



Meeting Summary

Implementation Workgroup Web Meeting 2, Option Year 2

The National Quality Forum (NQF) convened a web meeting for the CQMC Implementation Workgroup on May 12, 2021.

Welcome and Review of Web Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff reviewed the meeting objectives:

- Review Medicaid Core Sets
- Review of Potential Case Studies
- Recommend Updates to the Implementation Guide

Review of Medicaid Core Sets

NQF staff reminded the Workgroup that during Implementation Workgroup Meeting 1, two commercial core sets were shared. The presenters shared how the core sets were developed and implemented. At the end of Workgroup Meeting 1, a request was made for additional members to share their core sets with the Workgroup. The purpose of reviewing the core sets is for members to learn about implementation concerns, how those concerns are being addressed, and explore how to achieve greater alignment of measurement. In response to this request, Dr. Renee Fox from CMS shared the Medicaid 2021 Core Sets. Both the [Child Core Set](#) (Core Set of Children's Health Care Quality Measures for Medicaid and Children's Health Insurance Program (CHIP)) and the [Adult Core Set](#) were shared.

Dr. Renee Fox provided an overview of both core sets, indicating that the core sets were a result of Medicaid and CHIP working together to ensure measure harmonization. The Adult Core Set contains 32 measures within the domains of Primary Care Access and Preventative Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, Behavioral Health Care, Experience of Care and Long-Term Services & Supports. The Child Core Set contains 23 measures within the domains of Primary Care Access and Preventative Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, Behavioral Health Care, Dental and Oral Health Services, and Experience of Care. Dr. Fox indicated that the Child Core Set was established prior to the Adult Core Set and that it contains some maternal and perinatal measures in addition to pediatric-specific measures. The Child Core Set includes measures for dental and oral health services as these measures are mandated in the Medicaid program for children. While dental and oral health services are not included in the Adult Core Set because they are not mandated by statute, some states' Medicaid programs do cover select dental services for adults.



The purpose of these core sets is to estimate the quality of healthcare rendered to CHIP and Medicaid beneficiaries, and not currently intended to affect payment. The Medicaid and CHIP scorecard, implemented in 2017, contains a large subset of both core sets and aids in examining state level health system quality performance. Currently, reporting of both core sets is voluntary, but beginning in 2024, reporting on the Child Core Set and Behavioral Health in the Adult Core set will be mandatory.

Dr. Fox advised the Workgroup that the U.S. Congress mandates an annual review of the core sets to identify gaps, suggest updates, and make recommendations to improve on the core sets. The difference between the Medicaid Core Sets and the CQMC Core Sets is that the CQMC Core Sets are primarily developed by payers, insurance companies, and health systems, while the Medicaid Core Sets focus on measures that states report, resulting in the ability to examine these measures from a statewide perspective. Measures included in the Medicaid Core Sets must contribute to the estimates of quality, include detailed specifications appropriate for the state level, and be tested at the Medicaid and CHIP program levels. Currently, at least 25 states must report on a measure for it to be publicly reported. This allows useful and actionable results that can be used to drive quality improvement and can lead to recommendations for use through other programs.

Dr. Fox shared that the Medicaid Core Sets Workgroup's annual review recently ended. During the review, members vetted measures that were recommended for addition to and removal from the core sets, using a quality process that ensures measures meet all the required criteria. The next step will be developing a draft report that will undergo public comment before the final report is released. Upon completion of the final report, CMS will conduct outreach to states, an internal stakeholder outreach, and a federal review process to ensure alignment of the recommendations in the final report. U.S. Congress mandates that the Annual Core Set Update be published by December 31st each year.

A member inquired if measure *PC-01 Elective Delivery* will remain in the Medicaid Adult Core Set under the Maternity/Perinatal Health domain. In response, Dr. Fox indicated that the measure is not mandatory to report on, and that the version of the measure in the Adult Core Set has never been publicly reported. The measure has been recommended for removal because performance has topped out. The member agreed and shared that in their experience the measure had also topped out with only a few outliers. The member shared that from their experience, there is room for improvement on *PC-02 Cesarean Birth* (the number of nulliparous patients with live, term, singleton newborns in vertex position delivering via cesarean) having performance variation across the country. Additionally, it was reported that there is actionable evidence for improvement according to a recent study ([Hospital Quality Improvement Interventions, Statewide Policy Initiatives, and Rates of Cesarean Delivery for Nulliparous, Term, Singleton, Vertex Births in California](#)). Dr. Fox agreed with the recommendation that there is room for improvement for this measure but noted the challenge of being able to get at least 25 states reporting on the measure. The Workgroup was told that the preferred measure, which has been recommended for inclusion into the core set, is the *CDC elective cesarean section rate* from the state vital records. Dr. Fox highlighted that the challenge for the CDC measures is that the results are not actionable at the plan level, because the data is not at the hospital level, rather is from the state vital records and calculated by CMS.

A co-chair inquired if states have any responsibility to act on measures, (e.g., to take action to improve results if the state is identified as a negative outlier). Might a state be required to create an action plan to improve performance, or would no action be required. In response Dr. Fox indicated that originally the goal was to have as many states as possible reporting, however, the underlying goal is to drive quality improvement and improve outcomes for patients. Dr. Fox informed the Workgroup members of a new initiative underway that will be looking into the rate and quality of well-child visits in states, and the seating of a new maternal/infant workgroup (i.e., learning collaborative) that examines postpartum care (e.g., to track the visit rate and the care that is provided to provide insight into maternal morbidity and mortality post-hospital discharge). CMS encouraged workgroup members to urge their states join the new initiative.

A Workgroup member shared that from their experience, tracking long-term services and supports (LTSS) and outcomes for all populations is crucial for states and the member voiced their support for including more measures under the LTSS domain at the state level. The [NCI-AD survey](#) was recommended as it is already used by many states and provides data used for quality improvement. In response, Dr. Fox indicated the challenges that have been faced in collecting data through surveys due to COVID-19, and shared that the [LTSS Comprehensive Care Plans and Update](#) measure stewarded by NCQA was recommended for addition into both Medicaid Core Sets.

Members voiced support for including more LTSS and home community-based services (HCBS) recipients (e.g., those in the older age spectrum with multiple chronic conditions and higher social determinants of health). Also cited was the Health Affairs article titled, [The Hidden Curriculum of Hospice: Die Fast, Not Slow](#), which explores hospice and the move towards for-profit ownership and the effect on quality outcomes. A Workgroup member highlighted that this may be burdensome, especially to dual-eligible individuals, and needs to be addressed. In response, another member shared that state and Managed Medicaid programs are exploring sustainable solutions to measure the quality of care that is delivered to individuals with chronic and serious illness. The Workgroup was informed that the state of Hawaii Medicaid program (i.e., MedQuest) is working on applying for Section 1115 (1115) waivers to create a community-based palliative care benefit for Medicaid and dual-eligible populations. It was shared that there is interest in sustaining the work, but the challenge is in identifying good measures that can be used to track and standardize reporting (e.g., ensuring that things line up by encouraging value-based payment with an equity lens in mind and are held to a quality standard).

In response Dr. Fox indicated that 1115 waivers are not her expertise, but indicated that as waivers are being approved, there is collaboration across CMS departments to ensure that some of the core set measures are included in the specific terms and conditions that a state has when they are granted a waiver, and that they are held accountable to report those measures. Dr. Fox shared that Medicaid has moved from only being a payer to improving the quality of care provided, however, noting that this is a state and federal partnership, and ultimately states have the ownership. It was highlighted that since Medicare is exclusively federal, it can only provide technical assistance and implementation guidance to states (e.g., help to gather dual-eligible data which is often a high-cost challenge for states). The U.S. Congress does not provide funding for such activities at the state level. A member



affirmed that often states are stretched when it comes to dual-eligible populations, sharing their experience in integration of care for dual-eligible populations and financial and quality measurement alignment. It was noted that there is need for more technical support and capacity building at the state level.

Amy Moyer, a senior director from NQF, summarized the discussion and acknowledged the Workgroup's desire to move beyond CQMC's existing focus on measurement for clinicians/clinician groups in the ambulatory setting towards potential partnership and development in the space of LTSS, multiple social determinants of health (SDOH), multiple comorbidities (e.g., dual-eligible populations), and post-acute/long-term care settings. The Workgroup supported the future task to consider what such developments might mean for the broader CQMC and NQF work (i.e., how to transform the healthcare system to the care that we need as a country).

Ms. Moyer solicited from the Workgroup any ideas for broader implementation application after reviewing the public core sets that were presented by CMS and those measure sets presented in the previous meeting from an ACO and a health plan. A Workgroup member expressed interest in exploring implementation from the perspective of an employer/group employers (e.g., Purchaser Business Group on Health (PBGH) for a business use case that is examining the value in the quality of care that is being rendered). A member shared that there are some examples and cited the [Catalyst for Payment Reform](#) which supports purchasers by developing tool kits and guides that can be used to measure value and quality. Also noted was BlueShield-California, who is working closely with National Business Group on Health and PBGH, who both had early ideas on how to put together a framework on measuring the quality of the healthcare employer groups are purchasing. This is vital considering the recent trend of employer-based insurance extending into retirement. Another member shared that PBGH - California Quality Collaborative (CQC), examined advanced primary care data sets to create an advanced primary care movement using a data set and implementation across multiple employers, Medicaid, providers, and payers. A co-chair recommended exploring if there are any public-sector unions also working in this area (e.g., New Jersey Teachers Union). Recent CMS Innovation Center (CMMI) models were also highlighted (e.g., Rural Critical Access Hospitals implementation activities and how they align with Medicare and Medicaid) as potential use cases that involve linkages across public and private programs. A Workgroup member voiced support for the rural use case with dual-eligible patients, as it has the potential to show alignment across two programs (i.e., if there is a potential use case across Medicaid and Medicare programs). Another Workgroup member agreed, stating that part of the benefit argument is examining what alignment looks like. An example was provided of how Hawaii switched to an auto-assignment process (i.e., an auto-sign up) for its Medicare Dual-Eligibility project, which revealed 80 percent alignment in use case between Medicare and Medicaid plans, showing that measure alignment is possible. A member recommended the use case touching on value added to the state, managed care plan, and/or the individual (e.g., not requiring filling out multiple CAHPS survey will reduce patient burden, budget neutrality, reduction in premium cost etc.).

Review of Potential Case Studies

Ms. Moyer recapped that during the all-day virtual full Collaborative Meeting held on April 13, 2021,

the regional collaboratives Integrated Healthcare Association (IHA), Kentuckiana Health Collaborative (KHC) and Wisconsin Collaborative for Healthcare Quality (WCHQ) shared their respective governance structures, measure alignment, and stakeholder value propositions. The public/private partnership was highlighted as it can help with measurement alignment. It was noted that case studies can provide different stakeholder perspectives during implementation and will aid in finding solutions for all parties involved.

Ms. Moyer shared the idea of updating the Implementation Guide with examples of useful case studies. Two questions were posed to the Workgroup:

1. Is such information useful from an implementation perspective?
2. If yes, what should the case studies cover (e.g., what types of questions should be asked during the case study interviews, examples of additional associations/collaboratives that can be considered for the case studies)?

A co-chair shared that seeing what others are doing would be helpful, as it will provide information on governance (i.e., what type of structure works best), and sustainability (i.e., how long an organization has been operating and how they have been able to maintain momentum within this space). WCHQ was noted as being a voluntary, non-profit that has been in existence for more than 20-years. A member shared that governance structure is important but that bringing the right players at the table is equally as important. An example was provided of how IHA is a not-for-profit organization with a variety of stakeholders (e.g., plans, purchasers, consumers, groups, government, etc.). The member noted that having the right stakeholders discussing relevant issues reflective of the market space is a very important part of sustainability (e.g., IHA was one of the first to establish a pay-for-performance program and how it has now migrated from the program, to being the main driver for improvement).

A member agreed with the idea of having the right stakeholder over the governance structure. The member shared that the [Robert Bree Collaborative- Washington State](#) has the right stakeholders (i.e., government, large employers, health systems, health facilities, health plans etc.) bringing data to the table that is reviewed. This arrangement makes the collaborative special and nimble to focus on different value-based initiatives. The member noted that many of the successful collaboratives (e.g., [Value in Cancer Care Initiative \(VCCI\)– Hutchinson Institution in Washington State](#)) use this structure and have a centralized funding from the stakeholders.

A co-chair recommended that for future Workgroup meetings, someone from the organizations that were mentioned be invited to present on the organization's origin, as such information could be useful. The co-chair shared about hearing about the origins of [Arkansas Center for Health Improvement \(ACHI\)](#) and found it very helpful.

Ms. Moyer, summarized the discussion, noting that members wanted the case studies to include different perspectives, information on how the organization came about (i.e., origin stories), examples of what is working, how the organization is maintaining momentum, and the governance structure (i.e., getting the right people at the table taking on the right responsibilities).

A member inquired if IHA, KHC, and WCHQ had similar focus areas and the composition of stakeholders for each. In response, Ms. Moyer advised that the organizations have slightly different focuses, with WCHQ focusing on outpatient care and quality improvement, KHC focusing on the health plan from a local regional perspective, and IHA is the broadest of the three in terms of focus and stakeholder participation. Related to IHA, a member shared that the organization has evolved in its 20-years and is now looking at data sets and information from a variety of sources (e.g., state data from Medicaid, and data from plans/purchasers). The member shared that IHA is currently involved in the active development of an all-payer claims database (APCD) in California. The member shared that IHA has shifted its focus over the years (i.e., in the late 2000's focus was on pay-for-performance on the commercial side, and then moved to total-cost of care, and currently focuses on understanding different marketplaces and populations which has resulted in a geographical atlas with financial data, measures and their quality performance).

A member suggested including an appendix with organizations scope of work, information on gaps in data that were identified, and recommendations on how to collect and use data more efficiently. The member noted that throughout the pandemic, a lack of data collection has created and revealed systemic disparities.

Core Set Implementation Case Study

Ms. Moyer shared a case study idea that would examine a real-world implementation example for one of the measures in a CQMC core set. The measure in the potential case study is *Screening Colonoscopy Adenoma Detection Rate (MIPS ID 343)* measure from the CQMC Gastroenterology Core Set. A purchasing organization in Wisconsin wanted to incorporate the measure into a centers of excellence program and use the results in its performance-based reimbursement program. Ms. Moyer shared that the organization worked directly with WHCQ and health systems to implement the measure. From this effort, there are four health systems and providers starting to calculate results on the measure. The groups have used several different pathways to collect the data for the measure, including using the GI Quality Improvement Consortium (GIQuIC) registry, endoscopy software, smart notes/smart text in clinical notes, and manual chart abstraction. The Workgroup was asked whether including a case study that examines the different pathways being used by the different health systems/providers would be useful in the Implementation Guide update.

In response, a co-chair stated that examining the broadness versus narrowness of the measure, from a shoppable standpoint, allows one to gauge the quality of the colonoscopy. From a population health standpoint, there is a need to establish overall colon cancer screening rates. The co-chair stated that the case study may not be suitable because it does not cover a broad population as would a well child screening, pre-term birth weight or blood pressure control screening measures, but indicated that it is all dependent on the direction the Workgroup would like to take. In response, Ms. Moyer indicated that Wisconsin has high colon cancer screening rates and very high price variation for colonoscopies (e.g., six-fold pricing differences in some markets) and the purchaser did not want to treat the service as a commodity without looking at the data (i.e., is the quality of the \$7,000 colonoscopy better than the \$600 colonoscopy?). The co-chair stated that with the context that was



provided, such information could be useful, but wondered if the CQMC could indicate which commodity service was of better quality. Ms. Moyer also noted that from the exercise, the organization was able to compare ambulatory, hospital outpatient, and provider's office as a place of service, noting that the outcomes were setting neutral. The co-chair supported use of the case study if the full context is provided.

A member shared that reference pricing should examine whether it is possible to do quality adjustment reference pricing if there is variation in performance. An example was provided of hip and knee patient-reported outcome measures (PROMs) where the change from before surgery to six or eight months after surgery was dependent on the mobility or vitality of the patient prior, versus post procedure. This resulted in the use of a utilization evaluation and not a performance evaluation, further leading to exploring hip and knee reference prices that were quality adjusted as a different version of pay-for-performance, which can drive consumers' participation. The member supported the use of quality-adjusted referencing pricing as a case study.

A co-chair shared that they would be interested in seeing how the clinical data was retrieved, as this has always been a challenge across the nation especially for large payers. A fellow co-chair concurred highlighting that such challenges are a result of data being siloed (e.g., associations, hospital, insurance companies, health information exchanges (HIEs) who all have data that they do not share with each other). The co-chair agreed that lack of data sharing platforms is a challenge but that it may be improved with the introduction of fast health interoperability resources (FHIR). The co-chair noted that data use agreements are a major hindrance to information sharing and questioned if it was a state-level or federal-level legal problem.

Collection of Race, Ethnicity, and Language Case Study

Ms. Moyer shared that during the previous Workgroup meeting, a member recommended considering including information on how to obtain and include variables that should be taken into consideration during implementation such as race, ethnicity, and language. A recommendation was made for NQF to look at Minnesota Community Measurement (MNCM) which has been tracking this information and documented in the [Handbook in the Collection of Race/Ethnicity/Language and Data in Medical Groups](#). A question was posed to the Workgroup on whether information on how to collect the data, how to use the data, and a link to the handbook should be included in the Guide.

A co-chair responded that it is good information to have but is very complicated, noting that the information would be helpful when collected accurately and if it is able to be stratified. An example was given of how a health insurance company used its race/language/ethnicity data to determine which populations were most and least likely to get an influenza vaccine. The impact was more nuanced than a simple stratification by race or ethnicity.

A member noted that many measures have not been fully vetted with different populations or those who speak different languages. A recommendation was made for NQF to consider language and translations and validations of PROMs and patient-reported outcome performance measures (PRO-

PMs) in other languages.

Recommend Updates to the Implementation Guide

Ms. Moyer shared that NQF was open to additional recommendations for case studies, and/or case study topic areas for inclusion in the Guide update.

A member recommended including pandemic lessons learned, and how to start back up post-pandemic, which will most like be slow and uneven. Pediatric immunizations were noted to have slowed down, hospital-setting services were put on hold and other conditions fell through the cracks. Guidance on how to get back on track will be useful. A co-chair agreed and shared that in their state the Medicare Shared Savings Program for ACOs has data which shows how much things dropped back (e.g., annual wellness versus emergency-room visits) during the global pandemic, revealing wide variation on these measures based on location and the ability to do telehealth.

Another member recommended a case study where gaps in data were identified and whether there are alternative ways to allow efficient data collection to help in achieving the measures.

Ms. Moyer opened the meeting to comments from members of the public. No public comments were received during the meeting.

Next Steps

NQF staff shared that the web meeting summary will be shared with the workgroup, as well as the CQMC-wide update including the full Collaborative meeting summary. The Workgroup was informed that an updated draft of the Guide will be shared by mid-June. During closing remarks both co-chairs thanked the workgroup for their time and asked that as future meetings are being considered to have all key stakeholders invited to the table.