June 9, 2025

PQM Public Comment

RE: Comments on the Spring 2025 E&M Cycle

To Whom It May Concern,

Covered California appreciates the opportunity to comment on measures in the Spring 2025 endorsement and maintenance cycle. We recognize the importance of this annual review in enhancing the quality and efficiency of healthcare delivery across the United States. After careful consideration of the measures outlined, we wish to express our perspectives and recommendations.

Themes for Consideration:

1. **Significant Measurement Burden:** The healthcare landscape faces a significant challenge with the continuous proliferation of measures creating a substantial measurement burden on providers. Several of the measures included in this list are process-based measures (examples include Cardiac Rehabilitation Patient Referral, Therapy with Aspirin, Adherence to Antipsychotic Medications), and risk diluting the focus on actual outcomes of healthier, longer lives and reduced costs. Additionally, these measures are not clearly aligned with the previously released CMS Universal Measure Set nor the recently communicated priorities of CMS to eliminate waste and improve holistic health outcomes. Indeed, some of these measures may introduce added complexity and hinder alignment efforts across healthcare settings. The continued measure misalignment across government programs (PQM, QRS, Medicaid Core Set) interferes with the ability to successfully align across payers and continues to distract health care providers from their mission.
2. **Outcomes-focused Measures**: We recommend the use of a structured framework, such as that proposed in *Vital Signs: Core Metrics for Health and Health Care Progress* (DOI: 10.17226/19402) nearly ten years ago, when determining whether or not to endorse new measures. For example, the Oral Evaluation, Dental Services measure, and the Comprehensiveness of Care measure may have significant bodies of evidence to support their endorsement in the measure set. We recommend the endorsement of measures only where there is significant evidence that improved performance on a measure is directly tied to better outcomes and has systemic reach with utility at multiple levels. In the spirit of parsimony, we also encourage the sunsetting of measures that do not meet these goals.
3. **Total Cost of Care and Quality Reporting:** As highlighted in a JAMA article (Saraswathula, et al., JAMA Vol. 329, No. 21, pp 1840-47) on the impact of hospital quality reporting on the total cost of care, it is imperative that quality measures are evaluated not only on their immediate clinical impact but also on their broader financial implications. Measures should be assessed for the potential cost of data collection, with

a preference for electronic metrics, and for their ability to contribute to cost efficiency while maintaining or enhancing the quality of care.

4. **Gaps in Measure Development:** We recommend a focus on domains with gaps such as coordination across care settings (e.g., emergency room/urgent care to primary care transitions), specialty care quality, and outcomes-focused measures. Measures should be developed to ensure comprehensive coverage of quality and efficiency in healthcare delivery rather than to duplicate or create redundant metrics.
5. **Focus on performance improvement**: With the current set of measures, there has not been meaningful or sustained improvement across all populations. In fact, several areas have witnessed a decline during the pandemic, including life expectancy, perhaps one of our most important outcomes measures. A number of measures such as CIS-10 and Well Child Visit rates have yet to recover to pre-pandemic performance levels, underscoring the need for improvement and implementation of existing measures through an equity lens, and not for more measures.
6. **Considerations related to survey-based measures:** We encourage PQM and CMS to convene experts, add variables, and capture broader enrollee experience without contributing to the length of member surveys. We agree that many patient-reported outcomes have strong evidence, are often predictive of better outcomes and lower cost, and are generally underutilized. This disconnect is due in part to the burden of collection and the lack of widespread interoperability as well as challenges with member level attribution, which have yet to be resolved. In alignment with our recommended approach to other quality measures, and given the proliferation of survey-based measures, we encourage the sunsetting of survey-based measures that do not have evidence tied to better outcomes and lower cost.

In conclusion, Covered California is committed to collaborating with PQM, CMS, and other stakeholders to approach the continued endorsement of measures with caution and care. We highlight here where the Administration's communicated priorities do not appear to be cascading into programmatic initiatives. Our collective goal is to enhance healthcare quality and efficiency, ultimately benefiting patients and the healthcare system at large. We look forward to engaging in further discussions and contributing to the development of a focused, impactful core measure set. Thank you for considering our comments.

Sincerely,

S. Monica Soni, MD

Chief Medical Officer, Covered California