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 ACO/PCMH/Primary Care Workgroup on July 26, 2021.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff and co-chairs Dr. Amy Mullins and Dr. Lisa LaCarrubba welcomed participants to the meeting. NQF staff reviewed the antitrust statement and acknowledged 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 by organization 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 of ACO/PCMH/PC Workgroup Web Meeting 1
- Continue discussion of potential additions and removals to the ACO/PCMH/Primary Care Core Set as part of ad hoc maintenance
- Continue discussion on Medicare Shared Savings Program (MSSP) updates and alignment with ACO/PCMH/Primary Care Core Set

Review of Web Meeting 1

NQF staff provided a brief recap of Web Meeting, which included an overview of last year's CQMC work with particular focus on the ACO/PCMH/Primary Care Workgroup. It was noted that during Web Meeting 1, the Workgroup reviewed MSSP updates and discussed how they can interact with the core set. NQF staff highlighted that as part of the ad-hoc maintenance discussion, a total of five measures were brought forth for potential removal, and that the Workgroup agreed to keep four of the measures in the core set and to vote on the removal of one measure (i.e., measure *NQF #0057, HbA1c testing)*. The Workgroup was advised that it would continue the maintenance discussion by reviewing and discussing two measures that were brought forth for potential addition to the core set. Also up for discussion was the potential measure removal of *#0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy* and replacement by *N/A: Kidney Health Evaluation for Patients with Diabetes*, which was flagged by a Workgroup member.

Continuation of 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. It was noted that 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. The Workgroup was asked to consider the principles when reviewing and discussing the measures.

Potential Measures for Removal and Replacement

0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy

N/A: Kidney Health Evaluation for Patients with Diabetes

NQF staff noted that the measures were flagged by Workgroup members as part of the discussion on Comprehensive Diabetes Care measures and alignment with Healthcare Effectiveness Data and Information Set (HEDIS) during Web Meeting 1. It was noted that *#0062: Comprehensive Diabetes Care* is being retired from HEDIS and is being replaced by *N/A: Kidney Health Evaluation for Patients with Diabetes*. NQF staff shared with the Workgroup that the justification for retiring *#0062* is that its focus on Nephropathy resulted in the measure lacking precision in meeting the needs of kidney health evaluation and that it no longer aligned with clinical practice guideline recommendations. It was also shared that the measure provides an unclear signal of quality related to care for kidney health.

A co-chair shared that NCQA had replaced *#0062* with *N/A: Kidney Health Evaluation for Patients with Diabetes* in HEDIS Stars for Medicare 2021 and that the information had been available in 2020. It was further noted that measure *#0062* was no longer available for use in commercial membership and that measure *N/A: Kidney Health Evaluation for Patients with Diabetes* has been adopted in its place. Measure *#0062* was highlighted as still being used in the federal programs but will be gradually phased out (i.e., 2022 will be the last year for reporting). The Workgroup was advised that measure *N/A: Kidney Health Evaluation for Patients with Diabetes* will be submitted for consideration to replace *#0062* in federal programs.

A Workgroup member representing the measure steward shared that the measure would likely undergo NQF endorsement review after it undergoes a first-year performance analysis. The member also shared that the measure is specified at the health plan level of analysis but that the National Kidney Foundation (NKF) was working on a similar measure that would focus on the clinician level of analysis. The NKF measure was noted as undergoing additional work but that it was given preliminary approval for inclusion in the MUC list.

A co-chair recommended that the measures be considered separately when voting to remove from and/or add to the core set. The co-chair shared that they support voting on the removal of measure #*0062* and suggested that the Workgroup may want to wait until next year after considering the performance data and the results of the NQF endorsement to vote on whether to include *N/A: Kidney Health Evaluation for Patients with Diabetes* in the core set.

A member shared with the Workgroup that their experience has been that once a measure is dropped from reporting it becomes difficult to track via electronic health records (EHRs). Another

member shared that their organization's data at the provider and plan level indicated that measure #*0062: Comprehensive Diabetes Care* had topped out. The member indicated that their organization would no longer report measure #*0062* and would begin reporting *N/A: Kidney Health Evaluation for Patients with Diabetes* in 2022.

The Workgroup agreed to uncouple both measures and vote on the removal of #*0062: Comprehensive Diabetes Care* and the addition of *N/A: Kidney Health Evaluation for Patients with Diabetes* to the core set. NQF will provide the Workgroup with an update relating to NKF's progress on the clinician-level version of measure *N/A: Kidney Health Evaluation for Patients with Diabetes.*

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

NQF staff shared that the measure aligned with the existing core set gap of behavioral health and substance use. NQF summarized several points from the previous meeting when discussion on this measure began. It was noted that the measure was also reviewed by the Behavioral Health Workgroup and included in their voting list for potential measures to be added to the Behavioral Health Core Set. A co-chair highlighted to the Workgroup that measure excludes cancer patients and patients in hospice and that the 90-day or more supply (which defines "long-term" opioid therapy") was for an entire calendar year and did not have to be continuous.

A member who is also the measure steward added that the United States Preventive Services Task Force (USPSTF) recommendation on screening targets a broad population, and the intent of the measure is to increase screening for unhealthy drug use in individuals on long-term opioid therapy. It was noted that the measure does not include what should happen after the screening takes place but that providers can use a wide range of available resources and guidelines (e.g., Centers for Disease Prevention and Control [CDC] guidelines) to determine the best next course of action.

A member provided an example of where a patient is prescribed opioids by a variety of providers (e.g., their family physician, dentist, and ER physician), asking the measure steward to which provider the measure would be attributed. In response, the measure steward indicated that the measure would be attributed to the patient's family physician. Workgroup members noted concern about that the measure being specified at the health plan level based on the CQMC core set focus and suggested that attributing the measure to the family physician may be problematic as they are not always aware of what other providers prescribe.

A member indicated that the measure could be applicable in an ACO setting but would be less appropriate for accountability for primary care. The member shared that the measure serves as an example of a larger conversation that was previously held about whether it may be necessary to split the ACO/PCMH/Primary Care core set to have primary care as a stand-alone core set.

A member shared concerns that patients requiring long-term pain management experience challenges in accessing pain medication, especially opioids. The member indicated that the measure could result in unintended consequences (e.g., stigmatization faced by patients with chronic pain and physicians who treat them). The member also highlighted the measure does not guarantee that testing will lead to appropriate treatment. The member indicated that they did not support including

the measure in the core set. In response, the measure steward indicated that the measure is a patient safety measure and was not meant to be punitive. The steward indicated that the measure being a process measure, is meant to assess and help identify cases that may require an intervention that may otherwise go undetected.

A member inquired about the Behavioral Health voting results on the measure to help aid in the discussion. NQF staff shared that the voting results are yet to be tallied but reminded the group that workgroups can make their own decision on measure inclusion or removal depending on their specific discussion and scope. NQF staff indicated that they would share with the Workgroup the Behavioral Health voting results once finalized.

The Workgroup agreed not to include the measure on the voting list of measures for potential inclusion but to review the measure during the full maintenance review in 2022.

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

NQF staff shared with the Workgroup that they had discussed this measure in July 2019 before it had received endorsement and summarized the measure specifications. A co-chair shared that the measure had been recommended in the 2022 Medicare Physician Fee Schedule Proposed Rule for inclusion in several programs (i.e., Merit-based Incentive Payment System (MIPS) and MIPS Value Pathways (MVPs)). A co-chair voiced their personal support to include the measure into the core set.

NQF staff informed the Workgroup that the measure developer was present to help support the discussion by responding to technical questions and providing additional details when prompted.

A co-chair expressed general support for this measure being included within the core set. The other co-chair inquired about the current implementation of the measure. The measure developer shared that the measure had been implemented in several places, including through an internal medicine group in Toronto for two and a half years, the Board of Family Medicine through the PRIME Qualified Clinical Data Registry (QCDR), using a vendor (FIGmd) for patients to access, as well as the University of Missouri in its family medicine, pediatrics, and internal medicine departments through Press Ganey surveys. Anthem was noted to have a pilot project in both Colorado and Indiana called Cooperative Care, which has been operational for one year and is administering the survey via mail from Anthem with results provided back to the providers. The measure developer indicated that plans were underway to implement the measure at Virginia Commonwealth University (VCU) Health System and are testing the platform to ensure HIPAA compliance. Once finalized, the platform will be made available to any provider group that has 100 clinicians or fewer, free of charge. The survey was noted as being administered by paper, module, and third-party electronic but not via telephone.

A co-chair asked when the free platform would be made available. In response the measure developer indicated that they do not have an exact timeframe available but estimated that it could be available within the next six months.

A member shared that during their review of the measure, it was found to lack evidence that the measure could lead to improved outcomes, but that the testing results from the pilot may provide evidence in the future. The member added that the measure includes everyone who completes the survey without any exclusions or risk adjustment, which could result in a nonrepresentative sample. The member noted that the measure developer does provide some information on the reliability and validity of the instrument but indicated concern over some of the survey questions (e.g., '*The care I get takes into account knowledge of my family*) may not apply during some physician visits (e.g., visit for sore throat)). The member indicated that the answers to most of the questions would be dependent on a patient's health status and questioned how the measure would work in clinical practice where there may be multiple co-morbidities at play. The member indicated that their organization's consensus was that the measure did not apply to general internal medicine. The member inquired if any of the health plan members had implemented or planned on implementing the measure within their systems or structures.

The measure developer had the following responses to the above comment:

1. Through the NQF endorsement process, the measure developer provided evidence that supports that use of the measure aids in quality improvement. It was noted that a review of substantial literature indicates that the measure covers areas that if affected result in positive changes in health outcomes.
2. The measure covers the entire patient population, as during the validation work the measure was tested to see if there was a difference based on gender, age, income, and minority status. The results indicated that there was no association (i.e., the results indicated that the measure can be used across an entire patient population). It was noted that for the next update of the measure, the developers are exploring including case mix adjustment.
3. To address the concern that scoring dependent on health status (i.e., healthy people scoring higher and unhealthy individuals scoring lower), it was noted that the case mix adjustment is expected to correct this and the results from the testing are expected to undergo peer-review. Preliminary results indicate that there may be an association, but it is unclear if it should be updated at this time.
4. It was shared that the measure is applicable to individuals with different medical conditions and is not dependent on a particular health condition. The measure was noted as feasible in a general internal medicine population.
5. On the issue of face validity, the measure was noted as being in use by Anthem and being potentially piloted by Blue Cross Blue Shield-Massachusetts and in Governor's Taskforce in Virginia. When asked to 4,000 patients, the response from 93% was that this measure was important, less than .01% indicated that the survey was difficult to answer, and greater than 60% responded they felt if their clinicians knew their responses to their survey it would have a beneficial impact on their care. It was shared that 85% of clinicians found that measure important and meaningful.

A Workgroup member representing patients with disabilities shared that the measure developer's responses to the concerns voiced regarding the measure were reassuring. The member indicated that while proxy measures are not perfect, they are helpful and very important. The member indicated that they do not agree with the idea that person-reported experiences are not directly related to a precise clinical outcome. Also highlighted by the member was that almost every measure is not adequately risk adjusted, as the state of practice does not allow every measure to reflect the variety of people served. The member expressed concern over the perception that disregarding person-reported measures sends.

A member stated that having participated on NQF and CMS committees, while committees are made up of different levels of expertise, approval does not guarantee a measure is valid. It was noted that the NQF process has different levels of evidence, and measures that are collected by an instrument require a systematic assessment (i.e., grading of the quantity, quality, and consistency of the evidence) to link the measure to a desired outcome. The member questioned if there was an exception made to the evidence requirement for the measure, stating that if it was, that is cause for concern. NQF shared that during the endorsement process the measure passed on evidence, without an exception, noting that evidence for outcome measures must prove there are actions providers can take to impact measure performance.

In response to the question about evidence and validity, the measure developer indicated that the measure had undergone rigorous questioning regarding the methodology across many committees and that the outcomes indicated that the measure was valid. The developer shared that a sample size of over 2,000 surveys was used for validation when the minimum requirement was 150; the measure was also tested in the pediatric setting and in those in Medicaid. The measure developers indicated that they are yet to find any large gaps with the measure and that the data strongly indicates a strong confidence interval.

A co-chair noted that since workgroup members expressed different views on whether the measure should be added, the measure will be included in the voting survey for potential addition. A member asked for clarity on the CQMC's process for determining which measures move to voting. If the Workgroup is in consensus a measure should no longer be considered, it does not move to voting. If there are differences of opinions or if any changes are to be made to the core set (e.g., a Workgroup is in agreement to add a new measure) the measure must undergo formal voting following the meeting.

A member highlighted that the measure was headed in the right direction but expressed concern regarding the measure's evidence and specificity. The member indicated that the measure may not be ready for prime time until some of those issues were clarified.

A member asked for clarity on the CQMC's process for developer involvement in the measure discussion. NQF shared that developer and stewards are invited to answer questions posed by the

Workgroup. The member shared that the CQMC may need to consider asking the measure developer to depart after presenting or that the CQMC should consider if guidance is needed regarding when the developer should respond to questions to allow open discussion among the voting members of the Workgroup. NQF thanked the member for their feedback, noted that the process is open to improvement, and stated that the CQMC would consider additional guidance on this topic.

NQF staff shared that they would circulate to the Workgroup documents from the measure endorsement review process and publicly available Measure Applications Partnership (MAP) resources to help aid in the voting process.

Additional Notes in the Core Set Presentation

NQF staff asked the Workgroup whether the information in the "Notes" column of the current core set presentation was still accurate and relevant, or if any of the notes should be updated or removed. There were no verbal responses to this prompt. NQF encouraged the Workgroup to share any feedback via email after the meeting.

Continuation of Medicare Shared Savings Program (MSSP) Discussion

NQF staff reminded the Workgroup of the previous discussion on proposed updates to the Medicare Shared Savings Program (MSSP). During Web Meeting 1, the Workgroup discussed that MSSP would be reducing from 23 measures to 6 measures for reporting, and Workgroup members expressed concerns over readiness for sole eCQM reporting and the limited variety of conditions covered by ACOs within the updated MSSP measures. The Workgroup also discussed that the relationship between the CQMC ACO/PCMH/Primary Care set and the reporting requirements for federal and other reporting programs in the future. The broader scope of the ACO/PCMH/Primary Care core set was discussed related to ACO-only programs.

NQF staff shared there have been updates to the proposed MSSP changes since Web Meeting 1. NQF staff summarized the changes as presented in the Physician Fee Schedule Proposed Rule, including a longer transition period for ACOs to use Web Interface through performance year 2023. In 2022, ACOs would report 10 CMS Web Interface measures or three eCQMs/MIPS CQMs, and in 2023, ACOs would report 10 CMS Web Interface measures and at least one eCQM/MIPS CQM or three eCQMs/MIPS CQMs. The quality performance standard would be frozen at the 30th percentile in 2023 and would increase to the 40th percentile in 2024.

A CMS representative highlighted that an ACO can choose to report all three electronic Core Quality Measures (eCQMs)/MIPS Clinical Quality Measures (CQMs)and use performance on these measures for purposes of MIPS reporting under the Alternative Payment Model (APM) Performance Pathway (APP). CMS is providing an incentive for reporting the CQM measures, as providers only need to meet benchmarks for at least one of the three CQM measures to qualify for shared savings. CMS shared that they welcome additional comments from stakeholders as part of the rulemaking process on the revised timing and on whether additional time is needed to prepare for eCQM/MIPS CQM reporting,

as well as input on the proposed method of allowing providers to submit eCQM/MIPS CQM data at the Tax Identification Numbers (TIN) level for CMS to aggregate into an ACO-level score.

The co-chairs opened discussion on program updates and alignment by noting that there are many reporting programs outside of MSSP that may be relevant to ACOs. A co-chair asked the Workgroup whether there are specific programs or considerations that the CQMC should consider in terms of alignment to inform the process for the full measure review next year. A Workgroup member agreed that it would be helpful if CQMC was able to provide context on the application of measures across multiple reporting programs beyond MSSP, including programs outside of CMS. Another Workgroup member thanked CMS for implementing changes to the program. They noted that for the purposes of alignment, it would be helpful to align quality measures across programs (i.e., CMS would work with CQMC to determine what measures are helpful to include in MSSP).

NQF staff asked the group if there are specific programs that it would be most useful for CQMC to reference in terms of ACO/PCMH/Primary Care scope and alignment, as well as if there are any suggested strategies for gathering additional information on use of measures in private programs. A payer shared that they are focused on HEDIS and Medicare Stars measures and would support alignment with these programs.

Next Steps

NQF will provide additional information that NKF is able to share on the clinician-level measure for *Kidney Health Evaluation for Patients with Diabetes* and additional materials from endorsement and MAP related to *3568: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)* before circulating the Workgroup-level voting survey. NQF thanked Workgroup members for their participation, as well as the co-chairs for their leadership. The co-chairs thanked Workgroup members for their engagement and NQF for their preparation and facilitation.