cycle. During the last cycle of updates, the ACO/PCMH/Primary Care workgroup met eight times to discuss and update the measures before the final updated core set was published in November 2020. The final core set included 23 measures in the areas of Cardiovascular Care, Diabetes, Care Coordination/Patient Safety, Prevention & Wellness, Utilization & Cost/Overuse, Patient Experience, Behavioral Health, Pulmonary, and Readmissions. The Workgroup also identified gap areas for future consideration, which addressed a variety of issues including measure type (patient-reported measures) and clinical conditions (behavioral health measures). A full list of the gap areas is available as part of the [core set published online](#).

Medicare Shared Savings Program (MSSP) Update

NQF staff shared that due to updates to the Medicare Shared Savings Program (MSSP), several Workgroup members requested to discuss the relationship between these changes and the CQMC ACO/PCMH/Primary Care core set. NQF staff provided a brief overview of the changes to the MSSP, namely that MSSP will be reducing the measure set from 23 measures to 6 measures by performance year 2022. The CQMC ACO/PCMH/Primary Care core set shares nine measures with the 2021 MSSP measure set but would share only four measures with the 2022 MSSP measure set (#0005 CAHPS for MIPS; #0059 Diabetes: Hemoglobin A1c Poor Control; #0418/0418e Preventive Care and Screening: Screening for Depression and Follow-up Plan; and #0018 Controlling High Blood Pressure). A CMS representative provided additional detail that these measures were selected based on feedback from stakeholders including ACOs and were determined to be high-impact measures that address conditions with high cost and high prevalence in the Medicare population. The CMS representative also shared that these measures have been vetted by CMS medical officers and aim to reduce burden by better aligning with Merit-based Incentive Physician System (MIPS), electronic reporting, and registry reporting options. CMS will also phase the transition to these standards to reduce burden and will continue to monitor impact, hold listening sessions, and collect feedback from ACOs on the shift to these measures.

The co-chairs opened discussion by emphasizing that the overarching question is whether CQMC should align with MSSP and/or other programs (including private payer programs).

A Workgroup member shared that they applaud CMS' intent to reduce burden on ACOs and physicians by reducing the number of measures for reporting, but they expressed concerns that the reduction in measures does not actually reduce provider burden. The member shared that while there is a desire to drive towards eQMs, many electronic health record systems are not ready to report on these measures at scale yet, and that eQm measures may be less accurate compared to measures compiled from claims or abstracted manually. The member also shared concerns with equity, where ACOs that serve high-risk populations could be penalized for worse performance. Finally, the member shared that the remaining measures do not capture the full breadth of populations served in ACOs. Another member expressed agreement with these concerns with



implementation, potential for inequity, and the disregard of key topics such as patient safety in the reduced measure set.

A Workgroup member shared that from their experience, different programs have different intents and the CQMC core sets do not always meet the specific use cases of these programs. As a result, the core sets are not reducing physician burden – and different reporting requirements and different types of reporting continue to increase with the number of programs. The Workgroup member suggested that it may help if the CQMC core set aligns with some of the requirements for reporting that are mandated by Congress. Another Workgroup member shared that the core set should align with MSSP and other programs but are unsure of the best strategy to create this alignment. A private payer shared that the private sector is not in the same place as CMS and may not be ready to accept eCQMs on a wide scale – while the eventual goal is to transition to digital measures, private payers are reluctant to switch to eCQM-only measures all at once. Another Workgroup member shared that in their experience, EHR vendors are a limiting step rather than payers. Rather than automated electronic reporting from an EHR, payers receive electronic supplemental files regularly. At least two payers agreed with this comment, and one payer shared that smaller providers struggle to report electronic measures because of EHR restrictions and costs, and it is burdensome to ask that providers report on additional metrics that are not aligned with their payment model.

A Workgroup member asked whether the ACO/PCMH/Primary Care workgroup will eventually need to become two separate workgroups as value-based payments and ACO models evolve. A Workgroup member shared that the ACO/PCMH/Primary Care core set is a combined set that addresses multiple settings, and that many of the measures can be used across settings but this could be distinguished more clearly in the core set presentation notes. NQF staff also noted that the group has moved away from distinguishing between measures for each group (i.e., if a measure is applicable to only ACOs or both ACOs and PCMHs/Primary Care). Instead, the Workgroup favored including a note if a measure has potential denominator size concerns. AHIP responded that the ACO/PCMH/Primary Care workgroup should remain as one group during this ad-hoc maintenance year, but this could potentially be reconsidered in future years as value-based care continues to change. A Workgroup member shared that given the emphasis on moving toward Alternative Payment Models (APMs) and away from fee for services (FFS), the ACO and Primary Care/PCMH topics should remain in one combined workgroup. Another Workgroup member agreed with this comment.

A Workgroup member expressed concern with the mix of cost versus quality measures in the reduced six-measure MSSP set. The Workgroup member shared that ACOs have entirely different cost targets and incentives that are not directly connected to the measure sets they are contractually obligated to meet. Workgroup members flagged that two of the measures in the updated six-measure set are related to utilization (a proxy for cost), and CQMC would need to re-evaluate how to handle cost measures if the group wants to align with MSSP and other programs. AHIP shared that to date, CQMC has not included cost of care measures directly in the core sets as costs are built into individual organization's payment mechanisms. A Workgroup member commented that every condition has

potential cost implications, and there is also a quality component related to avoidable admissions and readmissions that provides insight into ability to manage chronic conditions. Another Workgroup member also commented that preventive care has long-term cost-saving implications that are not immediately realized.

NQF summarized discussion from the Workgroup as follows. CMS thanked the Workgroup for their robust discussion on the MSSP updates.

- There are challenges with requiring eCQM reporting (some ACOs are not ready; accuracy of eCQM data varies; equity concerns).
- The “menu” of measures included in the updated MSSP set is small and may not adequately represent the variety of conditions that ACOs cover.
- The current CQMC core set does not fit every program’s specific needs; as the CQMC ACO/PCMH/Primary Care core set evolves, the group should consider whether measures in the set should align with reporting requirements for programs and may reconsider the role of cost and utilization measures.
- The CQMC should revisit whether the ACO/PCMH/Primary Care workgroup should be split into multiple groups in the future.

Considerations for Ad-Hoc Maintenance

NQF staff opened the discussion on ad-hoc maintenance of the core sets by reminding Workgroup members of the measure selection principles for the CQMC core sets. Maintaining the core sets annually helps ensure that the core set measures remain person-centered and holistic; relevant, meaningful, and actionable; parsimonious; scientifically sound; feasible; and unlikely to promote unintended adverse consequences. During ad-hoc maintenance, NQF will not perform a comprehensive literature review for relevant measures to consider for the core set, but will flag major updates (e.g., measures that have lost endorsement) and review any measures that Workgroup members note should be urgently considered for addition or removal.

NQF shared the process for discussion, where NQF staff will introduce the measure and then the co-chairs will facilitate discussion by the Workgroup. NQF reminded the Workgroup that detailed information on the measures is available in the measure scan (Excel document attached to meeting invitation), and that formal voting will not be conducted during the meeting. The goal of today’s discussion is to determine whether measures should proceed to a vote for removal or addition, but the actual vote will be conducted electronically after the meetings. During the voting, proposed changes to the core set need to achieve a supermajority vote (at least 60% affirmative votes and at least one affirmative vote from each voting participant category) in order to pass.

Potential Measures for Removal

0418/0418e: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan

NQF staff shared background information on the first measure under consideration for removal, #0418/0418e Preventive Care and Screening: Screening for Depression and Follow-Up Plan. NQF staff

noted that this measure is one of three measures that address behavioral health in the ACO/PCMH/Primary Care core set and is included in multiple other core sets; the Pediatrics, Behavioral Health, and OB/GYN Workgroups discussed this measure during this year's ad-hoc maintenance and elected to keep these measures in their respective core sets. #0418/0418e is no longer endorsed, as the developer is no longer pursuing NQF endorsement maintenance due to limited resources; however, the developer plans to maintain the measure and it will continue to be used in CMS programs for the foreseeable future. NQF staff acknowledged that MIPS data is not representative of national performance but flagged that #0418/0418e has high performance in MIPS based on Medicare Part B claims data (not eCQM or MIPS CQM data).

A Workgroup member noted that behavioral health is a high priority area identified by the ACO/PCMH/Primary Care workgroup, and it makes sense to keep this measure in the core set to align with the Pediatrics, Behavioral Health, and OB/GYN Workgroups. At least four Workgroup members concurred that this topic remains valuable, especially with focused initiatives integrating behavioral health care into primary care.

A Workgroup member noted that the Workgroup should be consistent in their approach to evaluating measures based on their NQF endorsement status. The Workgroup member noted that NQF endorsement indicates that the measure has been strongly vetted for validity and feasibility by an external committee. While continued maintenance by the steward is helpful, it is not equivalent to continued endorsement. Workgroup members discussed that generally, NQF endorsed measures are favored because they have gone through the vetting process, but some stewards may not seek endorsement due to resource constraints. Widely used measures without endorsement may still be considered, but a higher burden of proof may be demanded for new, unendorsed measures (vs. previously endorsed measures that are not resubmitted for maintenance).

NQF staff confirmed that since the group reached consensus that #0418/0418e remains an important measure, this measure will remain in the core set and will not be included in the voting survey.

0421/0421e: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
NQF staff shared that the next measure under consideration for removal is #0421/0421e Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan. #0421/0421e is not in any other CQMC core sets but is currently active in the MIPS and Medicaid Promoting Interoperability Program for Eligible Professionals programs. Similar to #0418, this measure is no longer being submitted for NQF endorsement maintenance due to limited resources; however, the steward plans to continue maintaining this measure for the foreseeable future. The measure also has high performance in MIPS based on Medicare Part B claims data (not eCQM or MIPS CQM data).

A Workgroup member provided additional context on the measure, sharing that as of 2021, NCQA no longer uses this measure for adult populations. The member also shared that they have a different experience with measure performance – from their experience, providers that sent data on #0421/0421e via electronic formats performed well, while providers that sent data through claims had lower performance. The member shared feedback from providers that this measure is probably more indicative of a data gap than an activity gap, but it is helpful for getting providers used to

recording and reporting data. Another Workgroup member agreed that this area is more a data gathering gap than an activity gap, sharing that this data does not end up in claims often unless it can be hardwired into the electronic health record. Another Workgroup member also shared that most providers report BMI, but follow-up activities or interventions could be improved.

A Workgroup member noted that while the group is open to keeping this measure in the core set, other members do not seem strongly interested in the measure. The member shared that since the workgroup tends to have trouble removing measures, it may be helpful to return to this measure at the end of discussion and discuss whether it would be appropriate to remove #0421/0421e from the set to keep the overall set at a reasonable size, as long as clinicians do not oppose.

NQF staff confirmed that #0421/0421e will not be included on the voting list for removal at this time, but the group can revisit #0421/0421e after discussing all other measures and reconsider whether it should be a candidate for removal.

N/A: Non-Recommended Cervical Cancer Screening in Adolescent Females (MIPS ID 443)

NQF staff shared that this measure is currently in the OB/GYN core set and was discussed during their ad hoc maintenance review this year. NQF summarized that a payer in the OB/GYN workgroup shared that based on 2019 data, claims for inappropriate screenings were still high. The OB/GYN workgroup also discussed that this measure is consistent with recommendations from the American College of Obstetricians and Gynecologists (ACOG) and were in consensus to keep this measure in their core set. NQF staff also shared that this measure is still active in HEDIS and MIPS.

A Workgroup member noted that this is one of the few measures in the ACO/PCMH/Primary Care core set that discourages inappropriate care, and it seems important to keep this measure in the core set. At least two additional Workgroup members agreed with this, and a member noted that this measure aligns with the [Choosing Wisely](#) initiative, which aims to discourage over-screening.

A Workgroup member asked for additional information on the cost and quality implications for a non-recommended cervical cancer screening in this population. Another member shared that the concern is not cost so much as outcome, as false positives are elevated in younger patients. Intervention on these false positives can result in harm to patients. Another member noted that a performance gap persists in commercial populations. Multiple Workgroup members agreed that this measure should remain in the core set given the potential for harm.

NQF staff confirmed that this measure will remain in the core set and will not be included in the voting survey for ad hoc maintenance.

0028/0028e: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

NQF staff shared that the next measure to potentially consider for removal is #0028/0028e Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. This measure is also in the Cardiology and Behavioral Health core sets; the Behavioral Health workgroup was in consensus that this measure should remain in their core set, but the Cardiology workgroup is voting

on whether the measure should be removed due to high performance (as flagged by MIPS CQM performance). NQF staff shared that #0028/0028e is currently used in MIPS, Medicaid Promoting Interoperability Program for Eligible Professionals, and Million Hearts. A Workgroup member shared that it would be useful to overlap with the Cardiology group in this area, as cardiology is highly relevant to primary care.

A payer member noted that they have received feedback from clinicians that this measure is important to continue tracking, even though it is not part of NCQA-required reporting requirements. Workgroup members also discussed that this measure's specifications have not yet been updated to include screening for vaping or e-cigarettes, but it still serves as a prompt for clinicians to ask about e-cigarette use during the visit.

A Workgroup member flagged that this measure, along with #0418 (depression screening and follow-up) and #0421 (BMI screening and follow-up), are at risk for serving as "checkbox" measures instead of encouraging more meaningful action. The Workgroup discussed that #0418, #0421, and #0028 are not only screening measures but also require establishing a follow-up plan; clinicians could potentially "check off" screening but would fail audit if no follow-up plan is recorded. A Workgroup member expressed that there may always be potential for entities to try to game the system, but there is still value in the process of screening and promoting interventions when receiving positive screening results. Workgroup members also discussed that a viable outcome measure does not exist in this area, so the alternative to using this measure is ignoring tobacco use screening and cessation entirely. AHIP shared that this may be a useful topic to address through the Speaker Series, which connects CQMC members with measure developers to address gaps in the core sets and asked that the Workgroup share any suggestions for developer contacts working on meaningful measures in this area.

NQF staff confirmed with the group that this measure will remain in the core set and will not be included in the voting survey for ad hoc maintenance.

0057: Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Testing

NQF staff shared that the next measure to potentially consider for removal is #0057 Comprehensive Diabetes Care: Hemoglobin A1c Testing. NQF shared that this measure is one of several Comprehensive Diabetes Care measures included in the ACO/PCMH/Primary Care core set (#0059 HbA1c Poor Control; #0055 Eye Exam; #0062 Medical Attention for Nephropathy). This measure (#0057) is no longer used in any CMS programs, is not included in any other CQMC core sets, and is proposed to be retired from HEDIS in 2022.

A Workgroup member provided additional context on the removal of this measure from HEDIS; the measure is proposed for removal not only because of high performance, but also because of redundancy with other measures (i.e., overlap with the HbA1c Poor Control measure). The final removal of this measure is expected to be announced on August 1. Another Workgroup member shared that it seems appropriate to remove this measure from the ACO/PCMH/Primary Care core set, especially since a diabetes outcome measure already exists in the set. At least seven Workgroup members agreed that the measure should be removed, citing high performance, outcome measure

alternative, and the opportunity to align with HEDIS.

A Workgroup member shared an [additional update](#) from NCQA on the Comprehensive Diabetes Care measures, that measure #0062 Medical Attention for Nephropathy is also anticipated to retire from all programs in 2022 and will be replaced by another measure, Kidney Health Evaluation for Patients with Diabetes. Workgroup members expressed interest in discussing removal of #0062 and addition of the Kidney Health Evaluation measure during the next meeting.

NQF staff confirmed that they will include #0057 on the voting survey to formally confirm that this measure should be removed from the core set. NQF also shared that they will plan to discuss potential removal of #0062 Comprehensive Diabetes Care: Medical Attention for Nephropathy and potential addition of Kidney Health Evaluation for Patients with Diabetes during the next ACO/PCMH/Primary Care workgroup meeting.

Potential Measures for Addition

NQF staff noted that as part of the ad hoc maintenance process, they reviewed newly endorsed measures and measures supported for rulemaking during the Measure Applications Partnership (MAP) process. NQF identified two newly endorsed measures for the Workgroup to consider during this cycle, including #3451: Annual Monitoring for Persons on Long-Term Opioid Therapy and #3568: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM).

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy

NQF provided an overview of #3541 Annual Monitoring for Persons on Long-Term Opioid Therapy, which was recently endorsed as part of the Behavioral Health and Substance Use Fall 2019 endorsement cycle. NQF shared that this measure is the percentage of individuals 18 years and older on long-term opioid therapy who have not received drug testing at least once during the testing year. The measure is currently used in the Marketplace QRS program. NQF also shared that the measure steward is available to answer questions that the Workgroup may have about the measure.

NQF staff shared that this measure is also being considered by the CQMC Behavioral Health Workgroup for potential addition to their core set, and some workgroup members had expressed that this measure may be more relevant to primary care providers than behavioral health specialists. During the Behavioral Health Workgroup's discussion, some members expressed preference for this measure over other measures that focus on dose and duration of opioid use. The group also discussed that the topic is important, the measure is evidence-based, and there is an opportunity for improvement in this area. However, Behavioral Health workgroup members also expressed concerns that the measure could exacerbate disparities by reducing access to pain management based on differences by race/ethnicity and fear of stigma. The measure is endorsed and tested at the health plan level, although some Behavioral Health workgroup members expressed that clinicians could influence this measure.

The measure steward shared additional information with the Workgroup, emphasizing that annual

screening in this measure is supported by at least five clinical guidelines. The steward shared that the screening can help ensure that opioids are being used as prescribed and can flag indicators of opioid use disorder and need for interventions as part of a larger risk management and mitigation strategy. In testing, approximately 70% of patients were not receiving this screening, so a significant gap in monitoring remains. A Workgroup member also noted that the measure has exclusions for cancer and hospice care patients.

A Workgroup member asked for clarification on the definition of “long-term” opioid therapy. The steward clarified that this is defined as 90 or more days’ supply through prescription claims.

A Workgroup member asked whether the Workgroup should wait to discuss and vote on this measure, since the Behavioral Health workgroup is currently voting on the measure. A co-chair clarified that even if the Behavioral Health workgroup elects to include this measure in their core set (or elects not to), the measure can also be included in the ACO/PCMH/Primary Care core set if the Workgroup agrees that it is appropriate for the set.

Workgroup members began discussion of the evidence behind the measure. A Workgroup member shared that the United States Preventive Services Task Force (USPSTF) does not require a drug test as a means of screening, and instead recommends screening by asking questions about unhealthy drug use in adults, instead of testing biological specimens. Another Workgroup member shared that the CDC recommends urine drug screening. A Workgroup member also asked whether the measure designates a clear follow-up protocol for problematic drug tests, and whether there are alternative measures that address multiple providers and multiple pharmacies.

NQF staff shared that the Workgroup will continue discussing this measure during the next Workgroup meeting.

Next Steps

NQF staff shared that the workgroup will continue discussion on potential measures for removal and addition during the next workgroup meeting, scheduled for July 26. NQF reminded the group that the voting survey will not be circulated until after the second meeting. In the meantime, NQF will summarize the discussion from Meeting 1 and will post the summary on the CQMC SharePoint page. NQF and the co-chairs thanked workgroup members for their discussion.