Impact Assessment of CMS Quality and Efficiency Measures
Contract #: 75FCMC18D0026, Task Order #: 75FCMC19F0001

Technical Expert Panel Meeting Summary

Meeting Date: February 26, 2021

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HSAG HEALTH SERVICES ADVISORY GROUP

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I. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) has contracted with Health Services Advisory Group, Inc. (HSAG) to develop the CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) under Contract #75FCMC18D0026; Task Order #75FCMC19F0001. As part of this contract, HSAG ("the team") is also tasked to develop the CMS Quality Measure Index (QMI).

As part of this contract, HSAG convenes a technical expert panel (TEP) of patients and family caregivers, clinicians and representatives of professional societies, consumer advocates, quality measurement experts, and health information technology specialists to provide multi-stakeholder input on project tasks and reports. The 2019–2021 TEP was selected through a call for nominations posted at CMS.gov/Medicare/Quality/Initiatives-Patient-Assessment-Instruments/MMS/Technical-Expert-Panels.

On February 26, 2021, the team convened a webinar meeting of the Measure Development Plan (MDP) TEP to inform panel members of work on the QMI and obtain members' feedback. The meeting objectives were to:

- Review QMI background and progress to date
- Share preliminary findings from the 2020 QMI environmental scan
- Discuss QMI scoring variable refinements
- Review upcoming QMI milestones and timeline

II. MEETING PROCEEDINGS

Welcome and Opening Remarks

Presenter: Carolyn Lockwood, MSN, RN, HSAG
Ms. Lockwood, HSAG team lead for the QMI project, welcomed the participants and CMS guests. She noted the meeting will focus on the QMI and reviewed meeting objectives and the agenda.

TEP Roll Call and Disclosures of Conflict of Interest

Presenters: Amy Mullins, MD, CPE, FAAFP, American Academy of Family Physicians; Michael Phelan, MD, JD, FACEP, RDMS, CQM, Cleveland Clinic Health Systems (*Co-Chairs*)

Invited Attendees/Attendance:

TEP		CMS (optional)	HSAG
☒ Anders, Scott	☒ Mullen, Cody	☒ Chan, Sophia	☒ Campbell, Kyle
☐ Aran, Peter	☒ Mullins, Amy *(Co-Chair)*	☐ Dollar-Maples, Helen	☒ Hanley, Kendra
☒ Bossley, Heidi	☒ Nguyen Howell, Amy	☒ Durham, Maria	☒ Hall, Marie
☐ Fields, Robert	☐ Nielsen, Matthew	☒ Singh Shah, Nidhi	☒ Hemmingway,Susan
☒ Fishman, Eliot	☒ Phelan, Michael *(Co-Chair)*		☒ Keenan, Megan
☒ Furniss, Jeremy	☒ Rising, Kristin		☒ Lockwood, Carolyn
☒ Huang, Mark	☒ Rogut, Lynn		☒ Mackeprang, Julia
☒ Kaufman, Joel	☒ Suter, Lisa Gale		☒ Nguyen, Kim
☒ Malinowski, Jana	☒ Tierney, Samantha		☒ Peel, Allison
☐ Mosnaim, Giselle	☒ Wisham, Lindsey		☒ Pleasant, Michelle
			☒ Selvarajah, Shalini
			☒ Yang, Sherry
			☒ Ziemba, Rob

Disclosures of Conflict of Interest

- Dr. Suter stated she is a director of a contract to develop and implement measures for CMS; none have been directly discussed during the QMI work.
- Ms. Wisham noted her employer has CMS contracts; however, she does not believe this a conflict of interest with today's meeting topics.

QMI Overview and Update

Presenter: Carolyn Lockwood, MSN, RN, HSAG

Ms. Lockwood presented an overview of the QMI and provided an update of the tool's testing status. She noted the QMI was developed to be an objective and standardized means to assess the relative value of individual measures, based on key measure characteristics, in support of CMS efforts to develop and select meaningful measures to improve patient outcomes. The QMI, however, is not intended to replace existing measure assessment and selection procedures and instead enhances existing processes. Throughout development, the team has obtained multi-stakeholder feedback from CMS, the TEP, and TEP workgroup.

Ms. Lockwood reviewed the project's completed milestones, which include three comprehensive environmental scans to identify and confirm variables operationalized within the QMI. The latest environmental scan, completed in December 2020, was conducted to support the adaptation of the QMI for broader use in assessing measures for acute, post-acute and long-term care program settings.

Ms. Lockwood noted that through previous testing on clinician-level quality measures in all phases of the Measure Lifecycle, the team learned that publicly available measure documentation is heterogenous, imprecise, or missing, which limits fair comparisons of the relative value of quality measures. Access to standardized documentation, however, would improve measure quality assessment using the QMI. She added that moving forward, the team will be able to reach out to developers to solicit additional measure-related information not found in publicly available

sources. The team also learned that a subset of the QMI scoring variables are applicable to earlier phases of the Measure Lifecycle, specifically the conceptualization and specification phases.

Dr. Campbell informed the TEP that several team members, following advice from the TEP workgroup, are closely tracking discussions and outputs by the National Quality Forum (NQF) Scientific Methods Panel to align the QMI and NQF measure evaluation criteria.

- A TEP member asked Ms. Lockwood to elaborate on how prior testing showed that only a subset of QMI variables were applicable to the earlier phases of the Measure Lifecycle.
- Ms. Lockwood replied that based on the criteria identified in the CMS MMS Blueprint,[1] the team identified QMI scoring variables that would be expected at the completion of each of the phases of the Measure Lifecycle. The team had anticipated less complete information would be available for some of the QMI variables when assessing measures in the earlier Measure Lifecycle phases. For example, information about whether a measure is evidence-based would be expected to be reported among measures that had completed the conceptualization phase, but information about validity or reliability testing results would not be available until the completion of the testing phase. The team confirmed through review of measure information the scoring variables that would be expected at each phase of the Measure Lifecyle. Additional testing of the QMI on measures in various phases of the Measure Lifecyle will be completed by the end of 2021.

2020 QMI Environmental Scan and Empirical Analysis

Presenter: Michelle Pleasant, PhD, MA, HSAG

Dr. Pleasant reviewed the *2020 QMI Environmental Scan and Empirical Analysis* report and its results. She noted the scan's purpose was to confirm applicability of current QMI variables, determine if any additional variables should be proposed, and operationalize new or existing variable modifications.

Dr. Pleasant noted the environmental scan methodology, which included assessing measure characteristic applicability to additional care settings and the applicability and feasibility of where measure data could be found across the Measure Lifecycle. The scan showed these results:

- 19 of 27 QMI variables are applicable to additional care settings
- 4 scoring variables were recommended for refinement: *High Priority, Risk Adjustment, Reliability*, and *Validity*.
- 4 additional variables were identified for the QMI: *Alignment, Attribution, Unintended Consequences*, and *Usability*. However, the team recommends against pursuing these variables; definitions were imprecise and data availability could be limited.

Dr. Pleasant continued by noting feasibility assessment results for QMI variables: 23 of 27 showed high feasibility, meaning they have a clear definition and data are readily available; of these, four were recommended for proposed refinements of their operational definitions (*High Priority, Risk Adjustment, Reliability*, *Validity*). Meanwhile, four variables showed low feasibility (*Alignment, Attribution, Unintended Consequences*, *Usability*).

High Priority

Dr. Pleasant noted the *High Priority* variable was originally customized to assess clinician-level quality measures, using two sources to identify priorities:

- The Physician Fee Schedule 2020 Final Rule for the Quality Payment Program, where 7 priorities were identified, and
- The CMS Quality Measure Development Plan (MDP) environmental scan, which identified 12 high-priority medical specialties with measurement gaps.

As the QMI is applied to other programs, a broader set of criteria will be needed to reflect progress towards program-specific goals and CMS measurement priorities. For obtaining the total number of priorities reflected in a measure, the team has proposed revising the variable definition. The revision specifies these information sources: agency-wide CMS strategic measurement priorities paired with the Physician Fee Schedule Final Rule and measurement goals of specific quality programs.

- A TEP member agreed with the proposed refinement to the original *High Priority* definition but encouraged the team to consider a broader source of information, such as the NQF Measure Applications Partnership (MAP) reports and other committees that might publish reports about measure gaps for measure priority areas. She noted that CMS has a good system for flagging such reports but also encouraged tracking other sources such as the Medicare Payment Advisory Commission (MedPAC) or the Office of the Assistant Secretary for Planning and Evaluation (ASPE) that might publish recommendations that could influence measurement considerations.
- A TEP member expressed difficulty in understanding the definition, noting the revised operational definition starts with the "total number of high priorities …" He added the definition would be clearer if it began with "the measure is identified or defined as a high priority in applicable quality programs as most current." He stated this is important since the QMI aims to assess the measure itself, and not the actual high priority element.
- A TEP member said she liked the proposed revision but wants to make sure the team is aware that CMS has released a preview of the Meaningful Measures 2.0 framework[2] and to encourage the team to look to that framework in identifying high priority areas. Dr. Pleasant thanked the TEP member for her comment and confirmed the team is closely tracking the Meaningful Measures 2.0 framework.

Risk Adjustment

Dr. Pleasant reviewed the proposed refined definition for the *Risk Adjustment* variable that includes information about stratification and consideration of social risk factors. She noted adjustment for social risk factors is not a settled issue at NQF or CMS and that the team is tracking NQF's work on this issue to ensure QMI scoring is in alignment with NQF recommendations. She added the goal of the variable is to consider whether the QMI can capture additional information around risk adjustment and stratification and clarified the scoring approach would be refined with the TEP workgroup.

- A TEP member noted the importance of considering social risk with risk adjustment and stated that payors, electronic health record (EHR) vendors, and clinicians would need to

be involved in the effort to collect information on social risk factors that is not currently collected.

- Another TEP member suggested the QMI define social determinants and drivers of health appropriately and define how to collect the data.
  - Dr. Pleasant added that some of the variables identified in the environmental scan included race/ethnicity, socioeconomic status, language, gender, sexual orientation, age, and geographic location. She added these may not all be appropriate for risk models but were flagged in the literature search for further consideration.
- A TEP member agreed with the previous comments and noted that education, transportation, food insecurity, digital access, and other variables should be considered under social risk.
- A TEP member suggested the team consider whether special considerations would be needed for risk adjustment of patient-reported outcome performance measures in the QMI scoring variable.
- A TEP member agreed with the expanded thinking on how to define social determinants of health and the need for these data to be collected. She expressed concern about risk adjustment models accounting for social determinants of health and noted it may sometimes be more appropriate to account for those factors in the way the measures are implemented. She provided an example of where adjustment for race could mask disparities in care when it may be more appropriate to provide extra resources to providers to address or mitigate the underlying causes of disparate outcomes for non-white patients (e.g., patients who have less trust in the healthcare system or have experienced systemic racism in their healthcare). She added that the variable should be defined in such a way that it is clear that risk adjustment is not the only tool for addressing social risk so that developers are not encouraged to include social factors in their risk models when not appropriate.
  - Dr. Campbell agreed with the TEP member and noted this variable would be defined further with the workgroup. He added that how measures are implemented in a program is outside the purview of the QMI tool and that the goal is to give credit if developers evaluated social determinants of health and made a recommendation about risk adjustment or stratification by social determinants of health.
- Another TEP member submitted a comment in support of the previous TEP member's remarks about defining risk adjustment. Dr. Pleasant added the NQF Social Risk Factor Trial concluding in May should issue a report by July 2021.

Reliability

Dr. Pleasant reviewed the proposed refined definition for the *Reliabilty* variable. The refinement is to supplement the existing definition by requiring reliability testing to be aligned with the level of analysis for which the measure is specified for use. Dr. Pleasant noted that prior testing was conducted solely on clinician-level measures. As the QMI testing is being expanded to other care settings, this addition to the definition is needed for measures specified to be used for multiple levels of analysis.

- A TEP member suggested revising the proposed addition for language clarity.

- Another TEP member emphasized the need to align this variable with the work on reliability by the NQF Scientific Methods Panel. The Panel has been deliberating the types and levels of reliability that measure testing should demonstrate. In addition, the TEP member indicated that during the NQF Scientific Methods Panel meeting, there was discussion about whether the acceptable level of reliability would be different depending on the measure's intended use; for example, lower reliability may be acceptable for a clinician-level measure. The TEP member noted that having different thresholds based on the measure's intended use can be problematic; uses proposed during endorsement are not exclusive, and once the measure is endorsed, it can be adopted for other uses.
- Dr. Pleasant agreed the refined definition can be revised for clarity and noted the team is following the work of the NQF Scientific Methods Panel and will continue to monitor its progress.

Validity

Dr. Pleasant reviewed the proposed refined definition for the *Validity* variable and noted the change is similar to the *Reliability* variable refinement. The refinement requires validity testing to be aligned with the level of analysis for which the measure is specified for use.

- A TEP member asked through webinar chat if the team can provide the NQF measure evaluation algorithm for validity and reliability, to which Dr. Pleasant indicated the team would be happy to email the algorithm after the meeting.
- Another TEP member recommended adding language for both the *Validity* and *Reliability* variables to require the measure is tested for the right target level of analysis, and the appropriate test is used for the applicable level.
    - Dr. Pleasant inquired whether the TEP member was suggesting a measure in a facility-level program should demonstrate testing results at facility-level or whether the testing results for such a measure would need to meet a specific threshold.
    - Another TEP member helped to clarify by giving an example that if a measure is tested for clinician-level, the measure needs to be used at that level, and the testing results should not be applied to facility-level.
- A TEP member suggested broadening the rationale for the definition's refinement, noting that NQF endorses measures for accountability, which can include various uses, such as certification, public reporting, or pay-for-performance.
    - Dr. Campbell agreed that the language can be adjusted more broadly than "pay for performance or value-based program" as currently stated in the rationale.

Concluding Remarks and Next Steps

Presenter: Carolyn Lockwood, MSN, RN, HSAG

Ms. Lockwood reviewed next steps for the QMI, which include adapting the QMI for use across CMS quality reporting programs. She noted the QMI has been integrated into the 2021 Annual Call for Measures; the team is working on integrating the QMI into the 2022 Qualified Clinicial Data Registry (QCDR) Self-Nomination Process and for use in assessing measures under development. Additionally, the team is drafting a QMI methodology report and anticipates soliciting public comment.

The QMI TEP workgroup will be convened in late April/early May 2021 to continue discussion on variable refinements.

Ms. Lockwood also shared updates for the CMS Measure Development Plan: The MDP Population Health Environmental Scan and Gap Analysis Report was posted to the cms.gov website on Feb. 22, 2021, and the October 2020 TEP meeting summary was recently posted to the site. Lastly, the 2021 MDP Annual Report is now undergoing clearance with an anticipated posting date of May 1, 2021.

- A TEP member asked whether a conclusion was reached on the cross-cutting measures (for the MDP).
- Kendra Hendry, HSAG, replied the final prioritization vote of the TEP can be found in the October 2020 TEP meeting summary and the executive summary of the MDP environmental scan, posted this week to cms.gov. A link to the documents is shown on slide 45 of today's presentation (https://www.cms.gov/Medicare/Quality-Payment-Program/Measure-Development/Measure-development); this cms.gov site includes all MDP resources.

III. KEY TAKEAWAYS AND RECOMMENDATIONS

High Priority

- The team will consider multiple sources to identify measurement development priorities, such as the Meaningful Measures 2.0 framework and relevant MedPAC and ASPE publications.
- The operational definition of the *High Priority* variable will be modified to state, "The measure's total number of high priorities identified or defined as high priority…"

Risk Adjustment

- The TEP supported consideration of stratification of social determinants of health as well as risk adjustment in the QMI scoring methodology.
- Additional social determinants of health factors were documented to consider in future iterations of the *Risk Adjustment* variable.
- The team will continue to refine the *Risk Adjustment* variable with input from CMS and other stakeholders and data obtained from the 2021 testing with measures in CMS quality reporting programs.

Reliability and Validity

- The proposed refined definitions for both the *Reliability* and *Validity* variables will be reviewed to enhance clarity, as suggested in the meeting.
- The team will continue to follow the work of the NQF Scientific Methods Panel to inform the *Reliability* and *Validity* variables.

IV. POST MEETING COMMENTS

No additional comments were received post meeting.

REFERENCES

1. Centers for Medicare & Medicaid Services. *CMS Measures Management System Blueprint Version 16.0.* Baltimore, MD: US Department of Health and Human Services; 2020. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf. Accessed November 16, 2020.
2. Centers for Medicare & Medicaid Services. Meaningful Measures 2.0: Moving from measure reduction to modernization. Baltimore, MD: US Department of Health and Human Services; 2020. https://www.cms.gov/meaningful-measures-20-moving-measure-reduction-modernization. Accessed March 15, 2021.