CQMC Core Quality Measures Collaborative

Meeting Summary

CQMC Cardiology Workgroup Web Meeting 1

The National Quality Forum (NQF) convened a web meeting for the Cardiology Workgroup on July 26, 2022.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants to the meeting and introduced the new co-chair of the Cardiology Workgroup, Dr. Stephen Sokolyk, who 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 reviewed the meeting objectives:

- Review the CQMC's work from last year, including the 2021 Cardiology Core Set
- Discuss potential measure changes to the Cardiology Core Set as part of the annual maintenance

CQMC Overview and Recap of Previous Work

NQF staff reviewed the background and aims of the CQMC, recent accomplishments, current work, and future opportunities. Last year, in addition to core set maintenance, the CQMC updated and released the following reports: Approaches to Future Core Set Prioritization, Measure Selection Criteria, and the Implementation Guide. NQF staff shared that the CQMC convened a new Health Equity Workgroup, which met for the first time in early April, to analyze disparities-sensitive measures and identify health equity measures for future consideration.

2021 Cardiology Core Set Work

NQF staff shared that the Cardiology Workgroup last met in April 2021 to review and update their core set. The Cardiology core set includes a total of 27 measures in the domains of Acute Myocardial Infarction, Atrial Fibrillation, Heart Failure, Hypertension, Implantable Cardiac Defibrillators, Ischemic Heart Disease/Coronary Artery Disease, Percutaneous Coronary Intervention (including angioplasty and stents), Pediatric Heart Surgery, and Prevention. The 2021 update to the core set presentation included updates on notes related to telehealth eligibility for all measures and notes related to NQF measure #1525 *Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy.* Measures that were added to the core set include *Functional Status Assessments for Congestive Heart Failure* and *Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)*. NQF measures that were removed from the core set include #0715 *Standardized adverse event ratio for children < 18 years of age undergoing cardiac catheterization* and #0671 *Cardiac stress imaging not meeting appropriate use criteria: Routine testing after PCI*.

Measures for Maintenance

NQF staff shared that the CQMC measure selection principles help ensure that measures in the core sets remain person-centered and holistic; relevant, meaningful, and actionable; parsimonious, promoting alignment and efficiency; scientifically sound; balanced between burden and innovation; and unlikely to

promote unintended adverse consequences. The measure selection principles were updated in 2022; changes include greater focus on outcome measures and digital measures and emphasis on priority topic areas such as care coordination and health equity. NQF staff noted that the CQMC will not consider cost measures in the future, as cost is captured as part of the payment models in which the core set measures may be used.

NQF staff noted that the original intent of the CQMC core sets was to focus on ambulatory care measures that have been tested and specified at the clinician level of analysis. The core set measures are intended to focus on measures that can be influenced by outpatient providers, and can be used for accountability by both public and private payers. While workgroups may choose to discuss and include measures outside the clinician/group level of analysis, there should be clear rationale for discussing these measures (e.g., important topics in a specialty where care typically occurs at the hospital level, or high-priority topics that are not addressed by existing clinician-level measures). NQF staff noted that the Cardiology core set has traditionally included inpatient and facility-level measures based on Workgroup discussion and agreement that some hospital-level measures are necessary to capture important elements of cardiology care. NQF staff also emphasized that measures at different levels of analysis will be clearly delineated in the final core set presentations, and that Workgroups can add core set notes to indicate considerations for measure use or note important topics or measures that are not yet ready for inclusion in the set.

NQF staff then reminded the Workgroup that annual maintenance helps the core sets remain aligned with the measure selection principles. As part of the process, NQF will bring forward major updates for the Workgroup's consideration (i.e., changes to endorsement and program use; recently endorsed or fully developed measures in the topic area; measures recommended for use in federal programs), as well as measures identified for discussion by Workgroup members prior to the meeting. No formal voting will be conducted during the Workgroup meetings. Also, proposed changes to the core set will proceed to voting after the conclusion of all measure discussions. As a reminder, organizations can use summaries and other meeting materials to help inform voting.

Potential Removals from the Core Set

NQF staff shared the process used to identify potential removals from the Cardiology core set. The process includes reviewing the current core set and assessing measures based on changes in endorsement status, changes in program use (e.g., removal from Merit-Based Incentive Payment System [MIPS], Healthcare Effectiveness Data and Information Set [HEDIS]), and suggestions from Workgroup members.

#1525 Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy

The first measure discussed for potential removal was *Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy.* NQF staff shared that this measure focuses on the percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor (as determined by CHADS2 risk stratification) who are prescribed warfarin or another oral anticoagulant drug that is U.S. Food and Drug Administration approved for the prevention of thromboembolism.

NQF staff shared that this measure is no longer endorsed by NQF, as the developer was unable to submit the measure for maintenance due to lack of testing data. The developer did note that this measure is still being maintained independently to ensure alignment with guidelines and American College of Cardiology (ACC) and American Heart Association (AHA) performance measures, including

maintenance of ICD-10 and CPT codes during the annual update of Quality Payment Program (QPP) measures. ACC/AHA are still determining whether they will re-submit the measure for endorsement in the future. A Workgroup member recognized that there are currently only two atrial fibrillation measures in the core set and one of them focuses on complications following atrial fibrillation ablation. The member noted that if the Workgroup were to remove this measure, there would be no atrial fibrillation measure for outpatient management, and he encouraged the ACC to resubmit this measure for endorsement. A Workgroup member also shared that this measure is important, actionable, and can be measured at a clinician level. This Workgroup member supported keeping this measure in the core set. NQF staff shared that since the Workgroup is in consensus to keep this measure in the core set, this measure will remain in the core set without further voting.

Potential Additions to the Core Set

NQF staff shared that measures proposed for potential addition to the Cardiology core set are reviewed based on the following criteria: new NQF endorsement; new HEDIS measures; measures recommended for use in programs by the Measure Applications Partnership (MAP); review of Cardiology gap areas within the CMS Measure Inventory Tool (CMIT) and NQF's Quality Positioning System; and suggestions for discussion from Workgroup members.

#3612: Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System

The first measure discussed for addition was *Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System.* NQF staff shared that this measure focuses on the risk-standardized rate of acute, unplanned cardiovascular-related hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with heart failure (HF) or cardiomyopathy. NQF staff noted that this measure is not currently publicly reported or used in an accountability application. The measure's purpose is to incentivize high quality care for complex patients with heart failure and cardiomyopathy and the intended audience are primary care and cardiology ambulatory care practices. In the future, CMS may propose this measure for use under the Merit-based Incentive Payment System (MIPS). NQF staff also shared that this measure was newly endorsed as part of the All-Cause Admissions and Readmissions Spring 2021 Cycle.

A Workgroup member noted that a disadvantage of this measure is how it does not offer data on a patient's ultimate outcome and survival. The member also added that patients may be in and out of the hospital for factors outside the clinician's control and noted that implementing the measure could unfairly penalize primary care providers as cardiology specialists are more responsible for handling care related to heart failure. A Workgroup member commented that the measure should include observation stays. Another member noted that reducing admissions may lead to admitting the sickest patients, who are more likely to be readmitted, therefore increasing the readmission rate. A different Workgroup member added that admission and readmission related measures are important, but from a health equity perspective, social determinants of health (SDOH) may drive performance on this measure without being adequately captured by the measure's risk adjustment model. This member noted that recent CMS proposed rules recognize the need to better capture these risk factors. Members discussed that safety net providers who serve large Medicaid populations could be unintentionally penalized due to inadequate risk adjustment, and that this could lead to unintended negative consequences (e.g., leaving patients in observation instead of admitting them). NQF staff noted that the measure includes risk adjustment based on the Agency for Healthcare Research and Quality (AHRQ) Socioeconomic Status index; a member acknowledged that this is helpful but does not entirely account for the effects of SDOH

on measure performance, and based on expert experience there is still a disproportionate penalty to providers and hospital networks who are taking care of the most vulnerable populations.

A Workgroup member shared that this measure is being proposed in the Advancing Care for Heart Disease MIPS Value Pathway. Their organization expressed similar concerns on the use of this measure in the proposed rule, based on inadequate risk adjustment, attribution concerns, and potential carveouts for certain procedures (e.g., revascularization, device implantation and ablation). The co-chair summarized that due to the Workgroup's concerns with appropriate risk adjustment, the Workgroup will not consider this measure for addition this year. However, the Workgroup may revisit this measure in future cycles if there are any updates to the risk adjustment for this measure. NQF staff confirmed that this measure will not be included in the voting survey.

#3613e: Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)

The next measure brought forth for addition was *Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED).* NQF staff shared that this measure focuses on the percentage of ED patients with a diagnosis of STEMI who received appropriate and timely treatment. The measure will be calculated using electronic health record (EHR) data and is intended for use at the facility level in a CMS accountability program, through which it may be publicly reported. This measure was conditionally supported during the Measure Applications Partnership (MAP) process in 2021. This measure was endorsed as part of the Cardiovascular Spring 2021 cycle and is pending use in Hospital Outpatient Quality Reporting Program.

A Workgroup member asked to clarify the definition of appropriate treatment for this measure; NQF staff shared that the measure's numerator indicates appropriate treatment as ED STEMI patients aged 18 years and older whose time from ED arrival to fibrinolysis is 30 minutes or fewer or non-transfer ED STEMI patients who received percutaneous coronary intervention (PCI) at a PCI-capable hospital within 90 minutes of arrival or ED STEMI patients who were transferred from a non-PCI capable hospital within 45 minutes of ED arrival at a non-PCI capable hospital. The member shared that timely treatment is important to limit heart damage. Another member asked whether facility level measures could be included in the core set. NQF staff clarified that facility level measures are currently included in the core set, and these measures are appropriate to include as long as there is a clear rationale as to why the group is interested in adding the measure. No additional concerns or oppositions were brought forward. NQF staff shared that this measure would move forward to the formal voting process for potential addition to the core set.

#3534: 30-Day All-Cause Risk Standardized Mortality Odds Ratio Following Transcatheter Aortic Valve Replacement (TAVR)and #3610: 30-Day Risk Standardized Morbidity and Mortality Composite Following Transcatheter Aortic Valve Replacement (TAVR)

The last two measures were brought forward for discussion together. NQF staff first discussed #3534 *30-Day All-Cause Risk Standardized Mortality Odds Ratio Following Transcatheter Aortic Valve Replacement (TAVR).* The Cardiology Workgroup previously discussed this measure in April 2021 and agreed that this measure addresses an important topic. However, voting on the measure was deferred based on an update from the measure developer that this measure is being retired and replaced by measure #3610 *30-Day Risk Standardized Morbidity and Mortality Composite Following Transcatheter Aortic Valve Replacement (TAVR).*

Next NQF staff discussed *30-Day Risk Standardized Morbidity and Mortality Composite Following Transcatheter Aortic Valve Replacement (TAVR).* This TAVR 30-day morbidity/mortality composite uses a hierarchical, multiple outcome risk model that estimates risk standardized results (reported as a "site difference") for the purpose of benchmarking site performance. This measure estimates hospital risk standardized site difference for five endpoints (death from all causes, stroke, major or life-threatening bleeding, acute kidney injury, moderate or severe paravalvular aortic regurgitation) within 30 days following TAVR. The measure uses clinical data available in the Society of Thoracic Surgeons (STS)/ACC Transcatheter Valve Therapy (TVT) Registry for risk adjustment for the purposes of benchmarking site to site performance on a rolling three-year timeframe.

A Workgroup member shared that the reason measure #3534 is being replaced is because mortality rates are very low. The member noted that adding in other endpoints is important and will be more meaningful in terms of quality of assessment of TAVR, and that TAVR quality measures are important as TAVR becomes more commonly used. Other Workgroup members also shared that they are in favor of adding the new TAVR measure to the core set, and that paravalvular aortic regurgitation is an important clinical indicator linked to valve durability. The measure developer noted that there has been a modification to the risk adjustment method for measure #3610; the developer shared that ACC uses win ratios and weighs each of the five possible outcomes for this measure (e.g., deaths are weighted more heavily than moderate regurgitation). NQF staff confirmed that they will include #3610 in the formal voting survey for potential addition to the core set.

Future Work

Cardiology Draft Framework

NQF staff shared that the team is soliciting feedback from each of the workgroups on future activities and considerations for the CQMC. The CQMC received feedback from members on the need to consider the specific mix of subtopics represented in each core set in addition to the selection principles. The CQMC is developing a framework of priority conditions and topic areas for each core set to help guide Workgroup discussion on condition/topic areas most important to measure for each specialty area as part of value-based care.

NQF staff shared that the current core set includes the following topics:

- Acute Myocardial Infarction
- Atrial Fibrillation
- Heart Failure
- Hypertension
- Implantable Cardiac Defibrillators
- Ischemic Heart Disease/Coronary Artery Disease
- Percutaneous Coronary Intervention (including Angioplasty and Stents)
- Pediatric Heart Surgery
- Prevention

A co-chair asked the group what topics are not being covered in the core set and what topics the group may consider removing. A member suggested reviewing measures #2558 *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery* and #0119 *Risk-Adjusted Operative Mortality for CABG* and considering removal of one of these measures, as both address mortality rates following CABG. Similarly, measures #2515 *Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery* and #2514 *Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate (30-days)* both

cover CABG readmission, and removal of one of these measures may be helpful in limiting the overall size of the core set. A Workgroup member noted that both #2558 and #0119 will be reviewed by NQF's Surgery Standing Committee as part of the endorsement maintenance cycle this fall. Another member commented that if the group removes one measure, it may be helpful to keep the measures stewarded by CMS (#2558 and #2515) as they are required for accountable care organization reporting. NQF staff shared that these measures were compared and discussed in a past Workgroup meeting and the decision was to keep them in the core set. NQF will provide more information on these measures to the Workgroup so they can revisit them in the future.

Gap Areas for Future Consideration and Measure Development

NQF staff shared an overview of the current gap areas in the Cardiology core set. This list was developed last year by the Workgroup to represent potential gaps in the current core set.

NQF staff shared that the current list of gap areas includes the following topics:

- Pediatric surgery measures
- Long-term cardiovascular care
- Patient transitions between facilities, specifically cardiac rehabilitation
- Patient-reported outcomes (PROs) and PRO-based performance measures (PRO-PMs)
- Functional status measures
- Measures of disparities and social determinants of health

A Workgroup member noted that there is currently a pediatric surgery measure and functional status measure listed in the core set. A Workgroup member also noted that the *Functional Status Assessments for Congestive Heart Failure* measure would also overlap with the PROs area because it is a patient reported measure. The co-chair suggested removing pediatric surgery measures and functional status measures from the gap areas list after reviewing the current core set for these related measures.

A Workgroup member asked if NQF staff track how the measures are being used and which ones are reported publicly. NQF staff shared that while this information is not included directly in the final core set presentations posted online, the CQMC does keep track of which measures are being used in different reporting programs (e.g., CMS reporting, HEDIS) and provides this information within the Analysis of Measurement Gap Areas and Measure Alignment report.

NQF staff shared that in a prior version of the Cardiology core set, the measures were broken down into separate "chronic conditions" and "acute conditions" sections; NQF asked whether differentiating between categories of measures would be helpful for end users of the set. Workgroup members suggested keeping the measures separated by specialty but adding a notes section to the core set to label measures as inpatient or outpatient setting measures. NQF staff also noted that the team is considering an updated core set presentation draft template for future use which would include a new column specifying level of analysis. NQF staff also asked the group for any comments or suggestions on preferred data sources used for measures. A Workgroup member added that this is an important topic and digital data sources will likely be a requirement for the future. However, it was noted that digital data sources are not ready for use for many measures in the current Cardiology core set.

Next, a co-chair asked how the group can address health equity within the Cardiology core set. NQF staff shared that the Health Equity Workgroup plans to host another meeting in August and is in the final stages of developing recommendations. While the recommendations are not final, the Health Equity Workgroup identified cardiovascular care as one of the priority areas associated with disparities and all

the cardiovascular measures within this core set have been identified as disparity sensitive due to the identification of cardiovascular disease as a clinical area with known disparities. NQF staff will share future updates with the Workgroup as this work is still ongoing. A Workgroup member commented that flawed or incomplete race and ethnicity data for individual patients could pose a challenge for interpreting measure performance and understanding disparities. NQF staff asked the group if they thought any measures in the Cardiology core set are particularly vulnerable to disparities. A Workgroup member suggested the readmissions and mortality measures are more vulnerable to disparities compared to other measures. Process measures are less impacted by these factors, although subpopulations still experience disparities in these areas (e.g., achieving hypertension control) and opportunities for improvement remain. NQF staff thanked the group for their input and suggestions.

Next Steps

NQF staff shared that they would summarize the Workgroup's discussion and post the summary on the CQMC SharePoint page. NQF will also circulate a survey for Voting Workgroup members to vote on potential changes to the core set. Voting will be open for a four-week period; after votes are tallied and reviewed by the Steering Committee, NQF will follow up with the Workgroup via email for any additional clarifications. The potential changes to the core set will then proceed to the full Collaborative for final discussion and voting. NQF staff thanked the co-chairs and Workgroup for their participation before adjourning the meeting.