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

CMS Quality Measure Index (QMI) Technical Expert Panel (TEP) Meeting Summary

Meeting Date: March 23, 2023

Submitted: April 4, 2023

To: Nidhi Singh-Shah, MPH, QMI Project Lead
7501 Wisconsin Ave., Mail Stop 8-008
Bethesda, MD 20814-6519
Nidhi.singh-shah@cms.hhs.gov

Michelle King, MASS, BS, Contracting Officer's Representative (COR) III
Health Insurance Specialist
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard, Mail Stop S3-02-01
Baltimore, MD 21244-1850
Michelle.King@cms.hhs.gov

HSAG HEALTH SERVICES ADVISORY GROUP

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Executive Summary

- **QMI Refinements: Overview of QMI Tool Version 2.0**
  - HSAG described high-level proposed changes in QMI tool version 2.0, including revisions to the scoring category interpretations and to the Yellow category variable score.
  - TEP members agreed with the proposed revised interpretations for the QMI categories and confirmed these revisions aligned with discussions from the September 2022 workgroup meeting.
- **QMI Refinements: Agency High Priority Domain**
  - HSAG staff proposed a new Agency High Priority domain for QMI tool version 2.0, containing three variables: *Measure Focus*, *Digital Data Source,* and *Preferred Measure Type*. HSAG staff described how this the new domain would impact overall QMI scores.
  - TEP members agreed with creating a new domain for Agency High Priority and expressed concern about the ability to distinguish the contribution of the Agency High Priority domain on the overall QMI score from the contributions of the other domains which reflect other key criteria for quality measurement. The HSAG team responded that the QMI tool is intended to show a measure's strengths and weaknesses, and CMS will be able to view detailed measure scoring information and distinguish Agency High Priority scores from other domain scores.
- **QMI Refinements: Importance Domain**
  - HSAG presented the proposed changes in the Importance domain and described a new variable for this domain, *Patient Engagement*.
  - HSAG asked the TEP members for recommendations for acceptable outcome thresholds for the assessment of the concept, "Meaningful to patients," and if there should be a threshold for the minimum number of patients who provide input.
  - TEP members acknowledged issues with the way patient engagement is currently measured, which does not capture the quality of patient involvement, but recognized the limitations of the QMI tool in being able to comprehensively assess this.
- **QMI Refinements: Scientific Acceptability Domain**
  - HSAG presented the proposed changes for the Scientific Acceptability domain for the QMI tool version 2.0, including two revised variables, *Measure Score Reliability* and *Validity*.
  - TEP members generally agreed with the new approach for *Validity*, including having risk adjustment included as a component of *Validity* rather than as a standalone variable.
- **QMI Refinements: Feasibility Domain**
  - HSAG presented the proposed changes for the Feasibility domain for the QMI tool version 2.0, which included a minor revision to the *Feasibility of Data Elements* variable name and inclusion of a new variable, *Provider Burden (Impact on workflow)*.
  - HSAG asked the TEP for feedback regarding quantifying provider burden using a standardized method.
  - TEP members expressed concerns, including that this variable may disincentivize development of patient-reported outcome performance measures (PRO-PMs) or measures directly related to the clinical care process. TEP members also suggested the variable assess whether a measure imposes any additional burden on the provider, noting clinician burnout. HSAG added the variable is intended to provide CMS with information about strengths and weaknesses of a measure.

Introduction

The Centers for Medicare & Medicaid Services (CMS) has contracted with Health Services Advisory Group, Inc. (HSAG, "the team") to develop the CMS Quality Measure Index (QMI) under Contract #75FCMC18D0026; Task Order #75FCMC19F0001. As part of this contract, HSAG convenes a CMS Measure Development Plan (MDP)/QMI technical expert panel (TEP) comprised of patients and family caregivers, clinicians, representatives of professional societies, consumer advocates, and quality measurement experts to provide multi-stakeholder input on project tasks and reports. A TEP meeting was held on March 23, 2023 to review and obtain feedback on proposed revisions to the QMI tool.

Meeting Proceedings

Opening Remarks and Objectives

Presenter: Julia Mackeprang, MPH, PMP; Project Lead, QMI

Ms. Mackeprang, QMI project lead, welcomed the TEP members. After reviewing meeting objectives and standard ground rules for the meeting, she reviewed the meeting agenda (slides 2-4).

TEP Roll Call and Conflict of Interest Disclosures

Presenter: Samantha Tierney, MPH; Senior Scientist, Clinical Policy, American College of Physicians; TEP Co-Chair

Ms. Tierney, TEP co-chair conducted roll call. Thirteen of 15 TEP members were in attendance**.**

TEP Members	CMS	HSAG
☒Mary Baliker	☒Kimberly Go	☒Kyle Campbell
☐Crystal Barter	☒Nina Heggs	☒Eric Clark
☒Heidi Bossley	☒Michelle King	☒Hayley Dykhoff
☐Zeeshan Butt	☒Melissa Gross	☒Mariana Grass
☒Catherine (Carey) Eppes	☒Helen Dollar-Maples	☒Eric Gilbertson
☒Nupur Gupta	☒Nidhi Singh Shah	☒Marie Hall
☒Amy Nguyen Howell	☒Marsha Smith	☒Susan Hemmingway
☒Shu-Xia Li	☒Mei Zhang	☒Megan Keenan
☒John Martin *(Co-Chair)*		☒Mia McFarland
☒Gregg Miller		☒Julia Mackeprang
☒Connie Montgomery		☒Michelle Pleasant
☒Sarah Hudson Scholle		☒Jamila Shields
☒Anita Somplasky		☒Taryn Vaught
☒Samantha Tierney *(Co-Chair)*		☒Rob Ziemba
☒Lindsey Wisham		

TEP members disclosed the following conflicts of interest:

- Carey Eppes disclosed she is a CMS grant recipient to improve outcomes for pregnant women with opioid use disorder in Texas.
- Gregg Miller noted he is a partner in Vituity, a medical group with two qualified clinical data registries.
- Sarah Scholle stated she has no conflicts of interests other than her involvement in some of the National Committee for Quality Assurance (NCQA) measures.
- Lindsey Wisham disclosed her employer, Telligen, holds CMS contracts.

QMI Project Status Updates

Julia Mackeprang, MPH, PMP; Project Lead, QMI

Ms. Mackeprang reviewed the purpose of the QMI tool and its current use during pre-rulemaking. She acknowledged attendees of the September 2022 TEP workgroup meeting and reviewed overall goals for QMI tool refinement (slides 9-11).

QMI Refinements: Overview of QMI Tool Version 2.0

Presenter: Julia Mackeprang, MPH, PMP; Project Lead, QMI

Ms. Mackeprang detailed proposed changes in QMI tool version 2.0 and reviewed how they differed from QMI tool version 1.1. These included modifications to the list of classification variables, a proposed new domain (Agency High Priority), and proposed revisions for scoring variables. Additionally, she reviewed a proposal to revise the Yellow scoring category for scoring variables, which applies to three of the 10 scoring variables in QMI tool version 2.0 (slides 13-19).

TEP comments

- A TEP member asked whether HSAG had heard anything further about potential changes related to the consensus-based entity (CBE) and transition from the previous CBE.
    - HSAG (Ms. Mackeprang) responded that more information will be available once the transition has occurred.
    - CMS (Ms. Dollar-Maples) added that CMS does not yet have a lot of information to share other than to say that CMS recently awarded a new contract for the CBE through a competitive procurement process and the CBE is being transitioned. Starting March 27, 2023, the CBE will be with Battelle Memorial Institute (Battelle). CMS is continuing with the Annual Call for Quality Measures using the CMS Measures Under Consideration Entry/Review Information Tool (MERIT) system, which will close in May. CMS will use the QMI tool to inform their review of the submitted measures and a Measures Under Consideration (MUC) List will be published on or before Dec. 1.
    - Update: For public updates about the current and future state of the CBE and their work with CMS, please visit the CBE website: https://www.p4qm.org/. Some of the topics covered during the TEP meeting are addressed in the Frequently Asked Questions (FAQs) of that website.

TEP Discussion

The following question was presented for TEP discussion:

- Are the proposed revised interpretations for the QMI categories for scoring variables understandable and useful?

TEP Comments

- A TEP member said the revised interpretations seem reasonable.
- HSAG (Dr. Campbell) asked members of the workgroup to confirm the revisions reflect what the workgroup had discussed and requested at the September 2022 meeting.
    - A TEP workgroup member confirmed the revisions capture the workgroup recommendations.
    - Another TEP member, a patient, noted she appreciates that the revised interpretations offer more information compared to earlier versions. Because of the added information, the categories are well-explained.

Proposed Refinements, QMI Tool Version 2.0: Agency High Priority Domain

Presenter: Megan Keenan, MPH; Executive Director, HSAG

Ms. Keenan introduced a new proposed Agency High Priority domain for QMI tool version 2.0, which would contain three variables: *Measure Focus*, *Digital Data Source,* and *Preferred Measure Type*. She explained how this domain would differ from the *High Priority* variable in QMI tool version 1.1 and demonstrated how the new domain would impact overall QMI scores compared with the prior variable (slides 21-27).

TEP Discussion

Ms. Keenan reviewed the pros and cons for creating a new Agency High Priority domain. She asked whether the TEP agreed with the team's recommendation to include the new domain and create standalone variables for each priority type (slide 27).

TEP comments

- A TEP member stated she liked that the proposed domain ties to CMS priorities. She is concerned, however, about the weighting and clumping it all into a number. Potentially, there could be a "both/and" rating that shows the measure rating with and without the priority score. She emphasized that she is not advocating moving stellar measures ahead that are not priorities, but she would not want measures to move forward that are priorities but lack other key criteria for quality measurement.
    - HSAG (Ms. Keenan) replied that the team will consider how to interpret a high priority score together with other criteria related to the properties of the measure itself.
    - HSAG (Dr. Campbell) added that the QMI tool is intended to show a measure's strengths and weaknesses. For example, reviewers will be able to see if the scientific acceptability of a measure was poor, which would show up in a low Scientific Acceptability domain score and potentially Red scores for the domain's *Reliability* and/or *Validity* variables. That information would be clearly presented in addition to the overall QMI score in the current Excel workbook display provided to CMS.
- Another TEP member agreed with the prior TEP member's remarks. He suggested there may be an opportunity for a two-step process.
- A third TEP member agreed with those remarks. She noted she likes that CMS receives the overall domain scores and can see which variables within domains may have scored poorly. She added that an Agency High Priority domain could take on a more significant role compared to the other domains. It will make CMS preferences more transparent but also could open the door to measures that are not as scientifically acceptable or feasible.
- A TEP member suggested that the Agency High Priority domain would evolve over time. She asked when QMI scores are recomputed.
    - HSAG (Ms. Keenan) replied that part of the rationale for splitting the priority types into their own variables was to have a bit more stability in scoring as CMS priorities change. The team tried to be thoughtful about the key priority topic areas. For instance, if digital measurement evolves over the next couple of years, that one *Digital Data Source* variable can be updated without impacting the weight of the measure focus or measure type priorities.
- A TEP member noted the long time between MUC submission and implementation in a program and asked what happens to QMI scores if CMS priorities change in the meantime.
    - HSAG (Dr. Campbell) replied that the QMI version being discussed at this meeting is applicable to the 2023 pre-rulemaking process. Both MERIT and the QMI methodology are updated once annually. For example, if CMS designated a new Meaningful Measure priority next year, that

would be added into both MERIT and the QMI. The team is also evaluating the QMI tool for other uses regarding maintenance measures and measures under development and is still defining the frequency of re-scoring measures.
    - HSAG (Ms. Keenan) noted that the QMI is only intended to capture agency-wide priorities, which tend to be more stable over time. Programs can and should consider additional priorities specific to their program needs when selecting measures. Additionally, if a significant event occurs between QMI versions and changes CMS priorities (e.g., COVID-19), CMS can always consider additional priorities beyond those considered in the QMI score.
    - A TEP member agreed the selected priorities are relatively stable. For example, the last change to Meaningful Measures was several years ago.
- A TEP member noted that social determinants of health (SDOH) have become one of the top priorities for CMS and asked whether a SDOH measure would receive credit for addressing this priority.
    - HSAG (Ms. Keenan) stated that one of the Meaningful Measures 2.0 priorities is equity. In previous versions, developers were only allowed to select the Meaningful Measures area that was the measure's primary focus. However, this year, developers will be able to select secondary measure focuses. For example, a measure that addresses SDOH can now select equity as a Meaningful Measures 2.0 priority even if it isn't the primary focus of the measure to get credit for meeting that priority.

Proposed Refinement, QMI Tool Version 2.0: Importance Domain

Presenter: Mariana Grass, DHSc, MPH; Health Services Researcher, HSAG

Dr. Grass presented proposed changes in the Importance domain, comparing QMI tool version 1.1 and QMI tool version 2.0. She reviewed a proposed new variable for the domain, *Patient Engagement* and the TEP workgroup recommendation for the variable to apply to all measure types (slides 29-32).

TEP Discussion

TEP members were asked to consider two questions for future consideration related to the "Meaningful to Patients" concept:

- Do you have recommendations for acceptable outcome thresholds?
- Should there be a threshold for the minimum number of patients who provide input?

TEP comments

- A TEP member asked whether the team had considered an alternative to percentages for the acceptable outcome threshold. For example, she is concerned about there being engagement with patients on a measure development TEP which includes only two patients. The small denominator would allow for 50% approval if one patient liked the measure and the other patient didn't. She also is unsure that patients on measure development TEPs are officially surveyed on whether they agree the measure is meaningful to patients; this likely is something new that needs to be added to the Blueprint. If CMS indicated they want a higher number of patients on TEPs (e.g., a threshold of at least five), she would feel better. She is concerned about having a threshold of only one or two patients, but agrees the revisions provide a lot more context compared to a checkbox and thereby provide more value. The TEP member added she would need to think about what the best minimum would be in terms of a threshold. She noted the Measures Management System (MMS) Blueprint requires the engagement of persons and families and identifying a baseline number may be something to consider. She is not sure whether that exists today.

- A TEP member remarked that there are certain items for which she likes absolutes; however, a patient engagement baseline makes her nervous. Factors to consider are the measure's topic and the level of the patients' engagement. If we set a threshold, submitters will check the box and say that they had the correct number of patients. She suggested considering, at least in the interim, asking for a justification or an explanation of who patients were, including background and experience, and the measure focus. This would provide important context.
    - The TEP member gave an example of what she has seen submitters filling out in the MERIT tool and how they are affected in terms of patient engagement. She had one group with two patients on its TEP who participated in face validity. Both patients agreed the measure represented what it intended. However, when the submitters filled out the MERIT form section, they had to say "no" to questions on face validity because they had not had separate conversations or validity testing, for instance. So even though they made their best effort during measure development to ensure patients were actively participating in the process, they would score poorly right now. She suggested this is something for the TEP to think about.
        - HSAG (Dr. Campbell) responded that Row 080 in MERIT asks, "was input on the final performance measure collected from patients and/or caregivers?" For a project with patient engagement on a panel and face validity, the answer would be "Yes." He added that Rows 081 and 082 (denominator and numerator, respectively) do not get scored; however, including them in MERIT allows us to collect and evaluate these data for future consideration. He asked the TEP to consider that with the QMI tool, we need to have discrete variables, which CMS will review along with all qualitative information. He asked whether we need to consider some minimum, such as saying if the developer did not have a certain number of patients engaged in their process, they have not met CMS' minimum criteria.
    - A TEP member commented through the chat function that she agrees with the above remarks. The member added that there was a collaborative effort led by Pharmacy Quality Alliance (PQA), the National Health Council (NHC) and the National Quality Forum (NQF) to develop a rubric for patient engagement. She believes it is far too restrictive but something to consider or reference and provided a link: https://www.pqaalliance.org/assets/PQA-Patient-Engagement-Rubric.pdf
    - A TEP member noted the purpose of the criterion for *Patient Engagement* is there is involvement and representation. She suggested that settling on the percentage of people who did what and who approved at what stages seems underbaked as a criterion when we don't know the patient representative backgrounds, their understanding of the measure focus, or how they are selected. Rather than pinpointing a percentage, she might ask how people were involved and potentially give credit for, e.g., involvement in creating the concept or specifications or reviewing results. This way, the focus is on their meaningful engagement along the process.
    - A TEP member stated she agrees with wanting to measure the quality of engagement that a measure developer or measurement process may have with patients and family representatives. However, she does not know if we will get to that point for the QMI tool. If developers are completing this through the MERIT tool or an outside group is reviewing measures, the quality of patient engagement will be challenging to determine without a lot of other documentation. Although she would love to measure quality of engagement, she does not think it is feasible for the QMI tool.
    - A TEP member indicated that whatever we decide, we need to ensure there is a low barrier to entry for participation. He is concerned we would create an incentive for a quality measure to be created and built around patients who are already engaged and easy to access. Some of the most important quality measures in emergency medicine are focused on patients who are very difficult

to engage and work with within the acute care spectrum. For example, patients who may be struggling with behavioral health issues or housing issues. If we are requiring a large number of patients to be involved in the development process, that could steer developers away from measures that focus on disadvantaged patient populations and more towards measures that engage an already engaged group of patients.
    - A TEP member said that as a patient representative for this TEP, she is happy to see that patient engagement is being considered. However, as far as a metric for measuring its meaningfulness, we may need to measure it in a different way, such as whether the patient felt they were engaged in the process and had input.
    - A TEP member commented through the chat function that she agrees with everyone's remarks and that we are too early in classifying patient engagement as a percentage. She suggested we still do not know how many patients are enough, giving In-Center Hemodialysis Consumer Assessments of Healthcare Providers and Systems (ICH CAHPS) in dialysis as an example.

Proposed Refinements, QMI Tool Version 2.0: Scientific Acceptability Domain

Presenter: Megan Keenan, MPH, Executive Director, HSAG

Ms. Keenan discussed proposed changes for the Scientific Acceptability domain for QMI tool version 2.0, which includes two variables, *Measure Score Reliability* and *Validity.* Ms. Keenan also reviewed the four components of the *Validity* variable (slides 34-37).

TEP Discussion

- A TEP member noted he would not consider risk adjustment as a measure of validity. He was in favor of keeping risk adjustment as a separate variable.
    - HSAG (Ms. Keenan) responded that the QMI team proposes incorporating risk adjustment under *Validity* to better align with the CBE approach to risk adjustment. She noted that at a CBE Scientific Methods Panel (SMP) meeting on March 10, 2023, the panel was asked if they recommended risk adjustment be considered separately from validity. The panel decided not to separate risk adjustment for now. HSAG will track this issue to ensure continued alignment with the CBE.
- A TEP member commented that treating risk adjustment as its own variable in QMI tool version 1.1 gave it more weight than justified; she supports risk adjustment being incorporated as part of another variable. There are measures that don't require risk adjustment, so it is helpful to have it all in one variable for consistent weighting of variables.
- HSAG (Ms. Keenan) noted that at the September workgroup meeting, the workgroup indicated that the previous proposal for the *Validity* composite score was too strict because it would have required more than one component in order to score Green (1.0) for the *Validity* variable. She asked whether the updated proposed approach fully addressed the workgroup's feedback.
    - A TEP member agreed with the current proposal: scoring Grey does not result in a low score when risk adjustment is not relevant or does not apply. The current approach solves the problem of having different kinds of measures where different approaches for measuring validity come into play. Another TEP member (a patient representative) agreed.
- A TEP member questioned the approach of rolling up four components into a single validity variable. He is concerned that a measure could score poorly on one of the elements and still receive a high score.

- HSAG (Ms. Keenan) clarified that if a measure scores Red for any one component, e.g., *Data Element Validity*, the overall *Validity* variable will score Red. The rationale for this approach is that the requirements for each validity component are easier to pass because the CBE has not recommended the same kind of thresholds they have for measure score reliability testing. For example, there is no established threshold for correlation between measure scores; therefore, the QMI gives credit for any correlation in the hypothesized direction, regardless of the magnitude of that correlation. Similarly for face validity, the CBE does not have minimum criteria for a face validity vote so the QMI gives credit for face validity if 60% agree that the measure can differentiate good from poor performance, which allows for a good amount of disagreement. Given that these components are somewhat easier to pass, a failure on any one component indicates a threat to the validity of the measure.
- The TEP member replied the method made sense and asked for clarification on the interpretation of the Yellow score for the *Validity* variable.
- HSAG (Ms. Keenan) clarified that a measure could score Yellow on the *Validity* variable if the developer did not provide data element testing for a non-claims-based measure, or the developer did not provide a valid rationale for not risk adjusting an outcome measure. The approach of allowing for testing exceptions under some circumstances is aligned, to the extent feasible, with the CBE criteria. CMS can review the developer's justification for not providing those tests and determine whether an exception is appropriate. For instance, data element testing may not be needed if all data elements used to calculate the measure are in structured fields using standardized coding terminology.

- A TEP member commented that she likes the scoring and feels the QMI tool is moving in the right direction.

Proposed Refinements, QMI Tool Version 2.0: Feasibility Domain

Marie Hall, RN, Senior Nurse Informaticist, HSAG

Ms. Hall presented proposed refinements for the Feasibility domain for QMI tool version 2.0, which included a minor revision to the *Feasibility of Data Elements* variable name and inclusion of a new variable, *Provider Burden (Impact on workflow)* (slides 39-42).

TEP Discussion

Ms. Hall asked the TEP for feedback regarding quantifying provider burden using a standardized method.

TEP comments

- A TEP member noted that CMS puts a high priority on the development of PRO-PMs. Some data elements of the PRO-PM may not be routinely collected, such as vital signs. If we develop such an instrument and some data elements are not necessarily included in the workflow, will this hinder development of PRO-PMs? The measure would probably fail this criterion because adding a new survey or new data elements would interrupt the workflow.
  - HSAG (Ms. Hall) agreed PRO-PMs can be burdensome or labor-intensive for providers to implement because many PRO-PMs require additional questions being asked for the patient, and those data elements need to be incorporated into the workflow and documentation. But the provider burden element would only signify there is a greater level of burden associated with implementing that type of measure, particularly if those data elements were not part of the routine workflow. Identifying a measure with higher provider burden does not necessarily make it a bad

measure; however, when CMS evaluates this domain, they would see the implications of implementing such a measure.

- A TEP member stated she is concerned this might lead to preferences for measures that are not directly related to the clinical care process and therefore perhaps to measures that are less actionable. There are ways to get around this, e.g., the workflow for collecting data for surveys could be done outside the care visit or outside the clinical workflow, but that might mean the clinical team does not have access to the data to do anything about it. Therefore, there is a disconnect between what the measure is trying to accomplish and what the clinical team is aware of and can address. While she understands the rationale for this, she wants to encourage CMS and committees using the data to think about this within the context of a measure set. In other words, CMS might not want to add a lot of measures all at once that require many workflow changes, but the likelihood is that new measures that address new concepts might require new workflow or workflow in quality improvement. She is trying to think about how provider burden is represented in a way that does not stifle innovation and efforts to encourage care teams to think about quality as part of what they do and not as a measure that is being done to them from the outside.
- A TEP member provided feedback from the perspective of a bedside clinician who spends a lot of time documenting around quality measures. Burnout is rampant in healthcare and a big contributor is the burden we place on clinicians to spend more time in front of computers documenting and less time in front of patients providing quality care. He believes there are many ways to collect data for PRO-PMs that don't require clinicians to actually collect that information. He added that a measure should fail provider burden if it requires a clinician to alter workflow. Further, we are trying to find a threshold for when burden is low vs. moderate, but the question really should be no additional burden vs. any additional burden. There is so much data being captured ambiently through the electronic health record (EHR) and we should be looking to those to develop quality measures and not be asking clinicians to document anything additionally for a quality measure as we move forward.
    - A TEP member agreed, saying he has similar thoughts, particularly about the word "limited" in the acceptable area.
    - A TEP member agreed through the chat function that the sustainability of measures that increase provider burden is very likely to be poor.
    - A TEP member stated that initially she agreed with the approach presented on provider burden, but in listening to the TEP's discussion she is also thinking about some of the measures that CMS has proposed in recent years that require a bigger lift, e.g., social drivers of health and a recent radiation dose measure that will require new software in hospitals. There is always the assumption that we want to check "yes" on this question about workflow but somehow we have to figure out a way to indicate it's okay to check "no" and that's a signal to CMS that you need to phase measure implementation slowly.
    - A TEP member commented that NQF has further tried to define each of the elements in their criteria except feasibility. She suggested the feasibility scorecard is helpful, which is required for eCQMs. She wonders if there is a way in the future of incorporating that information or asking if some of the elements were assessed during testing.
- HSAG (Dr. Campbell) noted that he appreciated the robust discussion around this topic. He indicated that it is important to remember that the QMI shows strengths and weaknesses of a measure. So, there are many variables for which PRO-PMs could score well. The Agency High Priority domain has a variable for a PRO-PM. As the TEP member noted about the context of a measure set, if a lot of measures were submitted that all scored Red on *Provider Burden*, CMS needs to see this. But if a measure is important enough, and it reflects an agency priority, CMS can take that into consideration.

    - A TEP member repeated that this question should be binary – does the measure add burden or not? If the measure adds burden, it should fail this variable but could score well on multiple other metrics.
- A TEP member said that when we think about innovation in the measurement space, is there an opportunity to ask CMS to explore the potential of evaluating patient burden by asking the patient directly instead of evaluating provider burden if we are truly concerned about the burdens with implementing PRO-PMs?
    - HSAG (Dr. Campbell) replied he did not have an answer to her question, however, if information for PRO-PMs were collected from the patient, developers would check "No" on the MERIT form about provider burden.
    - The TEP member added that the patient population is changing, not only in age but in digital sophistication from previous generations. Why not capitalize on this in terms of collecting patient information? We need the data and to improve the patient experience, but perhaps we can do it in a different way.
    - A TEP member who is a patient representative agreed with obtaining the information directly from the people who are receiving the service and finding a way they can report so it's truly patient-reported.

Next Steps and Project Timeline

Julia Mackeprang, MPH, PMP, Project Lead, QMI

Ms. Mackeprang presented next steps for the QMI project and the project timeline. Next steps include automating generation of QMI scores for measures submitted to the 2023 Annual Call for Quality Measures and tentatively planning to reconvene the TEP in fall 2023 (slides 44-45).

CMS Quality Measure Development Plan (MDP) Status Updates

Michelle Pleasant, PhD, MA, Associate Director, MDP

Dr. Pleasant gave an update on the MDP project, noting the team gathered feedback on quality measure subtopic gaps and quality measures related to six clinical areas, including behavioral health, diabetes, hypertension, kidney disease, HIV/AIDS, and women's health and maternal care. The 2023 MDP Annual Report is currently in clearance and will be posted in May (slide 48).