

CMS Quality Measure Development Plan (MDP)/  
Quality Measure Index (QMI) Project  
Contract #: 75FCMC18D0026 Task Order #:75FCMC19F0001

# Technical Expert Panel Meeting Summary

*MACRA Section 102*

December 11, 2019

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# Technical Expert Panel Meeting Summary

## I. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) 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)*<sup>1</sup> under Contract #75FCMC18D0026; Task Order #75FCMC19F0001. As part of this contract, HSAG (“the team”) is also tasked to develop the CMS Quality Measure Index. HSAG convened a multidisciplinary technical expert panel (TEP) of stakeholders (e.g., patients and family caregivers, clinicians and representatives of professional societies, consumer advocates, quality measurement experts, and health information technology specialists) to gather their recommendations on the Quality Measure Index.

## II. BACKGROUND

On December 11, 2019, HSAG convened the first meeting of the 2019–2021 Measure Development Plan (MDP) and Quality Measure Index (QMI) TEP by webinar. The meeting’s key purpose was to provide updates on the QMI and solicit TEP input on the newly conceptualized *Impact* variables, proposed changes to the domain weighting, and the feasibility assessment of new and updated variables confirmed by the 2019 QMI Environmental Scan and Empirical Analysis. Fifteen of 21 TEP members attended, along with HSAG staff. The six TEP members not in attendance were sent the meeting recording and encouraged to provide feedback. Present from CMS was Nidhi Singh Shah, Project Lead. The objectives of the meeting were to:

- Review QMI background and progress to date.
- Present the newly conceptualized *Impact* variables for discussion.
- Review and refine the domain weighting scheme for the QMI.
- Confirm the results of the environmental scan.
- Review the feasibility assessment conducted with existing, previously specified, and newly specified variables.

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<sup>1</sup> Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services. *CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)*. Baltimore, MD: US Department of Health and Human Services; 2016. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf>. Accessed November 13, 2018.

### III. MEETING PROCEEDINGS

#### Welcome and Opening Remarks

**Presenter: Kendra Hanley, MS HSAG**

Ms. Hanley, the Measure Development Plan Team Lead, welcomed the TEP members and attendees from CMS. Ms. Hanley noted that HSAG was recording the meeting, provided technical guidance for participating in the webinar; and reminded participants that meeting materials are proprietary to the project and cannot be shared without permission from CMS. She displayed the *TEP Meeting Agenda* (Appendix A) and outlined the objectives of the webinar.

#### TEP Roll Call, TEP Charter, and Disclosures of Conflict of Interest

**Presenter: Amy Mullins, MD, American Academy of Family Physicians (Co-Chair)**

Dr. Mullins conducted a roll call. Fifteen TEP members attended, as indicated by the checkboxes. TEP members unanimously approved the 2019–2021 TEP Charter, voting during the meeting or through email if unable to attend.

#### TEP Members

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Scott Anders, MD, MBA, CPE, FAAFP          | <input checked="" type="checkbox"/> Amy Mullins, MD, CPE, FAAFP<br>( <i>TEP Co-Chair</i> ) |
| <input checked="" type="checkbox"/> Peter Aran, MD                             |  |
| <input checked="" type="checkbox"/> Heidi Bossley, MSN, MBA                    | <input checked="" type="checkbox"/> Amy Nguyen Howell, MD, MBA, FAAFP                      |
| <input type="checkbox"/> Robert Fields, MD, MHA                                | <input checked="" type="checkbox"/> Matthew E. Nielsen, MD, MS, FASC                       |
| <input checked="" type="checkbox"/> Eliot Fishman, PhD                         | <input checked="" type="checkbox"/> Michael Phelan, MD ( <i>TEP Co-Chair</i> )             |
| <input checked="" type="checkbox"/> Jeremy Furniss, OTD, OTR/L, BCG            | <input type="checkbox"/> Kristin Rising, MD, MSHP, FACEP                                   |
| <input checked="" type="checkbox"/> Mark Huang, MD                             | <input checked="" type="checkbox"/> Lynn Rogut, MCRP                                       |
| <input type="checkbox"/> Joel Kaufman, MD, FAAN                                | <input type="checkbox"/> Heather Smith, PT, MPH  |
| <input checked="" type="checkbox"/> Jana Malinowski, BA                        | <input checked="" type="checkbox"/> Lisa Gale Suter, MD                                    |
| <input checked="" type="checkbox"/> Giselle Mosnaim, MD, MS, FAAAAI,<br>FACAAI | <input type="checkbox"/> Samantha Tierney, MPH   |
| <input checked="" type="checkbox"/> Cody Mullen, PhD                           | <input type="checkbox"/> Lindsey Wisham, MPA   |

Members disclosed or restated information about potential conflicts of interest:

- M. Huang continues to participate on the National Quality Foundation (NQF) Measure Feedback Loop Committee.
- G. Mosnaim holds stock options, performs research, and participates in consulting and/or advisory activities on behalf of companies she has previously disclosed.
- A. Mullins disclosed that her husband currently works for the Cerner Corporation.
- M. Nielsen is the Chair of the Quality Improvement & Patient Safety Committee for the American Urological Association and serves on the American College of Physicians Performance Measurement Committee.

- L. Suter is the Director of Quality Measurement Programs at Yale Center for Outcomes Research and Evaluation overseeing a Medicare contract to develop, maintain, and implement measures across federal programs, including the Quality Payment Program. Dr. Suter also oversees quality measure development at the American College of Rheumatology and sits on the NQF patient experience committee.

## Quality Measure Index Development Overview and Update

### Presenter: Carolyn Lockwood, MSN, RN, HSAG

Ms. Lockwood reviewed the goals and potential uses of the QMI. The index will provide a transparent framework to assess the relative value of individual measures based on measure variables and to support CMS efforts to develop and select meaningful measures to improve patient outcomes with less burden. Once developed, the index will support CMS stakeholders as they prioritize measures for development and continued implementation, and it will inform measure developers about measures that could become more meaningful with updates.

Ms. Lockwood reminded the TEP how the QMI score is generated: The index user abstracts measure information from publicly available sources relevant to the scoring variables (e.g., feasibility and reliability), analyzes the information, and calculates a score of zero to 100. This score places measures into the Good, Moderate, or Needs Improvement category.

Ms. Lockwood reviewed the steps that the team has taken in developing and testing the index: performing an environmental scan to identify variables; developing the abstraction tool; conducting two phases of alpha testing; convening webinar workgroups to discuss the index content validity and weighting; and conducting beta testing. Finally, Ms. Lockwood presented CMS feedback asking the team to incorporate variables to assess the impact or clinical significance of a measure in the QMI tool.

### Exploration of New QMI Variables

#### Presenter: Dr. Kyle Campbell, PharmD, HSAG

Dr. Campbell presented five *Impact* variables proposed to objectively assess the clinical significance of a measure: *Meaningful to Patients and Clinicians*, *Reach of the Measure*, *Clinical Significance*, *Value of Health Outcomes*, and *Predicted Return on Investment*. For the five variables, he described the proposed operational definitions, data sources, and methods of calculation. Dr. Campbell then facilitated discussion with the TEP members to gather input on each of the five variables (Table 1).

**Table 1. Potential Impact Variables**

Variable	Operational Definition	Data Sources	Calculation(s)
Meaningful to Patients and Clinicians	<ul style="list-style-type: none"> <li>• Evidence that the measure is meaningful to patients in improving quality of health</li> <li>• Evidence that the measure is meaningful to clinicians in improving quality of health</li> </ul>	Surveys, focus groups, interviews, published literature	Yes/No

Variable	Operational Definition	Data Sources	Calculation(s)
Reach of Measure	<ul style="list-style-type: none"> <li>Evidence on the prevalence of the condition</li> </ul>	Published literature, government reports	Proportion/number of eligible patients included or facilities or clinicians with at least 30 cases
Clinical Significance	<ul style="list-style-type: none"> <li>Evidence that the measure relates to a top volume or cost condition or procedure within Medicare</li> <li>Evidence that the measure relates to a top volume or cost condition within a selected clinical specialty</li> </ul>	Published literature, government reports, claims analysis	Yes/No
Value of Health Outcomes	<ul style="list-style-type: none"> <li>Evidence of the Quality-Adjusted Life Years</li> </ul>	Published literature, PROMs, national surveys	Determined by multiplying preference-weighted health states by length of time in health state; value between 0 and 1
Potential Return on Investment	<ul style="list-style-type: none"> <li>Evidence regarding the cost avoided or incurred related to proposed quality improvement interventions</li> <li>Evidence of impact on health outcomes</li> </ul>	Published literature, contract expenditures, PROMs	Potential ROI benefit (total cost savings/total costs); quality-adjusted life years (QALYs) on a 0–1 scale

### **TEP Comments and Feedback**

#### **Key Discussion Theme:**

- Review of the proposed *Impact* variables confirmed the importance of the concepts, but execution of the *Value of Health Outcomes* and *Predicted Return on Investment* variables would be challenging in quality measurement. Potential challenges noted were as follows:
  - *Value of Health Outcomes* – Quality adjusted life years (QALY), a summary measure of disease burden that considers the quantity and quality of life lived, is often used in economic evaluations of medical interventions. The concept may not be appropriate for some patient populations, data are not readily available for all measures, and assessment may be too costly.
  - *Predicted Return on Investment* – Predicting a return on investment for a measure is complicated and could have unintended implications for patient care.

#### *Meaningful to Patients and Clinicians*

Dr. Campbell pointed out on the slide the definitions and data sources for the five prospective *Impact* variables. The discussion began with *Meaningful to Patients and Clinicians*.

- A TEP member asked whether the emphasis was on choosing variables that diminish reporting burden among frontline clinicians ... and if that was part of this measure or dealt with elsewhere?
  - Dr. Campbell responded that reporting burden would be a separate concept. The *Meaningful to Patients and Clinicians* variable captures evidence from the measure

developer that patients and or clinicians have agreed that this measure would be useful to improve care.

- A second TEP member asked if burden was part of the broader QMI.
  - Dr. Campbell confirmed that while not part of this variable, burden is addressed in the QMI.
- Three members observed that the *Meaningful to Patients and Clinicians* variable looks at two different things—meaningful to patients and meaningful to clinicians—and should be two different variables. One member noted that if both aspects remained in the same variable, one response could negate the other.
- A TEP member asked about the use of “health” instead of “health care” in the operational definition of the *Meaningful to Patients and Clinicians*.
  - Dr. Campbell thanked the member for this feedback and confirmed that the team is open to any refinements in the language of the variables.
- A member commented that the response for this variable seems binary and asked [rhetorically] “How many measures aren’t meaningful?” He hoped that a measure wouldn’t be developed if it’s not improving health. He suggested that perhaps the response could be stratified or measured on a Likert scale.
  - Dr. Campbell clarified that the team is thinking the QMI could be used during the measure development process, and if the response is no, that response could indicate the measure developer needs to go back to the drawing board.
  - In response to the suggestion of calculating the variable on a scale, Dr. Campbell noted concerns of comparing mixed methods on a Likert scale. Suggestions to split the variable and modify the language were confirmed as possible.
- A member asked if the term “meaningful” has the same meaning to everyone and suggested reexamining the term and the intended meaning.
- Another member questioned the concept “meaningful to clinicians.” The term meaningful means that it is evidence-based, reliable, and valid, so this variable would give an extra point when these concepts are covered in other variables.
  - Dr. Campbell noted the difference here is between qualitative versus quantitative information.
- A member shared a follow-up question from the perspective of a consumer representative and asked if this variable captures something that is important in distinguishing quality of care.
- A member suggested using the CMS Meaningful Measures definition to have a common understanding of the term meaningful. Another supported this idea.

Recommendations from the TEP related to the variable of *Meaningful to Patients and Clinicians* for the team to consider were to create two distinct variables, *Meaningful to Patients* and *Meaningful to Clinicians*; change “health” to “health care” in the operational definition; stratify responses to the variable to better ascertain the measure’s impact; and incorporate the CMS Meaningful Measures definition of “meaningful” to create a common understanding of the term.

### *Reach of Measure*

Dr. Campbell provided an example using the national prevalence of diabetes to extrapolate how many physicians would have an adequate number of patients to report a measure on diabetes. A measure's reach could be important to CMS to assess how many physicians can report the measure and how many patients are being impacted.

- A member suggested structuring the variable to assess the impact of a group of clinicians first and then at the individual clinician level.
- Another member asked about unintended consequences with this concept, such as perhaps encouraging measurement in areas that are already saturated with measures.
- A member asked whether the *Reach of the Measure* variable looks at attribution or risk adjustment, noting that attribution does come into play when reporting at the Tax Identification Number (TIN) or the individual physician level. The data may not be the same as for the overall number of patients impacted by a given clinician.
  - Dr. Campbell responded that attribution would be what percentage of providers a measure would be feasible for or applicable to and said that no risk adjustment was intended to be captured in *Reach of Measure*.

### *Clinical Significance*

Dr. Campbell presented two existing QMI variables that could assess clinical significance: *Evidence-Based*, which categorizes the level of evidence and the extent to which the measure's benefits outweigh undesirable effects, and *Measure Performance*, which is the relative distance between the mean performance score and the performance benchmark, indicating room for improvement. Dr. Campbell reminded the panel to consider the clinical significance variable at the population level.

- A member stated that the variable may not need the evidence as it relates both to a top volume/cost condition or procedure and to a top volume/condition within a specialty. Measuring within a specialty might miss patients in primary care, and splitting the variable will not give a full picture of conditions and where they exist.
- A member noted the way clinical significance is defined could also be a characteristic of the *Reach of the Measure* variable.
- In response to Dr. Campbell's original question about the definition of the variable, a member suggested to remove volume from the definition and focus on cost variable assessment.
  - In response, another member suggested a focus on affordability versus cost.

Dr. Campbell recapped the main takeaways from this discussion: suggestions to combine this variable with reach and look more at affordability.

### *Value of Health Outcomes*

Dr. Campbell gave a brief overview of a quality adjusted life years (QALYs), a summary measure of disease burden that considers the quantity and quality of life lived, often used in economic evaluations of medical interventions.

- A member noted that this variable focused on QALYs and the *Meaningful to Patients and Clinicians* variable concepts may have a lot of crossover.
  - Dr. Campbell noted that QALY would be a more robust analysis but more difficult to assess methodologically.
- A member stated that measurement of QALY requires time, money, and effort and may be too costly for quality measurement.
  - Another member noted that QALYs are aspirational and “in a perfect world” could be reliably estimated, but the evidence in the published literature is not great.
  - A third member agreed with the prior statements, adding that a QALY is where we want to be but there is unlikely to be information we can collect.
- A member noted that the QALY comes up short for people with disabilities. A valued health treatment may help improve their lives greatly but would be unlikely to improve a QALY score much. A concern was noted that this may not be appropriate for patients.
- Another member suggested that QALYs could be a subset of outcomes, as there are many measures for which QALY data are not available. This member agreed with the concept, but was unsure how to apply it unless there is an analysis of intervention versus no intervention.
- A chat message from a member stated that QALYs seem out of reach, but the member advised further discussion of QALYs and what would be needed to incorporate them in quality measurement.

Dr. Campbell summarized that *Meaningful to Patients and Clinicians* is more feasible than assessing QALYs, which may not capture all types of patients.

#### *Potential Return on Investment*

Dr. Campbell said *Return on Investment* is typically used to evaluate the efficiency of an investment—in this case, as it applies to measure development and implementation. He noted that control of chronic disease processes can lead to lower complication rates and a decrease in overall cost of care.

- A TEP member noted that since we are already capturing cost related to a condition, could this concept assess the cost incurred in measure development?
- A member noted that ROIs can be complicated and commented that death can be considered cost savings. Broader implications of ROI are complex and needs to be assessed measure by measure, program by program.
- In response, another member noted that ROI informs profitability and discouraged including it in the index. ROI is different from measurement of cost and may not be appropriate.

Overall, TEP members expressed concerns with the implications of assessing a measure’s predicted return on investment because it is complicated and could have broader unintended implications. Members suggested changing the variable name to capture the cost incurred in measure development.

## Weighting Considerations

**Presenter: Rob Ziembra, PhD, MPH, HSAG**

Dr. Ziembra reviewed the results of the June 2019 TEP meeting, when a majority of TEP members recommended to weight the index by multiple domains. Two questions remained after the June 2019 vote: Is *NQF Endorsement Status* a key measurement domain? And are the key domains equally important?

After receiving CMS suggestions similar to prior TEP feedback, the team recommended to reclassify the *NQF Endorsement Status* variable from a scoring variable to a classification variable. Dr. Ziembra explained that with this modification, measure scores could be stratified by *NQF Endorsement Status*, and a measure would no longer be penalized for the inability to obtain endorsement or having endorsement removed. The reclassification also acknowledges that for various reasons, not all quality measures undergo NQF endorsement review.

In June 2019, the TEP voted in support of domain weighting, reflective of the measure evaluation criteria outlined in the CMS Measure Management System Blueprint,<sup>2</sup> with the caveat of revising the domain definitions. Addressing a concern expressed in June about overemphasizing a single variable in the index, the team recommended combining the conceptually related domains of *Feasibility* and *Usability* (Figure 1). Lastly, Dr. Ziembra presented the team’s recommendation to proceed with equal domain weighting, as it allows for variation in priorities over time without requiring further expert input.

**Figure 1. Domain Weighting**



### TEP Comments and Feedback

#### **Key Discussion Themes:**

- TEP members were responsive and approved the recommended methodology to reclassify the *NQF Endorsement* variable as a classification variable
- The TEP recommended equal domain weighting in the index using the three domains of Importance, Feasibility and Usability, and Scientific Acceptability.

#### *NQF Endorsement Recommendation*

- A member stated he would “100% agree with this recommendation” to reclassify *NQF Endorsement* from a scoring variable to a classification variable and mentioned it would be

<sup>2</sup> Centers for Medicare & Medicaid Services. Blueprint for the CMS Measures Management System Version 15.0. Baltimore, MD: US Department of Health and Human Services; 2019. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf>. Accessed January 7, 2020.

“great” to be able to distinguish between two similar measures. He further stated that leaving NQF out of the QMI [scoring variables] provides flexibility to get more relevant measures for subspecialties.

- Another member said, “Thank you. You heard us, and this is a great solution.”

A TEP co-chair proposed to proceed with voting to convert the *NQF Endorsement Status* scoring variable to a classification variable.

### **Voting Results:**

21 TEP members recommended to convert *NQF Endorsement Status* to a classification variable; 1 member abstained.

### *Domain Weighting – Combining Feasibility and Usability into a Single Domain*

- Two TEP members asked for clarification on how the *Shared Accountability* variable, included within the Feasibility and Usability domain, was specified and measured in the QMI.
- Ms. Lockwood explained that *Shared Accountability* is defined as the number of levels of analysis specified for the measure.
- One TEP member noted that the *Shared Accountability* variable may put at risk certain measure types, such as hybrid measures or patient-reported outcome measures (PROMs), because they are harder to develop and have less data available.
  - In response, Dr. Campbell mentioned that *Measure Type* is a classification variable that allows for stratification.
  - Dr. Ziemba said that if the Usability and Feasibility domains are combined, PROMs will be favored because the *Shared Accountability* variable will no longer be a single-variable domain.
  - Two TEP members said the point of shared accountability is not that a measure could be used across levels, but that accountability would be across settings and programs. The members agreed that it was the label *Shared Accountability* that they were struggling with.
  - If a measure does not cross all settings but can be specified at multiple levels, such as health plan, facility, and clinician, that might suggest to CMS that the measure has increased value to drive quality improvement in an area, Dr. Campbell said.
- Dr. Campbell asked whether there were there strong concerns about the three proposed domains: Importance, Feasibility and Usability, and Scientific Acceptability. He stated that the QMI has the flexibility to weight the domains differently and that all variables within a domain would receive equal weighting.
- Dr. Campbell summarized the TEP’s recommendations to rename the variable *Shared Accountability* but to keep the operational definition. Also, the TEP recommended to combine the Usability and Feasibility domains, noting that variables may be updated in the future.

- A TEP member stated, “Equal weighting of the domains makes me feel better about combining the domains of Usability and Feasibility, as they appropriately balance one another.”
- The HSAG team will consider alternatives to the variable name, *Shared Accountability*, and will present these options to the TEP at a future meeting.

The TEP co-chair proposed to proceed to vote on combining the Feasibility and Usability domains and the recommendation for equal weighting among the three domains.

**Voting Results:**

20 TEP members recommended equal weighting of the three domains presented: Importance, Scientific Acceptability, and Feasibility and Usability; 1 member did not submit a vote.

**2019 Environmental Scan and Empirical Analysis**

**Presenter: Carolyn Lockwood, MSN, RN, HSAG**

Ms. Lockwood explained the objectives of the 2019 QMI Environmental Scan and Empirical Analysis: to ensure that existing QMI variables remain relevant, to identify new variables applicable to measures in development, and to evaluate the feasibility of existing, previously specified, and newly specified variables at each phase of measure development. Ms. Lockwood discussed the methods of the environmental scan and presented results: refinements for two existing scoring variables and the identification of three new scoring variables and a new classification variable.

Ms. Lockwood described the operational definitions and feasibility assessments for two refined variables and four new variables (Tables 2 and 3). She asked the TEP members to provide feedback via email by 12/13/19 and noted that they would receive the QMI Environmental Scan and Empirical Analysis summary for reference.

**Table 2. Proposed Refined Definitions for Scoring Variables**

Variable	Proposed Operational Definition	Feasibility Assessment
<i>Evidence-Based</i>	Evidence represents the latest guidance and is not out of date (Y/N)	<p><b>Moderate</b></p> <ul style="list-style-type: none"> <li>● Unclear how to define “out of date” objectively</li> <li>● Data about when a review of literature was completed are typically available</li> </ul>
<i>Risk Adjustment</i>	Measure adjusts for social determinants of health (Y/N)	<p><b>Low</b></p> <ul style="list-style-type: none"> <li>● Unclear how to define appropriate adjustment objectively</li> <li>● Data about risk adjustment for social determinants not widely available</li> </ul>

**Table 3. New Scoring Variables**

Variable	Proposed Operational Definition	Feasibility Assessment
<i>Accountability/ Attribution</i>	Measure is attributed to the provider that can affect (is accountable for) the care process or outcome specified in the measure	<b>Low</b> <ul style="list-style-type: none"> <li>Variable is not precisely defined</li> <li>Data are not readily available</li> </ul>
<i>Applicability for Quality Improvement Activity</i>	Measure can be used to support a quality improvement activity defined under the Merit-based Incentive Payment System (MIPS)	<b>Moderate</b> <ul style="list-style-type: none"> <li>Variable is clearly defined</li> <li>Data are not readily available; no direct mapping to activities is being done</li> </ul>
<i>Culturally Appropriate</i>	Measure is culturally appropriate such that it allows for incorporation of patient values, traditions, and behavior	<b>Low</b> <ul style="list-style-type: none"> <li>Variable is not precisely defined</li> <li>Data are not readily available; means of collection is undetermined</li> </ul>

**TEP Comments and Feedback**

**Key Discussion Theme:**

- TEP members agreed with the feasibility analysis of two refined scoring variables and four new variables identified the 2019 QMI Environmental Scan and Empirical Analysis.

The following feedback was provided post-meeting from seven of the 21 TEP members regarding the feasibility assessment of refined and newly identified variables:

*Evidence-Based:*

- Members agreed with the *Evidence-Based* variable’s operational definition and feasibility rating. Comments were largely in response to how to define “out of date.” Suggestions were to add a time frame of 10–15 years with exceptions for landmark studies, to add annual reevaluations and maintenance activities, and to frame the variable as aligned with current guidelines. To ensure relevance, one member proposed an alternate definition to the operational definition—that a literature review has been completed in the last 12 months.

*Risk Adjustment:*

- Four TEP members provided detailed feedback to refine the *Risk Adjustment* variable. Suggestions ranged from adjusting for social risk factors instead of social determinants of health; not to limit to adjustments, but rather to include “accounts for social risk”; and to change the variable name to *Risk Assessment* instead of *Risk Adjustment*. One comment suggested keeping this as a classification variable to avoid implementation consequences.

*Accountability/Attribution:*

- Members agreed with the operational definition and feasibility assessment for *Accountability/ Attribution*. One comment agreed that multiple providers can impact measure results and that shared accountability is a common theme among stakeholders.

#### *Applicability of Quality Improvement:*

- Two members agreed that the feasibility rating for *Quality Improvement* should improve over time as CMS continues to refine quality improvement domains and measures in the MIPS Value Pathways (MVPs).

#### *Culturally Appropriate:*

- Respondents agreed that the variable is central to building patient-clinician trust and meeting patients' needs but acknowledge challenge of feasibility of this variable, which one member characterized as aspirational.

#### *New Variable Concepts:*

- A member suggested bringing back the crosscutting measure and reporting burden variables from previous QMI work. Another member suggested a variable for social determinants of equity for future consideration.

## Next Steps

### **Presenter: Carolyn Lockwood, MSN, RN, HSAG**

Ms. Lockwood stated the team's next steps would be to incorporate TEP and CMS feedback and continue to evaluate variables for inclusion and refinement to strengthen the QMI. The project will begin testing the 16 highly feasible variables with measures in development, newly developed, or under consideration for a CMS quality reporting program.

The next TEP meeting, in May 2020, will focus on the MDP environmental scan and gap analysis of population health measures. A QMI workgroup meeting is also planned for 2020.

## Post-Meeting Notes and Recommendations

- A TEP member who was unable to attend the meeting emailed feedback on the proposed *Meaningful for Patients and Clinicians* variable. The member recommended separating the variable and noted that while improving health is not always possible, improvements in a patient's care process in the face of chronic and progressive disease may be an important factor to patients.
- A second TEP member emailed a recommendation to place the *Value of Health Outcomes* variable under *Meaningful to Patients and Clinicians* as a subcategory.
- Another member acknowledged a philosophical value in trying to add variables related to impact but stated that the feasibility of collecting and assessing them across a group of measures would be very low. The member suggested that the one with the greatest feasibility would be *Reach of the Measure*, particularly the prevalence of a condition.
- A fourth TEP member emailed feedback on the *Impact* variable and Weighting Considerations section of the presentation.
  - *Impact Variable*
    - *Meaningful to Patient and Clinician* – The TEP member felt that PROMs support things that are meaningful to patients. As another option, the team could consider whether patients were included in the measure development

- process, such as on a TEP. However, meaningfulness is negated if the data are not available to the patient.
- *Reach of Measure* – The member agreed with the addition of this variable and stated that it also aligns with the number of patients impacted (prevalence of condition) and could directly correlate to the usefulness of data by the patient. However, it was emphasized that to provide value to patients, the data must be made accessible through public reporting or other means.
  - *Clinical Significance* – The member agreed with fellow members’ comments that tying cost to volume may not be appropriate for the QMI and may be challenging to collect if a measure is filling an identified gap area or condition.
  - *Value of Health Outcomes* – The member agreed with previous comments on the variable by the group. Also, the member felt that QALY may be challenging to collect and may not accurately measure patients with chronic or terminal illnesses. Based on the name of the proposed variable, the member noted that PROMs and outcome measures should meet the criteria for this variable but would advise not limiting it to QALY.
  - *Predicted Return on Investment* – The TEP member felt that this variable would be challenging to collect. Discussed that from a patient perspective, the impact of a condition or disease may have costs and financial implications that are not represented in this calculation. They felt that from a patient perspective, this variable provided limited benefit.
  - Weighting considerations – The member supported equal domain weighting and combining Feasibility and Usability. Also, they supported the recommendation made on the call to rename the variable *Shared Accountability*. The member suggested renaming the variable to “something that would relay that the measure has applicability across care settings.”



## APPENDIX A – TEP AGENDA

### Technical Expert Panel Meeting December 11, 2019, 3:00 p.m. to 5:00 p.m. ET

Agenda		
3:00–3:05 p.m.	Welcome and Opening Remarks	Kendra Hanley, MS, HSAG
3:05–3:15 p.m.	TEP Roll Call and Disclosures of Conflict of Interest	Amy Mullins, MD, CPE, FAAFP, American Academy of Family Physicians Michael Phelan, MD, JD, FACEP, RDMS, CQM Cleveland Clinic Health Systems (Co-Chairs)
3:15–3:25 p.m.	Quality Measure Index (QMI) Overview and Update	Carolyn Lockwood, MSN, RN HSAG
3:25–3:55 p.m.	Exploration of New QMI Variables	Kyle Campbell, PharmD HSAG
3:55–4:25 p.m.	Weighting Considerations	Rob Ziemba, PhD, MPH HSAG
4:25–4:50 p.m.	2019 Environmental Scan and Empirical Analysis	Carolyn Lockwood, MSN, RN HSAG
4:50–5:00 p.m.	Next Steps/Closing	Carolyn Lockwood, MSN, RN HSAG