**Washington Performance Measures Coordinating Committee**
**Ad Hoc Workgroup for an Aligned Primary Care Measure Set**
**Implementation Guidelines**
**Drafted August 2024**

## Introduction

The Performance Measures Coordinating Committee (PMCC) is responsible for recommending a Common Measure Set to monitor health care quality performance in the state. The PMCC uses a transparent review process with providers, payers, purchasers, and quality experts. Before the Committee finalizes its recommendations, it offers a public comment period. The Common Measure Set supports the Health Care Authority's quality monitoring strategy and its value-based purchasing incentives.

The PMCC convened an ad hoc workgroup to recommend an updated set of aligned primary care measures. The workgroup was comprised of more than thirty experts—including primary care providers, Federally Qualified Health Centers, medical associations, payers, quality review organizations, and more.

## Primary Care Measure Set Principles

The Primary Care Measures ad hoc workgroup agreed to the following principles to guide its measure selection:

- The measure list should be robust but 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
- The measure list should cover a range of patient groups, needs, domains, and conditions
    - Children, youth, and adults
    - Prevention and screening, chronic disease management, behavioral health, cost and utilization
- 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
- The measure list should align with other measurement efforts where appropriate, including the CMMI Making Care Primary demonstration model
- Administrative burden on providers should be minimized as much as possible

## Aligned Primary Care Measure Set (Core and Alternative)

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 |
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| **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) |

| 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. However, 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)

**Guiding Principles for Use of the Aligned Measure Set in Contracts**

The ad hoc workgroup recommends that purchasers adopt the Core Set of Aligned Primary Care Measures in any primary-care-related quality incentive programs, performance guarantees, etc. with carriers, or in direct contracting arrangements with providers. The ad hoc workgroup acknowledges that purchasers may have additional quality measures in such contractual

programs for other parts of the healthcare system (e.g. hospital care, specialty care), tailored specifically to their covered population, or in partnership with payers/providers.

While the focus of the ad hoc workgroup is on recommending an aligned set of primary care quality measures and not on the broader terms of value-based care contracts, the workgroup developed a set of guiding principles for those seeking to implement the Aligned Primary Care Measure Set.

***Selection of Alternative Measures***

For those providers and payers who choose to adopt the Aligned Measure Set, we recommend that the Core Set be adopted in full—except in circumstances where a measure is not applicable to the provider's patient population. The Alternative Set allows providers and payers to supplement the Core Set, but the ad hoc workgroup recommends that contracts limit use of Alternative measures to allow providers to focus on key, aligned opportunities for improvement and to minimize provider administrative burden. However, if a provider's patient population does not meet the specifications for a Core Set measure (e.g. provider has an inadequate denominator size), providers and payers can replace that Core Set measure with an Alternative Set measure more applicable to the provider's practice.

***Implementing New Measures***

The workgroup is keen to support advancements in measuring critical patient health indicators, including, but not limited to patient satisfaction, screening and follow up for health-related social needs, and behavioral health outcomes. Widespread adoption of these outcomes-oriented quality measures will best support our shared goal to identify the population health needs and health inequities that require collective investment and intervention. However, the workgroup cautions that new and updated measures should be phased in to value-based care contracts to allot sufficient time for (1) providers and community-based organizations to create and refine clinical workflows, (2) all parties to implement the necessary data capture and sharing infrastructure. The workgroup emphasizes that the use of reasonable performance targets is particularly essential for new, outcomes-based measures to reward adoption and steady improvement on these more meaningful health indicators, even if performance is relatively low in early years of adoption. Furthermore, the workgroup acknowledges that the goal is not to achieve perfection but rather a collective effort to begin to move in the direction of more meaningful measurement through the adoption of more outcomes-based measures.

***Reasonable Performance Targets***

The ad hoc workgroup recommends that provider organizations and payers negotiate performance targets that:

- are not below current provider performance,
- are achievable by the provider organization (achievement targets should not be so far above baseline provider performance as to discourage improvement efforts), and
- reflect a reasonable understanding of high performance relative to standardized benchmarks.

Furthermore, the quality incentive program should not be structured in a way that penalizes providers for caring for populations with higher clinical and/or social risk.

***Adequate Denominators***
Provider organizations and payers are encouraged to not use measures in contracts if denominators are too small to report a reliable measurement[1]. To the extent that any measure does not meet minimum denominator size, as defined by the measure steward, the payer and provider may elect to not include the measure when applying a performance incentive and/or disincentive provision in the contract.

***Total Number of Measures for Use in a Contract***
The workgroup aims to align the use of quality measures across contracts and to reduce administrative burden on providers. In pursuit of those aims, the workgroup recommends that payers and providers limit the number of measures used in any given contract to avoid burdening provider practices and to dilute the value or meaningfulness of the incentives.

***Measuring Disparity Reduction***
Payers and providers may add a race, ethnicity, language, sexual orientation, gender identity, age, and/or disability inequity reduction complement to any Core or Menu measure. Such measure(s) will be considered a separate measure and will be regarded as in fidelity with the Aligned Measure Set.

**Annual Review Process**

The PMCC evaluates the Washington State Common Measure Set, and related subsets of measures like this Aligned Primary Care Measure Set, every other year.

The workgroup recommends that the Aligned Primary Care Measure Set remain stable to monitor how sustained, aligned focus supports collective performance improvement over time. The workgroup acknowledges that changes may be necessary to the Aligned Measure Set pending unforeseen industry trends. To that end, HCA staff will conduct an annual review process to maintain the Aligned Primary Care Measure Set. HCA will escalate any potential changes to the PMCC (and any appointed workgroups) in its review process every other year, considering the following:

1. Substantive changes to measure specifications,
2. Alignment of the measure set with statewide health priorities or CMS requirements,
3. Patient and community feedback about population health priorities,
4. Unforeseen barriers to adoption of the measure set,
5. Opportunities for improvement in performance measures—including new industry-standard measures,
6. Any other PMCC or ad hoc workgroup recommended changes.

[1] For this purpose, the NQF definition of reliability of the measure score is used: "Reliability of the measure score refers to the proportion of variation in the performance scores due to systematic differences across the measured entities (or signal) in relation to random error (or noise)." www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=87595.