We will begin shortly.
The CMS Universal Foundation to Align Quality Measures: What It Means for You

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July 14, 2023
The Universal Foundation
Aligning Quality Measures Across CMS

Michelle Schreiber, MD
Center for Medicare & Medicaid Services
Deputy Director of Quality, Center for Clinical Standards and Quality
Director, Quality Measurement and Value-based Incentives Group
Where we are now

- CMS runs over twenty different quality programs, including programs for individual clinicians, hospitals, SNFs, health insurance plans, and various value-based arrangements, each with different statutory authorities.
- CMS uses over 500 quality measures for quality reporting and performance evaluation.
- Quality measures used in different value-based care and quality reporting programs are not always aligned. As a result:
  - It is difficult to make quality and equity comparisons across programs and settings.
  - Provider attention is not focused on the most meaningful measures.
  - The complexity of reporting requirements contributes to provider burden.
- There is inherent tension between incorporating measures that capture important aspects of quality in our health care system and developing a streamlined set of measures to drive quality improvement.
- CMS convened the National Quality Strategy Quality Working Group (QWG), overseen by an Executive Steering Committee (CCSQ, CM, CMCS, CMMI, CCIIO, OMH, MMCO, OBRHI), to figure out a path forward.
Mission and Vision of the CMS National Quality Strategy

Mission
To achieve optimal health and well-being for all individuals.

Vision
CMS, a trusted partner, is shaping a resilient, high-value American health care system that delivers high-quality, safe, and equitable care for all.
CMS National Quality Strategy Goals

The Eight Goals of the CMS National Quality Strategy are Organized into Four Priority Areas:

**Equity**
Advance health equity and whole-person care

**Engagement**
Engage individuals and communities to become partners in their care

**Safety**
Achieve zero preventable harm

**Resiliency**
Enable a responsive and resilient health care system to improve quality

**Outcomes**
Improve quality and health outcomes across the care journey

**Alignment**
Align and coordinate across programs and care settings

**Interoperability**
Accelerate and support the transition to a digital and data-driven health care system

**Scientific Advancement**
Transform health care using science, analytics, and technology
The Universal Foundation

Overview

CMS is introducing a “Universal Foundation” of quality measures to advance the overall vision of the National Quality Strategy and increase alignment across CMS quality programs.

The preliminary adult and pediatric measures were announced in a NEJM article published in February.

❖ Additional measures for specific settings or populations will be identified as “add-ons” that can be implemented consistently across programs. These add-ons may include:

- Maternal
- Hospital
- Specialty (MIPS Value Pathways)
- Post-acute Care
- Long-term Care
The Universal Foundation of quality measures will:

- **Improve health outcomes** by focusing provider attention on high-priority areas and measures that are:
  - Meaningful
  - Broadly applicable
  - Digitally reported
  - Capable of being stratified to identify and track disparities

- **Reduce provider burden** by streamlining and aligning measures across programs

- **Improve standardization** of measurement (e.g., stratification for equity)

- **Promote interoperability** by prioritizing measures for transition to interoperable digital data
Selection Criteria

- The measure is of a high national impact
- The measure can be benchmarked nationally and globally
- The measure is applicable to multiple populations and settings
- The measure is appropriate for stratification to identify disparity gaps
- The measure has scientific acceptability
- The measure is feasible and computable (or capable of becoming digital)
- The measure has no unintended consequences

These measures will be used across CMS quality programs and are prioritized for stratification and digitization. CMMI retains the role to test new and innovative measures.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Identification Number and Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness and prevention</strong></td>
<td>139: Colorectal cancer screening&lt;br&gt;93: Breast cancer screening&lt;br&gt;26: Adult immunization status</td>
</tr>
<tr>
<td><strong>Chronic conditions</strong></td>
<td>167: Controlling high blood pressure&lt;br&gt;204: Hemoglobin A1c poor control (&gt;9%)</td>
</tr>
<tr>
<td><strong>Behavioral health</strong></td>
<td>672: Screening for depression and follow-up plan&lt;br&gt;394: Initiation and engagement of substance use disorder treatment</td>
</tr>
<tr>
<td><strong>Seamless care coordination</strong></td>
<td>561 or 44: Plan all-cause readmissions or all-cause hospital readmissions</td>
</tr>
<tr>
<td><strong>Person-centered care</strong></td>
<td>158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures (CAHPS)</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>Identification number undetermined: Screening for social drivers of health</td>
</tr>
</tbody>
</table>

Domains are from [Meaningful Measures 2.0](https://www.cms.gov/mqm)
Names and identification numbers are from the [CMS Measures Inventory Tool](https://www.cms.gov)
<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Identification Number and Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness and prevention</strong></td>
<td>761 and 123: Well-child visits (well-child visits in the first 30 months of life; child and adolescent well-care visits)</td>
</tr>
<tr>
<td></td>
<td>124 and 363: Immunization (childhood immunization status; immunizations for adolescents)</td>
</tr>
<tr>
<td></td>
<td>760: Weight assessment and counseling for nutrition and physical activity for children and adolescents</td>
</tr>
<tr>
<td></td>
<td>897: Oral evaluation, dental services</td>
</tr>
<tr>
<td><strong>Chronic conditions</strong></td>
<td>80: Asthma medication ratio (reflects appropriate medication management of asthma)</td>
</tr>
<tr>
<td></td>
<td>672: Screening for depression and follow-up plan</td>
</tr>
<tr>
<td></td>
<td>268: Follow-up after hospitalization for mental illness</td>
</tr>
<tr>
<td><strong>Behavioral health</strong></td>
<td>264: Follow-up after emergency department visit for substance use</td>
</tr>
<tr>
<td></td>
<td>743: Use of first-line psychosocial care for children and adolescents on antipsychotics</td>
</tr>
<tr>
<td></td>
<td>271: Follow-up care for children prescribed attention deficit-hyperactivity disorder medicine</td>
</tr>
<tr>
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The Universal Foundation

Measures for The Future That Might Require Development

Adult measures
- Well-being measure
- Diabetes composite measure
- Safety-focused measure
- Tobacco cessation measure

Pediatric measures
- Contraception measure
Universal Foundation
Aligning Quality Measures across CMS – the Universal Foundation, NEJM article
Aligning Quality Measures across CMS – the Universal Foundation, website

CMS NQS Additional Information
The CMS National Quality Strategy: A Person-Centered Approach to Improving Quality, blog post
CMS National Quality Strategy Fact Sheet, PDF

CMS NQS Website
CMS National Quality Strategy Website
We need your input to succeed.

CMS needs the collaboration and concentrated efforts of partners like you to continue to advance the goals of the NQS. Your input is critical to help us forge a high-quality health care system that is impactful to all individuals, families, providers, and payers.

Send feedback to: QualityStrategy@cms.hhs.gov
Thank you!
Eric Schneider, MD, M.Sc.
EVP Quality Measurement and Research Group
NCQA
The Future of HEDIS: Digital Alignment to Achieve High Quality Health Care

EVP Quality Measurement and Research Group
NCQA

July 2023
70% of Preliminary Universal Foundation measures are HEDIS measures.

How can HEDIS help the Universal Foundation even more?
NCQA’s HEDIS Origins: In an Analog Health System Focus on Health Insurers

The Good…
- Focus on health outcomes and processes of care for populations
- Claims data are relatively standardized
- Large enough samples for statistical comparison

The Bad…
- Claims data limit the number meaningful measures
- Quality of care varies significantly among delivery organizations and clinicians
- Important areas for quality improvement not addressed

The Ugly…
- Little incentive to improve clinical data systems for quality

Broad brush: Low resolution snapshots
Traditional Reporting Methods for HEDIS

**Administrative Method**: Transaction Data  
*Enrollment, Claims, Encounter*

**Hybrid Method**: Administrative + Sample  
*Manual Medical Record Review*

**Survey Method**  
*CAHPS®, Medicare Health Outcomes Survey*
How Do We Get a Better Portrait of Quality?
Add Clinical Data

*the finer brushes and colors needed to produce a higher resolution portrait of quality*
NCQA recognized the need for a digital health data ecosystem long before the ecosystem emerged.

Essential features:

1. Data elements for measures
2. Linkage between elements and individuals’ records
3. Standardized data definitions
4. Automated (“computable”)
5. Data quality validation
6. Security and privacy
7. Data exchange protocols
That future is arriving

**Computing advances** that make complex analytics feasible

- Less expensive hardware
- New software capabilities
- Scalable, secure data exchange via the Internet
- Cloud computing
- CQL (Clinical Quality Language)

**Policy advances** that provide the tailwinds for implementation

- HITECH Act provides incentives to digitize clinical information (EHRs)
- ACA drives value-based care contracting
- FHIR data standards for health data exchange
- Regulations create incentives for data exchange via Application Programming Interfaces (APIs)

**Administrative Method**: Transaction Data
- Enrollment, Claims, Encounter

**Hybrid Method**: Administrative + Sample
- Manual Medical Record Review

**Survey Method**
- CAHPS®, Medicare Health Outcomes Survey

**Electronic Clinical Data Systems Method**
- Enrollment, Claims, Encounter, EHRs, HIEs, Registries, Case Management

Guidelines for collecting and reporting structured electronic data for purposes of HEDIS measurement
ECDS, dQMs, eCQMs

Related but not synonymous

• ECDS
  • a reporting standard that describes the digital data sources allowed when reporting a HEDIS measure
  • intended to encourage electronic exchange of clinical data (but does not require it)
  • can include dQMs

• dQM
  • computer interpretable, fully specified, standards-based (i.e., CQL-FHIR) measure content
  • agnostic to data source and data model if elements properly mapped to required data standards (FHIR, CARIN Blue Button)

• eCQM
  • CMS-defined digital measures derived from EHR only (Quality Data Model and/or FHIR)
NCQA is converting current HEDIS measures to digital…
Future measures: Person-focused, relevant points of care, broader range of organizations

Traditional focus of measure development (plans and clinical services)
Future State: Person-Centered Measurement

Toward a Meaningful High-Value Measurement Enterprise

Current HEDIS Description

- The percentage of women 52–74 years of age who have been enrolled in a health plan for at least two years and who have had a mammogram to screen for breast cancer every other year.

  - Does not account for higher patient risk profile
  - Does not include women who recently changed plans
  - Does not account for patient preferences
  - Does not consider the significance of positive or negative findings

Future HEDIS Measure Description

- A woman …

  …is she receiving care that matches individualized clinical risks, preferences & social needs?

  - If risk is higher based on genetic or other data, is she receiving MRI every 6 months instead of mammogram every 2 years?
  - What is her experience of access, timeliness, coordination and outcomes of care?
Future State: Quality Content Rooted in Measurement

Focus on person-centered measures (health outcomes, care processes) and measures sensitive to the impact of population and community level interventions

Define populations based on individualized health journeys within Chapters (life stage) and Episodes (well, acute, chronic, multi-morbidity, palliative, etc.)

Develop quality content focused on access, timeliness, and appropriateness of services (behavioral health, equity, diabetes, primary care services)

Develop standards-related content based on effective use of operational and management processes that improve quality, enhance equity, and increase access

Develop quality content that fosters and strengthens the health data exchange ecosystem
Danielle A. Lloyd
SVP, Private Market Innovations & Quality Initiatives
AHIP
About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Visit www.ahip.org to learn how working together, we are Guiding Greater Health.
The Need Part 1

Medicare Advantage Stars
Skilled Nursing Facility QRP
Qualified Health Plan Quality Rating System

MIPS
Medicaid Child Core Set
Medicaid Quality Rating System
Hospital IQR

Home Health QRP
MSSP
Hospital OQR
Medicaid Adult Core Set
The Need Part 2
The Need Part 3

Government

Private Sector
AHIP Quality Efforts

• Strive to improve the affordability, quality, equity, patient and provider experience of care.
  – Value-based care (VBC) and payment arrangements hold promise to achieve quintuple aim.
  – Quality measurement is the essential underpinning of the transition of to VBC.

• Leverage quality measurement to inform VBC and incentives to drive change.
  – Support aligned quality measurement to have a greater impact
  – Play a unique role in the measurement enterprise as both measured entities and measurers.

• Undertake work to ensure the success of quality measurement and VBC such as:
  – Promote performance measure alignment through the Core Quality Measures Collaborative
  – Build consensus with physicians on measuring and benchmarking appropriate use through our Appropriateness Measures Project
  – Providing guidance on measurement science through participation in the National Quality Forum’ work on risk adjustment for social factors and aggregating individual measures into accurate and actionable measurement systems.
  – Drive measurement to promote equity by developing a core set of equity measures for use in VBC arrangements
  – Developing modernized patient and provider demographic data content standards
CQMC Goals

- **Align** measures across public & private payers
- **Identify** high-value, high-impact, evidence-based measures
- **Improve** health outcomes
- **Reduce** the burden of measurement
- **Provide** consumers with actionable information
Current CQMC Core Sets

ACO/PCMHP/PC  Gastroenterology  Cardiology  Orthopedics
Obstetrics & Gynecology  Medical Oncology  HIV & Hep C  Pediatrics
Behavioral Health  Neurology

https://p4qm.org/CQMC/core-sets

Not updated in 2022
Implementation

Identify barriers and solutions to uptake and implementation of core set measures. Develop an implementation guide to facilitate use of the core measure sets in VBC arrangements.

Health Equity

Define opportunities to align proactively on equity measures and measurement methods.

Digital Measurement

Enable measure-driven prioritization of data standards.

Measure Model Alignment

Explore a model for centralizing components of measurement (e.g., data collection and calculation, dashboards).

Cross-Cutting

Identify measures relevant to multiple settings and specialties.
Alignment with the Universal Foundation

• **Seven out of ten measures** in the Adult Universal Foundation are in the CQMC Core Measure Sets. Not included in a CQMC Core Measure Set are:
  – Adult immunization status
  – Initiation and engagement of substance use disorder treatment
  – Screening for social drivers of health

• **Seven out of thirteen measures** in the Pediatric Universal Foundation are in the CQMC Core Measure Set. Not included are:
  – Well-child visits in the first 30 months of life
  – Oral evaluation, dental services
  – Follow-up after hospitalization for mental illness
  – Follow-up after emergency department visit for substance use
  – Use of first-line psychosocial care for children and adolescents on antipsychotics
AHIP Impressions

- Support focus on health promotion and the goal of creating shared accountability for improving health
- Breaks down traditional silos within agency
- Might help break down silos across agencies
- Significant overlap with the CQMC
- Alignment not uniformity
- Starting with low hanging fruit
- Many are long-standing HEDIS measures
- Appreciate the effort to align plans and providers
- Many measures are not tested at the facility or clinician level
- Agree with emphasis on behavioral health
- Next step should be to focus on gaps in sets
- Later step is to focus on gaps in measures
- Ongoing partnership is key
A Decade in the Making

PROPOSED STRATEGY FOR EXECUTION OF THE
HEALTH INFORMATION TECHNOLOGY INVESTMENT PROGRAM

Draft, February 24, 2009

EXECUTIVE SUMMARY

The $19 billion health information technology (HIT) investment authorized in the American Recovery and Reinvestment Act (ARRA) represents a landmark opportunity to improve health care. In considering how best to execute on this opportunity, it is critical to understand that to treat the HIT investment program as a pure technology implementation program is to effectively guarantee its failure. HIT is not magic. In the absence of provider payment reform and care delivery innovation, it is all too easy to imagine spending $19 billion on HIT adoption and producing little tangible social benefit. However, there is a clear path to victory:

- If we avoid focusing the HIT investment program narrowly on HIT adoption and instead focus it explicitly on the actual improvement of population health, and
- If we use the HIT investment to catalyze a “virtuous cycle” of (1) provider payment reform, (2) care delivery innovation, and (3) HIT adoption
- Then: the HIT investment can literally transform health care as we know it.

Source: https://obamawhitehouse.archives.gov/the-press-office/2016/02/25/fact-sheet-obama-administration-announces-key-actions-accelerate;

1. Consumer (Application Access) Rights to Health Data, Prices, Quality
2. Clinician (Application Access) Rights to EHR, Hospital ADT, Longitudinal Data
3. Partner (Application Access) to Certified Data Elements

"...consumers have access to their own health data – and to the applications and services that can safely and accurately analyze it..." – President Obama (January 2015)
The Need for Real World Testing

Cures Act EHRs must certify & provide all three CURES Act APIs (consumer, physician, population “bulk”)

CMS IP Rule physician fee schedule (final) Providers must adopt the 2015 Cures Update edition for an EHR reporting period in CY 2023

December 31, 2022

September 2023

Cures Act (EHR Certification)

Provider Adoption (Cures Update)

December 31, 2022

September 30, 2023

Certified Health IT Product List

267

Certifications

• for §170.315(g)(10) for standardized APIs for patient and population services
  • 250+ unique products across 200+ developers certified as of 4/14/23
  • Approximately 30.3% of certifications “relied upon” vendor software to meet the requirement

New coalition to spur wider Bulk FHIR use launches at HIMSS23

Healthcare organizations including ONC, Advocate Health, Mt. Sinai, Tufts Medicine, UC Davis Health and the VA are participating, and will share implementation tips and best practices to enable broader adoption of the interoperability standard.

Building TEFCA
Micky Tripathi and Mariann Yeager, CEO, The Sequoia Project (the TEF Entity) | FEBRUARY 13, 2023

Stage 2
Network-Facilitated FHIR Exchange

✓ QHIN-facilitated FHIR-based exchange available as an option under TEFCA.
Cancer Moonshot “First Out of the Gate”

Table 3: EOM CDE Names by Reporting Option

<table>
<thead>
<tr>
<th>HDR Excel Template Data Element Name</th>
<th>HL7 FHIR-Based API Data Element Name (mCODE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 Diagnosis Code</td>
<td>Primary (Initial) Cancer Condition</td>
</tr>
<tr>
<td>Initial Date of Diagnosis</td>
<td>Primary (Initial) Cancer Diagnosis Date</td>
</tr>
<tr>
<td>Patient Deceased</td>
<td>Patient Deceased</td>
</tr>
<tr>
<td>Date Patient Died</td>
<td>Date Patient Died</td>
</tr>
<tr>
<td>Recurrence/Relapse Clinical Status</td>
<td>Condition Clinical Status</td>
</tr>
<tr>
<td>Current Clinical Status Trend</td>
<td>Current Cancer Condition's Trend</td>
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<tr>
<td>Current Cancer Observation Status</td>
<td>Current Cancer Observation Status</td>
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<tr>
<td>Current or History of Metastatic Disease*</td>
<td>Not Available</td>
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<tr>
<td>Current Clinical Status Date</td>
<td>Cancer Disease Status Observation Effective Date</td>
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<td>Primary Tumor (T) Stage</td>
<td>Primary Tumor Staging Observation</td>
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<td>Primary Tumor Staging Observation - AJCC</td>
<td>Primary Tumor Staging Observation - AJCC</td>
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<tr>
<td>Primary Tumor Staging Observation Status</td>
<td>Primary Tumor Staging Observation Status</td>
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<tr>
<td>Nodal Disease (N) Stage</td>
<td>Nodal Disease Observation</td>
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<td>Nodal Disease Observation - AJCC</td>
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<td>Nodal Disease Observation Status</td>
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<td>Metastasis (M) Stage</td>
<td>Distant Metastases Observation</td>
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<td>Distant Metastases Observation - AJCC</td>
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<td>Distant Metastases Observation Status</td>
<td>Distant Metastases Observation Status</td>
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<td>Estrogen Receptor (ER) Test Result</td>
<td>Tumor Marker - Estrogen Receptor Observation Status</td>
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<td>Tumor Marker - Estrogen Receptor Observation Value</td>
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<td>Tumor Marker – Estrogen Receptor Observation Value</td>
<td>Tumor Marker - Estrogen Receptor Observation Status</td>
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<tr>
<td>Tumor Marker - Progesterone Receptor Observation Status</td>
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</tbody>
</table>
Questions
Thank you