Performance Measures Coordinating Committee Council Meeting

Friday, October 25, 2024
9 – 11 a.m.

Washington State Health Care Authority

Housekeeping

- No formal break, so feel free to step out briefly if needed.
- For committee members:
  - Please keep your phone line muted when not speaking.
- For members of the public:
  - Please keep your phone line muted at all times.
  - There will be dedicated time for questions and comments.
  - Please use the chat box to submit your question/comment and it will be addressed in the order received.

Public Process

- Maintaining a transparent process is important.
- Public comment opportunities:
  - PMCC meetings are open to the public.
  - There is time on the agenda for public comment prior to action on measures.
  - Meeting materials are posted on the Health Care Authority website*
  - Comments can be submitted to HCA anytime at hcapmcc@hca.wa.gov

*https://www.hca.wa.gov/about-hca/who-we-are/washington-state-common-measure-set

Today's Objectives

- Welcome and Introductions
- Briefly recap the May PMCC meeting
- NCQA 2025 changes to HEDIS measures
- Rural Health Ad Hoc Workgroup update
- Review of Health Equity Ad Hoc workgroup
- Review of Primary Care Measures Ad Hoc Workgroup
- Looking forward to 2025
- Public Comment
- Wrap Up

Welcome & Introductions

- Please share the following
  - Your name
  - Your role
  - Your organization
- Welcome to our newest member:
  - Alastair Matheson, Data Modernization Director at Public Health—Seattle & King County

Recap of the May PMCC Meeting

Sharon Eloranta, MD, WHA

Washington State Health Care Authority

Recap of the May 2024 PMCC Meeting

- PMCC members were notified in March that they must complete the online, self paced training and membership application form to maintain voting eligibility.
  - Please email the HCA PMCC mailbox when completed HCAPMCC@hca.wa.gov
- Overview of the Primary Care Measures and Health Equity Ad Hoc Workgroups
- Rural Health Collaborative overview
- Updated standards from OMB and CMS
- Guest Presentation: The Quality Measure Alignment Task Force (Clara Filice and Joshua Twombley, MA Medicaid).

NCQA 2025 Changes to Measures

Heleena Hufnagel, HCA

Washington State Health Care Authority

NCQA Final Changes

- NCQA added (3) new HEDIS measures (All ECDS)
- NCQA has fully retired (1) measure
- NCQA has made “smaller changes” across multiple measures
- Addition:
  - NCQA continues to transition away from hybrid to ECDS only reporting.
  - NCQA has stratified additional measures by R/E as part of their goal to stratify measure set by 2030.
  - NCQA has made changes to methodology for R/E stratification

New measures

- Documented Assessment After Mammogram (DBM-E)
  - The percentage of episodes for members 40–74 years of age with mammograms documented in the form of a BI-RADS assessment within 14 days of the mammogram.
- Follow-Up After Abnormal Breast Cancer Assessment (BCF-E)
  - The percentage of episodes for members 40–74 years of age with inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of the assessment.
- Blood Pressure Control for Patients With Hypertension (BPC-E)
  - The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose most recent blood pressure was <140/90 mm Hg during the measurement period.
    1. *It uses the ECDS reporting method.*
    2. *The denominator includes a pharmacy data method with a hypertension diagnosis.*
    3. *Stratified by R/E for 2025*

HEDIS MY 2025: What's New, What's Changed, What's Retired - NCQA

Acute Hospital Utilization (AHU):

- NCQA expanded this measure to include the Medicaid product line for members 18–64 years of age.
- This initiative was motivated by the retirement of the Inpatient Utilization measure in MY 2024, and by NCQA's commitment to improving quality across diverse populations.
- Medicaid members with six or more inpatient or observation stay discharges during the measurement year would be excluded as outliers.

Retired Measure: Antidepressant Medication Management (AMM)

- **Reasoning:** While there is broad agreement that medication adherence is an important driver of patient-centered outcomes for depression care, several factors informed retirement of this measure:
  - The measure does not address other guideline-recommended, non-pharmacological components of care.
  - Measure specifications do not adequately capture appropriate clinical judgment to avoid pharmacological treatments.
  - NCQA has a more comprehensive set of measures of depression screening, follow-up and routine monitoring, and improvement in outcomes. NCQA is committed to expanding the use of these measures in reporting programs.

Changes to Existing Measures:

- **Follow-Up After Emergency Department Visit for Mental Illness(FUM) and Follow-Up After Hospitalization for Mental Illness(FUH):**
  - NCQA updated denominator criteria to include phobia diagnoses, anxiety diagnoses, intentional self-harm X-chapter codes and the R45.851 suicidal ideation code. These measures expanded the numerator criteria with additional follow-up options, including expansion of provider-type options, inclusion of psychiatric residential treatment and peer support services for mental health.

Changes to Existing Measures Cont.

- **Adult Immunization Status (AIS-E):**
- PMCC added to WSCMS for 2024.
- NCQA added an indicator assessing hepatitis B immunization for adults 19–59 years of age.
- NCQA removed the herpes zoster live vaccine from the existing herpes zoster immunization indicator and revised the numerator criteria to assess receipt of the recombinant zoster vaccine on or after October 1, 2017.
- For the existing pneumococcal immunization indicator, NCQA updated the denominator age range to assess immunization for adults 65 and older.

Changes to Existing Measures Cont.

- **Eye Exam for Patients With Diabetes (EED):**
  - NCQA retired the Hybrid Method; this measure is now reported using the Administrative Method only.

- **Well-Child Visits in the First 30 Months of Life (W-30) and Child and Adolescent Well-Care Visits (WCV):**
  - NCQA is removing telehealth visits; these were added temporarily in response to the COVID-19 pandemic. Removing telehealth well-care visits aligns the measures with updated guideline recommendations.

Gender Affirming Care: Chlamydia Screening (CHL):

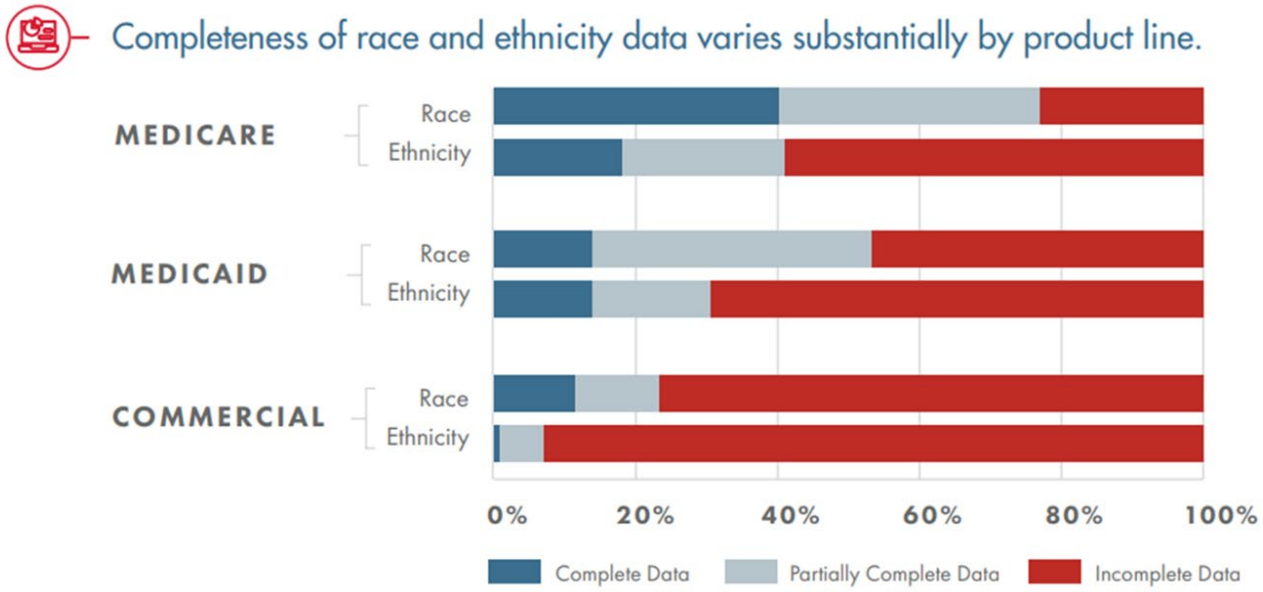
- As part of a cross-cutting project to ensure that HEDIS measures appropriately acknowledge and affirm members' gender identity, NCQA updated the Chlamydia Screening in Women measure to include transgender members recommended for routine chlamydia screening and renamed the measure "Chlamydia Screening".
- As such, NCQA proposed to rename the measure to Chlamydia Screening in Adolescents and Adults (CHL)
  - Defined: The percentage of members 16–24 years of age recommended for routine chlamydia screening who were identified as sexually active and who had a chlamydia test within the measurement year.
- Issue Brief from NCQA regarding HHS final rule 2024 on SOGI link

Measures Transitioned to ECDS-only reporting:

Measure ID	Measure	MY Required for Public Reporting
PRS-E	Prenatal Immunization Status	MY 2020
AIS-E	Adult Immunization Status	MY 2022
BCS-E	Breast Cancer Screening	MY 2022
PDS-E	Postpartum Depression Screening and Follow-Up	MY 2022
PND-E	Prenatal Depression Screening and Follow-Up	MY 2022
DRR-E	Depression Remission and Response	MY 2023
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	MY 2023
COL-E	Colorectal Cancer Screening	MY 2024
ADD-E	Follow-Up Care for Children Prescribed ADHD Medication	MY 2024
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics	MY 2024
CCS-E	Cervical Cancer Screening	MY 2025
CIS-S	Childhood Immunization Status Combo 10	MY 2025
IMA-E	Immunizations for Adolescents	MY 2025

HEDIS Electronic Clinical Data Systems (ECDS) Reporting - NCQA

Challenges to Race Ethnicity Reporting



- NCQA received commentary expressing concern with R/E reporting requirements, citing significant administrative burden from the number of indicators that must be reported (direct, indirect and unknown).
- Respondents asked NCQA to refine and/or remove the required R/E data indicators.

Updates to Race and Ethnicity Reporting for 2025:

- In response to public comment, NCQA removed the data source reporting requirement from stratified measures in MY 2025.
  - NCQA retained the data source reporting requirement for the Race and Ethnicity Diversity of Membership (RDM) descriptive measure only, to allow transparency into the types of data sources organizations leverage.
- NCQA further refined the data source reporting categories to facilitate ease of reporting; clarified the distinction between member-self reported data and other data types; and clarified the intent of the imputation source category.

Measures Stratified by R/E in 2025:

- There are currently 22 HEDIS measures stratified by R/E.
- For MY 2025, NCQA has added one new measure for R/E stratification
  - Blood Pressure Control for Patients With Hypertension (BPC-E)
- NCQA's goal is to fully stratify measures by R/E in 2030.

Socioeconomic Status and Disability:

- Currently, HEDIS requires an SES and disability stratification for four measures: Breast Cancer Screening, Colorectal Cancer Screening, Comprehensive Diabetes Care—Eye Exam and Plan All-Cause Readmission. This *only applies to Medicare product lines*.
- Dual Eligibility (DE)(status remains one of the strongest predictors of outcome, even after accounting for other social and functional risks.
- Identifying Quality Measures for People With IDD
- IEC was awarded a grant from the Robert Wood Johnson Foundation to identify quality measures that will support IDD health outcomes standards. NCQA will be a partner on the project this coming year and will work toward the inclusion of the IDD population in HEDIS measures.

NCQA States that “There is broad acknowledgment that social factors such as employment status, physical environment and access to food contribute significantly to health outcomes. HEDIS does not yet require stratifications by SDOH other than SES and does not include any SDOH-specific measures. NCQA sees this as an opportunity to expand the scope of HEDIS quality measurement and encourage health plan accountability for acknowledging members’ social needs, as well as clinical needs.”

Considerations for the PMCC

- How could these changes impact the WSCMS?
- What conversations do we need to have with commercial carriers or MCOs who will be collecting this information for reporting purposes?
  - "Certain programs that involve interconnected data across multiple agencies or offices, or that rely on data collected and provided by non-Federal entities, may take longer to implement [these changes] than programs like statistical surveys"

Rural Health Ad Hoc Workgroup Update

Laura Pennington, Kim Emery, Kelly Shaw

Washington State Health Care Authority

Rural Health Ad Hoc Workgroup

- The request for this workgroup came from feedback we received from the Rural Collaborative Quality Committee
- Learned there is not a universal understanding of what the WSCMS is and how those measures are used
  - Who is required to report and where do these get reported?
  - Do we have benchmarks?
  - Are these only for Medicaid or all payors?
  - For the hospital-only measures, where are those reported?
- At the May 2024 PMCC meeting the committee agreed to convene an ad hoc workgroup to discuss the following:
  - Understand how the WSCMS can support rural health providers and if there are specific measures they use that are not in the WSCMS
  - Consider opportunities for ongoing collaboration

Additional opportunities for consideration

- We can create a rural health subcommittee to provide ongoing expertise and recommendations for the PMCC to promote the rural health perspective
- Work more closely with the Rural Health Collaborative Quality Improvement Committee
  - Provide ongoing updates, as needed
  - Reach out, when a broader rural health voice is critical to the conversation

Rural Health Ad Hoc Workgroup kick-off

- Currently gathering membership with a planned start date of late 2024/early 2025
- Kim Emery and Kelly Shaw will co-lead the discussions
- The goal is to:
  - Identify current alignment of measures and gaps within the WSCMS
  - Review additional measures for addition to the WSCMS
  - Explore opportunities to consistently apply a rural lens during the measure review process
  - Consider how the PMCC can work more closely with rural health communities and tap into their expertise
  - Identify opportunities to promote rural health priorities through the WSCMS
  - Other?

Next steps

- Please submit nominations for participation to Heleena Hufnagel at Heleena.Hufnagel@hca.wa.gov by November 15, 2024
- Include name, organization, and email of potential member
- Let us know if you have any questions or suggestions!

Review of Ad Hoc discussion: Health Equity Workgroup

Heleena Hufnagel, HCA

Washington State Health Care Authority

Brief Overview of discussion

- Participating members of the PMCC and the HCA Pro Equity Anti Racism (PEAR) group convened an ad hoc workgroup over the summer to discuss opportunities to address health equity in the WSCMS.
- The goal of this workgroup was to:
  - Review the role of the PMCC and the purpose of the WSCMS
  - Revisit the initial 2021 ad hoc discussion around the future of quality measurement.
  - Consider different opportunities that now exist to incorporate a health equity lens into the PMCC.
  - Bring forward recommendations for advancing HE 2025 in 2025 at the October 2024 Meeting.

Questions this group considered

- How do we define health equity?
- What are the opportunities for the PMCC to address health equity in the WSCMS?
- How do we monitor our progress and identify gap areas?
- How do we share this information?
- How can the PMCC engage our partners and community organizations in a meaningful way?
- What would the PMCC need to accomplish these goals?

Opportunities (Broad and Narrow)

- The Washington State Common Measure Set
  - Historic, current and future state of measurement
  - Core set size
  - Process vs Outcome measures
- Data focus
  - Accessibility
  - Accuracy
  - Power Sharing: " How do we tell a story?"
- Relationship Building and getting to quality outcomes
  - What are we doing in WA state? What gap areas still exist?
  - Do the performance measures help us to answer these questions?
  - What opportunities are there for the PMCC to support public education around the WSCMS and promote community engagement in meetings?
  - What opportunities are there to support organizations who may be doing this work already?

Final Recommendations From Workgroup

Measure Set

- The PMCC can consider a smaller set of core measures.
- Consideration for subset of measures
- The PMCC can promote outcomes and QOL measures.
- Add an equity component to the set of measures where possible.
- Conduct small scale evaluation annually, high level and ad hoc as needed.

Data Focus

- National data can be used as starting point(North Star)
- Focus on identifying strengths and limitations of data sources.
- WA Specific: Potential to also use the ADI or other tools used by WHA to home in on the measures we select to take a deep dive.
- Potential to build in disaggregation of measures to support HE review.
- Health Equity Data/ PEAR annual presentation.
- Outreach to community partners to understand what data they are collecting and how we can collaborate.

Relationship Building

- Collaborate with community representatives to understand how individuals may be impacted by these identified disparities.
- PMCC can share public level data that may be used by partners in their community engagement and request feedback from them.
- Support community participation in the PMCC and ad hoc workgroups to address health inequities identified in the WSCMS.

Decision/Vote:

Measure Set	1.) Begin with the existing Measure Set and determine if the current measures we have are able to identify health disparities and if there is a potential to advance health equity.
Data Focus	2.) Identify and leverage the existing data streams available to the PMCC.
Relationship Building	3.) Promote participation with WA community partners in PMCC activities to inform the Committee as to how the WSCMS is achieving the goal of improving public health outcomes.

Next Steps

- Begin to incorporate these recommendations into the 2025 agenda planning and shared with the PMCC during the December meeting.
- The PMCC will continue to support partner engagement and work with HCA PEAR team and other appropriate partners to bring WSCMS updates and opportunities for ad hoc participation to future PEAR community advisory meetings.
- Additional questions or recommendations please send to HCAPMCC@hca.wa.gov

Review of Ad Hoc discussion: Primary Care Measures Workgroup

Judy Zerzan-Thul, MD HCA

Washington State Health Care Authority

2024 Primary Care Measures Workgroup

- Met four times between May and July
- 32 members representing:
  - Primary care providers
  - Pediatrics
  - FQHCs
  - Seattle Indian Health Board
  - Larger health systems (UW, VM, Multicare, Seattle Children's)
  - Rural health organizations
  - Medicaid and Commercial payers
  - Community Health Organizations (ICHS)
  - Quality Organizations
- 8 members participated in 2021 Primary Care Measures Workgroup

Goals

- In 2021, the first Primary Care Measures Workgroup was convened
  - They selected 12 measures that were presented to the Performance Measures Coordinating Committee for adoption
  - The measures have been used to support primary care initiatives
  - HCA has actively incorporated the initial measures into our purchasing contracts, where able
- 2024 goals
  - Review and finalize an updated set of measures to support implementation of Washington Primary Care Transformation Initiative (PCTI)
  - Maintain the Primary Care Measure Set, as it will need to evolve over time as needs and measures change
  - It is the goal of the Health Care Authority to begin to move to more outcomes-based measures

WA HCA Multi-Payer and Provider Primary Care Efforts

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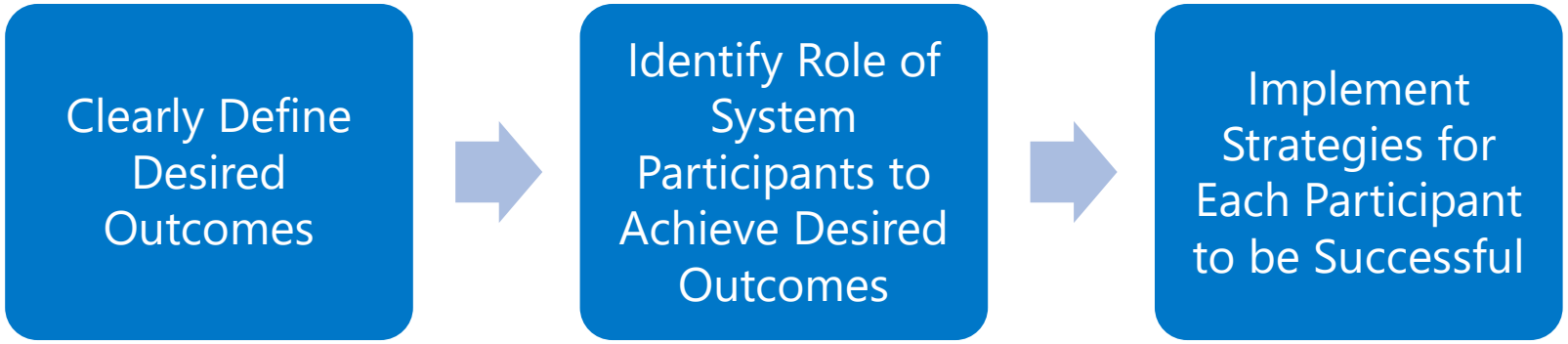
WA Primary Care Transformation Model (PCTM) alignment and design process

- Multistakeholder approach since 2019
  - Primary Care Provider Summits
  - Multi-Payer Collaborative
  - Purchaser Roundtable
  - Learning Cohort (combining payers and providers together)
- Identify ideal primary care experience and how to get there



Making Care Primary (MCP) Summary

(Announced 2023, Launching July 2024)

Goals

- 10.5 years
- Cost neutral
- Improve quality
- Sustainable transformation
- Multi-payer alignment

Care Teams

- Care management & coordination
- Specialty care integration
- BH integration
- Address health related social needs and equity

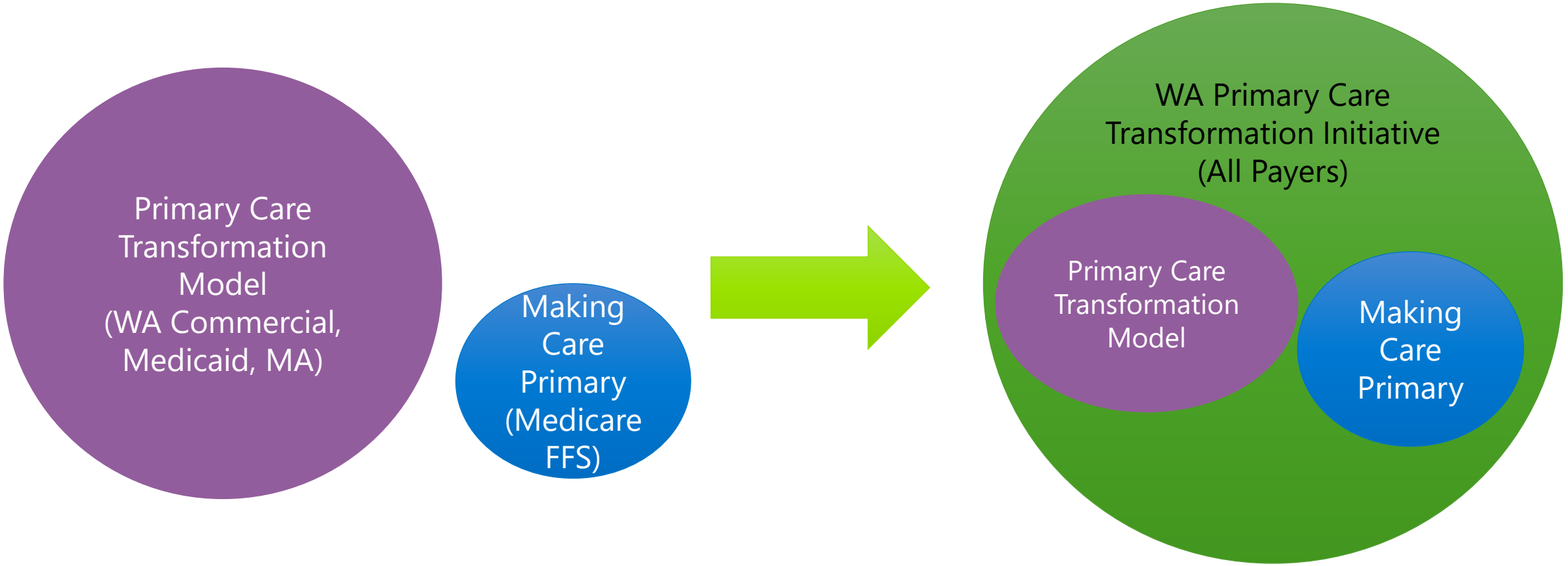
Flexible Payment

- Progression to prospective payment
- Progression in accountability
- Specialty integration payments
- Reward quality outcomes

CMS Making Care Primary Model

Washington State Health Care Authority

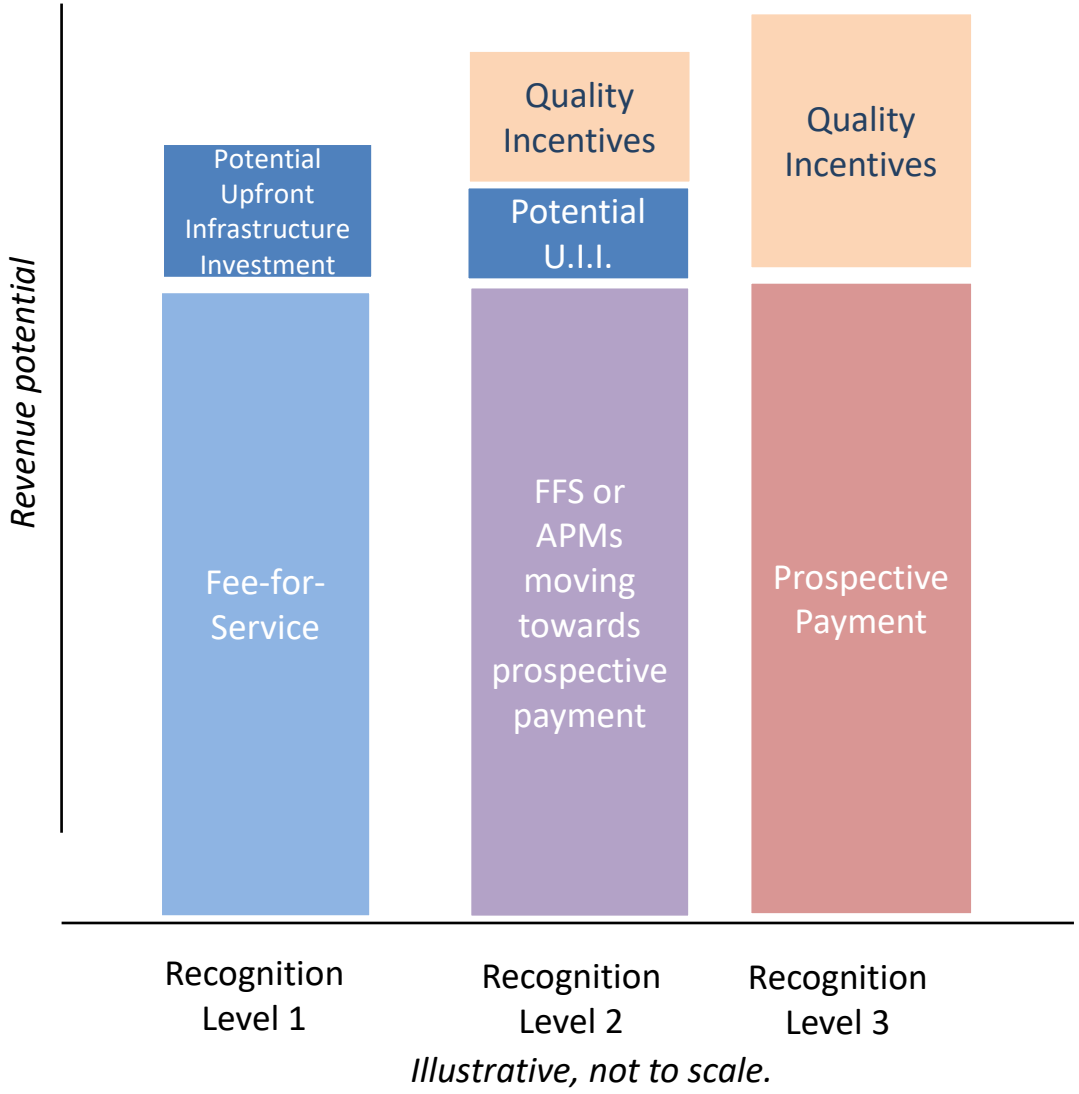
Primary Care Transformation Initiative (PCTI)- Aligning primary care transformation efforts



Primary Care Transformation Initiative fact sheet (wa.gov)

WA Primary Care Transformation Initiative Approach

- Support providers to develop infrastructure and capabilities
- Match payment method to provider's self-identified capabilities
- As providers improve capacity and capabilities…
  - Shift towards prospective payments
  - Increase accountability and potential earnings for quality performance



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Primary Care Measure Alignment

	MA Stars	Medicaid Core Set	Universal Foundation	CQMC	AR Payer Overlap	CO STC	NC STC	Covered CA	CA Advanced Primary Care Initiative
Controlling High Blood Pressure	**C11**	**CMIT 167**	**CMIT 167**	**CBE 0018**	**6/6**	**CBE 0018**	**CBE 0018**	**CBE 0018**	**CBE 0018**
Breast Cancer Screening*	**C01**	**CMIT 93**	**CMIT 93**	**CBE 2372**	**5/6**	**CBE 2372**			
Colorectal Cancer Screening**	**C02**	**CMIT 139**	**CMIT 139**	**CBE 0034**	**3/6**	**CBE 0034**		**CBE 0034**	**CBE 0034**
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (<8%)***	**C10** HbA1c Control (<8.0%)	**CMIT 148** HbA1c Poor Control (>9.0%)	**CMIT 204** HbA1c Poor Control (>9.0%)	**CBE 0059** HbA1c Poor Control (>9.0%)	**4/6** *Mostly use HbA1c Poor Control (>9.0%)	**CBE 0059** HbA1c Poor Control (>9.0%)	**CBE 0575** HbA1c Control (<8.0%)	**CBE 0575** HbA1c Control (<8.0%)	**CBE 0059** HbA1c Poor Control (>9.0%)
Childhood Immunization Status (Combo 10)		**CMIT 124**	**CMIT 124**	**CBE 0038**		**CBE 0038**	**CBE 0038**	**CBE 0038**	**CBE 0038**

** Breast cancer screening denominators differ. 50-74 (CBE 2372) vs. 52-74 (CMIT 93). CMIT exclusion criteria are currently unavailable.*

***Colorectal cancer screening numerators and denominators differ. Ages 50-75 & 51-75 (CBE 0034) vs. ages 45-75 & 46-75 (CMIT 139).*

****Hemoglobin A1c Control for Patients with Diabetes (<8%) is measured as an inverse for some programs – Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*

HCPLAN
Health Care Payment Learning & Action Network

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Proposed measures for consideration by workgroup

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Measure selection principles

- List should be robust but of manageable size
- Measures should be clinically impactful (morbidity, mortality, quality of life, and health equity)
- Measures should be amenable to influence of primary care providers
- List should cover a range of patient groups, needs, and conditions
  - Child and adults
  - Prevention/screening, chronic disease management
- Measures should apply to a significant number of patients
  - Scale for significant impact
  - Sufficient numerator and denominator size to produce valid and reliable results
- Measures should be drawn from the Washington State Common Measure Set
- List should align with other measurement efforts where appropriate
- Administrative burden on providers should be minimized as much as possible

Measure domains

Wellness and Prevention

Chronic Disease Management

Behavioral Health

Cost/Utilization

Draft clinical quality measures

Domain	Measure	Steward
Wellness & Prevention	1. Child and Adolescent Well Child Visits (WCV)- Ages 3-11*	NCQA
	2. Colorectal Cancer Screening* (COL-E) or CMS130v13	NCQA/CMS
Chronic Disease Management	3. Glycemic Status Assessment for Patients With Diabetes (GSD) Poor control (>9.0%)	NCQA
Behavioral Health	4. Follow up after Emergency Department Visit for Substance Use (FUA)* (30-day, total)	NCQA
	5. Depression Remission or Response for Adolescents and Adults (DRR-E)**	NCQA/CMS
Cost/ Utilization	6. Total Per Capital Cost (TPCC) (for measurement/reporting only)	CMS

*On 2021 Primary Care Measure Set

**CMS version is Depression Remission at Twelve Months CMS159v13

Additional options for consideration

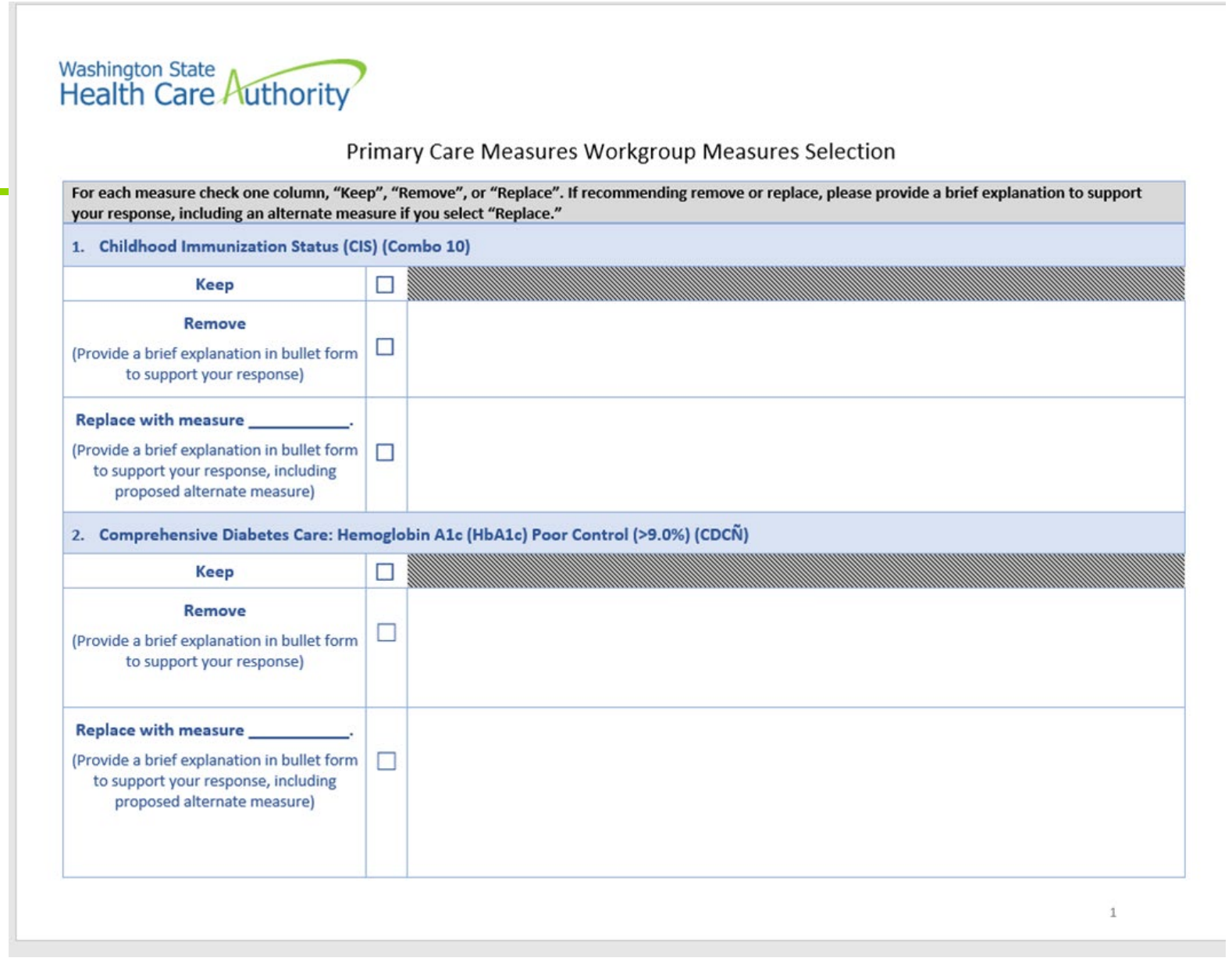
Domain	Measure	Steward
Wellness & Prevention	Breast Cancer Screening (BCS-E)*	NCQA
	Childhood Immunization Status (CIS) (Combo 10)*	NCQA
	Timeliness of Prenatal and Postpartum Care (PPC)	NCQA
Chronic Disease Management	Controlling High Blood Pressure (CBP) or CMS165v13	NCQA/CMS
	Asthma Medication Ratio (AMR)*	NCQA
Behavioral Health	Follow Up After Hospitalization For Mental Illness (FUH) (30-day, total)	NCQA
	Depression Screening and Follow up for Adolescents and Adults (DSF-E)* or CMS2v14	NCQA/CMS
Cost/ Utilization	Emergency Department Utilization (EDU)	NCQA

*On 2021 Primary Care Measure Set

Measures added by the workgroup

- Antibiotic Utilization for Respiratory Conditions (AXR)
- Chlamydia Screening in Women (CHL)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- Use of Opioids at High Dosage (HDO)

Homework



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Primary Care Measures Workgroup Measures Selection

For each measure check one column, "Keep", "Remove", or "Replace". If recommending remove or replace, please provide a brief explanation to support your response, including an alternate measure if you select "Replace."		
1. Childhood Immunization Status (CIS) (Combo 10)		
Keep	☐	
Remove (Provide a brief explanation in bullet form to support your response)	☐	
Replace with measure _____. (Provide a brief explanation in bullet form to support your response, including proposed alternate measure)	☐	
2. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDCÑ)		
Keep	☐	
Remove (Provide a brief explanation in bullet form to support your response)	☐	
Replace with measure _____. (Provide a brief explanation in bullet form to support your response, including proposed alternate measure)	☐	

1

Measure	# Selected for Core Set	# Selected for Voluntary Set	# Selected to Remove	# Selected to Replace
Glycemic Status Assessment for Patients With Diabetes (GSD) Poor control (>9.0%)	18	0	0	0
Colorectal Cancer Screening (COL-E) or CMS130v13	17	0	1	0
Breast Cancer Screening (BCS-E)	16	1	0	0
Controlling High Blood Pressure (CBP) or CMS165v13	16	1	1	0
Childhood Immunization Status (CIS) (Combo 10)	15	3	1	0
Depression Screening and Follow up for Adolescents and Adults (DSF-E) or CMS2v14	10	6	1	0
Child and Adolescent Well Care Visits (WCV) – 3-11 years	8/8*	1	0	1
Total Per Capital Cost (TPCC) (for measurement/reporting only)	6	5	4	2
Emergency Department Utilization (EDU)	4	9	3	1
Use of Opioids at High Dosage (HDO)	6	7	5	0
Antibiotic Utilization for Respiratory Conditions (AXR)	4	6	5	0
Follow Up After Hospitalization For Mental Illness (FUH) (30-day, total)	3	2	11	1
Follow up after Emergency Department Visit for Substance Use (FUA) (30-day, total)	5	2	10	1
Prenatal and Postpartum Care (PPC)	4	4	9	2
Chlamydia Screening in Women (CHL)	4	5	9	1
Depression Remission or Response in Adolescents & Adults (DRR-E)	4	5	5	7

- **Measures selected to include in Core Set**
- **Measures selected for voluntary reporting only**
- **Measures selected for removal**
- **Measures selected to be replaced with another measure**

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Key feedback from workgroup members

- Keep the list of measures smaller
- Offer flexibility to accommodate different types of practices
- Important to align to reduce administrative burden on providers
- Consider offering a phased approach to support implementation of more difficult measures

Aligned Primary Care Measure Set-Core

- Adoption of the following Aligned Primary Care Measure Set is *highly encouraged* to promote alignment, reduce administrative burden and address current state priorities.

Core Set of Aligned Measures
Wellness and Prevention
Child and Adolescent Well Child Visits (WCV)- Ages 3-11
Colorectal Cancer Screening (COL-E) or CMS130v13
Chronic Disease Management
Controlling High Blood Pressure (CBP) or CMS165v13
Glycemic Status Assessment for Patients With Diabetes (GSD) Poor control (>9.0%)
Behavioral Health
Depression Screening and Follow up for Adolescents and Adults (DSF-E) or CMS2v14
Depression Remission or Response for Adolescents and Adults (DRR-E)

Aligned Primary Care Measure Set-Alternative

- Additional priority measures that provide opportunities for specific provider types

Alternative Measures
Wellness and Prevention
Breast Cancer Screening (BCS-E)
Child and Adolescent Well Child Visits (WCV)- Expand to include 12 – 21 years
Childhood Immunization Status (CIS) (Combo 10)
Chronic Disease Management
Asthma Medication Ratio (AMR)
Behavioral Health
Follow up after Emergency Department Visit for Substance Use (FUA) (30-day, total)
Follow Up After Emergency Department Visit For Mental Illness (FUM) (30-day, total)

Measuring Cost and Utilization

The workgroup's focus was on identifying an aligned set of clinical quality measures to support quality in primary care

The group strongly encourages purchaser, payers, and providers to consider how to mutually share, evaluate, make transparent, and incentivize appropriate cost and utilization measures

Examples of recommended measures include:

Emergency Department Utilization (EDU)	Total Per Capita Cost (TPCC) (for measurement/ reporting only)

Primary Care Measures Implementation Guidelines

Guiding principles for use of the aligned measure sets in contracts

Allow sufficient time for payers and providers to **implement new, outcomes-based measures**

Set **reasonable benchmarks** that reward adopting meaningful measures and improvement

Measures must have an **adequate denominator** to support reliable measurement

Measure and reward **reducing inequities**

Comments from workgroup members/public

- Opportunity for members from the Primary Care Measures Workgroup and public to add any additional comments.
  - Please enter your question or comment into the chat box.
  - If you prefer to speak, raise your hand or enter your name into the chat box and unmute yourself when called upon.
  - If speaking, please limit your comments to 2 minutes.

Decision/Vote

- Do we agree with the recommendations from the Primary Care Measures Workgroup to adopt the following 6 core measures?

Core Set of Aligned Measures
Wellness and Prevention
Child and Adolescent Well Child Visits (WCV)- Ages 3-11
Colorectal Cancer Screening (COL-E) or CMS130v13
Chronic Disease Management
Controlling High Blood Pressure (CBP) or CMS165v13
Glycemic Status Assessment for Patients With Diabetes (GSD) Poor control (>9.0%)
Behavioral Health
Depression Screening and Follow up for Adolescents and Adults (DSF-E) or CMS2v14
Depression Remission or Response for Adolescents and Adults (DRR-E)

Decision/Vote

- Do we agree with the recommendations from the Primary Care Measures Workgroup to adopt the following 6 alternative measures?

Alternative Measures
Wellness and Prevention
Breast Cancer Screening (BCS-E)
Child and Adolescent Well Child Visits (WCV)- Expand to include 12 – 21 years
Childhood Immunization Status (CIS) (Combo 10)
Chronic Disease Management
Asthma Medication Ratio (AMR)
Behavioral Health
Follow up after Emergency Department Visit for Substance Use (FUA) (30-day, total)
Follow Up After Emergency Department Visit For Mental Illness (FUM) (30-day, total)

Next steps

- The final core and alternative measure sets will be incorporated into the PCTI Implementation Guidelines
- The measures will be used to support alignment across payers and providers to support primary care transformation efforts

Looking Forward to 2025

Laura Pennington, HCA

Washington State Health Care Authority

PMCC priorities in 2025

- Are there topics of interest that the committee may want to explore?
- What are people in Washington talking about and are there any conversations that the PMCC should be tracking?
- Other ideas?

Public Comment

Sharon Eloranta, MD

Washington State Health Care Authority

Public Comment

- Please enter your question or comment into the chat box.
- If you prefer to speak, enter your name into the chat box and unmute yourself when called upon.
- If speaking, please limit your comments to 2 minutes.

Wrap Up and Next Steps

Judy Zerzan-Thul, MD

Washington State Health Care Authority

Wrap Up/Next steps

- Next meeting December 9 at 1 -3 p.m.
- Proposed agenda topics:
  - Leap Frog Hospital Survey Presentation: Missy Danforth
  - PMCC priorities/timelines for activities in 2025
  - Year in Review 2024

- Send additional topics to hcapmcc@hca.wa.gov ATTN: Heleena and Laura