

MEASURE APPLICATIONS PARTNERSHIP

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# MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS

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## EXECUTIVE SUMMARY

The Measure Applications Partnership (MAP) is in its second cycle of providing pre-rulemaking recommendations to the Department of Health and Human Services (HHS) on performance measures under consideration for federal programs. MAP was established pursuant to statutory requirement, and its primary purpose is to provide input to HHS on selecting performance measures for public reporting, performance-based payment, and other purposes. The MAP pre-rulemaking provision represents an important innovation in the regulatory process by affording the opportunity for more global and strategic upstream input to HHS.

MAP is a public-private partnership convened by the National Quality Forum (NQF). MAP's composition is carefully balanced across 110 members who represent consumers, business and purchasers, labor, health plans, clinicians, hospitals, other providers, communities and states, suppliers, accreditation and certification organizations, and federal agencies. MAP membership also includes numerous subject matter experts on topics such as population health, safety, care coordination, rural health, mental health, child health, team-based care, shared decision-making, and healthcare disparities. MAP's diverse nature and widely collaborative process ensure that a broad cross section of stakeholder perspectives is behind MAP's recommendations on the measures under consideration by HHS for future federal rulemaking.

MAP's goals are to achieve improvement, transparency, and value in health care, in furtherance of the three-part aim of the National Quality Strategy (NQS): better care, affordable care, and healthy people in healthy communities. MAP's objectives are to improve outcomes for patients and their families; align quality

measurement across settings and federal, state, and private-sector programs; and enhance coordination across the system. Building on its first pre-rulemaking cycle, MAP provides recommendations in this report about the best use of available measures, while promoting alignment across programs and sectors and identifying high-priority measure gaps. MAP's recommendations are intended to streamline the costs of measurement, stimulate improvement, and create a cache of information to support decisions of patients and their families and those paying for care.

MAP reviewed more than 500 measures on HHS' list of measures under consideration for 20 federal programs covering clinician, hospital, and post-acute care/long-term care. MAP supports the application of 141 measures within federal programs and supports the direction of another 166 measures, contingent on further development, testing, or endorsement. MAP does not support 165 measures under consideration for inclusion in federal programs. Further, MAP recommends phased removal of 64 measures and addition of 6 measures that are not on HHS' list of measures

under consideration (See MAP Recommendations – [Appendix A](#)).

Given the large number of measures under review, particularly for the clinician performance measurement programs, the MAP Clinician and Hospital Workgroups developed guiding principles to facilitate their decisions about the application of measures to specific programs. The guiding principles are not absolute rules and are intended to complement statutory and regulatory requirements and the broader MAP Measure Selection Criteria. Workgroup members, including Centers for Medicare & Medicaid Services (CMS) representatives, found the principles to be valuable for thinking through measure selection for specific programs while also accounting for the inter-relationships among the programs.

In this report, MAP recommends the use of high-impact measures to achieve parsimonious measure sets for assessing the value of healthcare services. Themes that emerged across all 20 federal programs during this pre-rulemaking cycle include:

- System-level measurement (e.g., at the level of health plans, accountable care organizations, integrated delivery systems) can be a catalyst for comprehensively assessing care across settings and populations and addressing all aspects of the NQS three-part aim.

- As program incentive structures evolve from pay-for-reporting to pay-for-performance, performance measurement should be more rigorous to match the increasing level of provider accountability.
- Shared accountability for healthcare delivery and engagement of community and social supports systems are needed to address diverse needs and fragmented care, particularly of vulnerable populations.
- To capture the value of healthcare services provided, measures of clinical quality, particularly outcomes, should be linked to cost measures. All stakeholders should be cognizant of the costs of care.

In addition to recommending measures for federal programs, this report identifies priority measure gaps and presents NQF's intention to play an activist role in filling measure gaps by working closely with measure developers and establishing a "measure incubator" for stimulating the development and testing of the highest priority measures. NQF will also establish feedback loops to further understanding of measure implementation experience, use, usefulness, and impact. MAP will coordinate with NQF's efforts by engaging MAP members and other stakeholders in these activities.

## I. INTRODUCTION

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for the purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for use in federal public reporting, performance-based payment programs, and other purposes (see MAP Background – [Appendix B](#)). MAP’s unique collaboration and careful balance of interests is designed to provide HHS and the field with thoughtful and varied input from organizations that are invested in the use of measures (see MAP Coordinating Committee and workgroup rosters – [Appendix C](#)). MAP also assesses and promotes alignment of measurement across federal programs and between public- and private-sector initiatives to streamline the costs of measurement and focus improvement efforts on patients.

MAP’s recommendations seek to further the three-part aim of the National Quality Strategy (NQS): creating better care, more affordable care, and healthier people living in healthy communities. MAP informs the selection of performance measures to achieve its stated goals of improvement, transparency, and value for all. MAP’s objectives are to:

- Improve outcomes in high-leverage areas for patients and their families;
- Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value; and

- Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden.

Under statute, HHS is required to publish annually a list of measures under consideration for future federal rulemaking and to consider MAP’s recommendations about the measures during the rulemaking process. This annual pre-rulemaking process affords MAP the opportunity to review the measures under consideration and provide upstream input to HHS in a global and strategic manner.

During its review of the measures under consideration in this pre-rulemaking cycle, MAP employed several of its strategies and tactics outlined in the [MAP Strategic Plan 2012-2015](#) to enable more granular pre-rulemaking input, while continuing to emphasize alignment across programs and to identify high-priority areas where measures are needed to fill gaps in measurement. This MAP Pre-Rulemaking Report provides recommendations on more than 500 measures under consideration by HHS for 20 clinician, hospital, and post-acute care/long-term care performance measurement programs.

## II. PROGRESS ON MEASURE ALIGNMENT

MAP has evaluated progress toward aligned measurement across multiple dimensions. This section of the report analyzes the alignment of measures in HHS programs with the NQS priorities, promotion of alignment by the MAP Families of Measures, alignment through the use of a core set of measures across settings for the dual eligible beneficiary population, alignment of cost of care measures across settings, and two additional examples of efforts driving alignment—the Buying Value initiative and the Institute of Medicine’s (IOM’s) Core Metrics Workshop.

### National Quality Strategy Priorities Addressed by HHS Programs

In accordance with its Measure Selection Criteria (see [Appendix D](#)), MAP recommends selection of the best measures to advance the six priority areas of the NQS (see Figure 1). MAP’s input to HHS about measures to be added and removed from programs is based, in part, on how well the program measure sets align with the NQS priorities.

**FIGURE 1: NATIONAL QUALITY STRATEGY AIMS AND PRIORITIES**



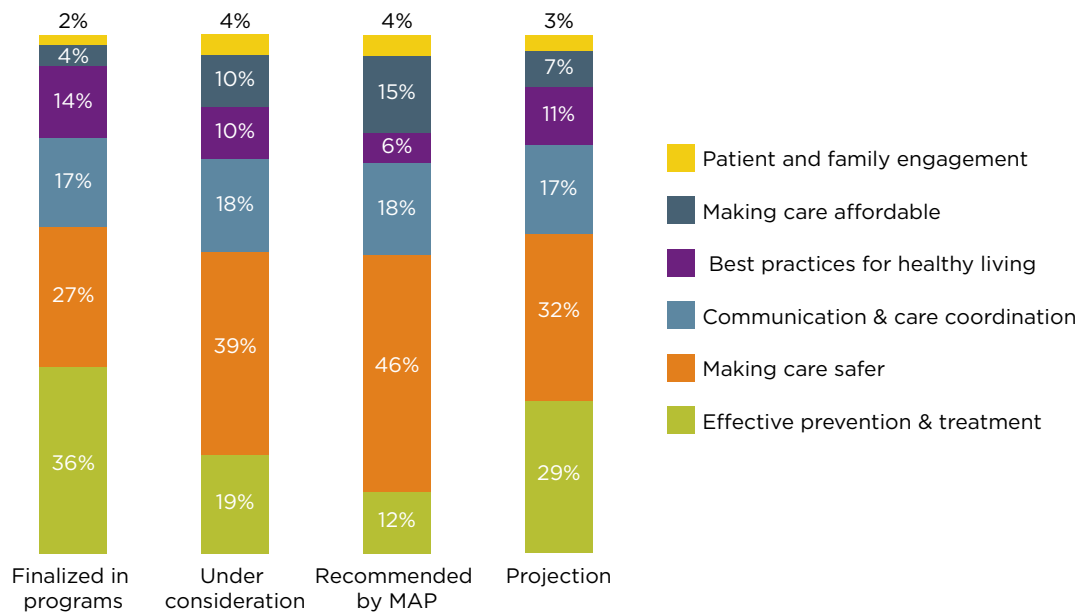
**FIGURE 2: DISTRIBUTION BY NQS PRIORITY OF MEASURES IN HHS PROGRAMS**

Figure 2, above, illustrates the distribution of measures in federal programs across the NQS priorities. From left to right, the columns indicate the measures that are currently finalized for programs through rulemaking, are under consideration by HHS and MAP during the current pre-rulemaking cycle, are recommended by MAP with a decision of “support” or “support direction,” and a projection of the future distribution if measures recommended by MAP are finalized for use in programs.

General observations can be made about the relative proportion and directionality of the measure distribution across NQS priorities. More than one-third of measures already finalized for use in programs address effective prevention and treatment, while less than 20 percent of measures currently under consideration fit that priority area. This may indicate that the effective prevention and treatment priority is fairly well-saturated compared to other priorities. By contrast, the priority area related to improving the affordability of care is a target for increasing the use of relevant measures of resource use, efficiency, and other topics. MAP supported or supported the

direction of 78 percent of the measures under consideration for affordability, the highest level of any of the priorities. Looking forward, MAP encourages a more even distribution of measures across the NQS priorities as HHS adopts MAP’s recommendations to add or remove measures over time. However, MAP recognizes the need to fill gaps in measures related to certain NQS priorities before a more even distribution can be fully realized.

Figure 2 should be interpreted with the understanding that the ideal distribution of measures across the priorities is not known and depends on program-specific context. In some areas, such as patient and family engagement, a small number of measures can be very powerful. For example, expanding the use of the many specialized versions of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) tools across healthcare settings will provide rich data about the experience of care without dramatically shifting the total number of measures in use or their distribution. In other priority areas, an increased number of measures may be needed. For example, performance measurement for safety



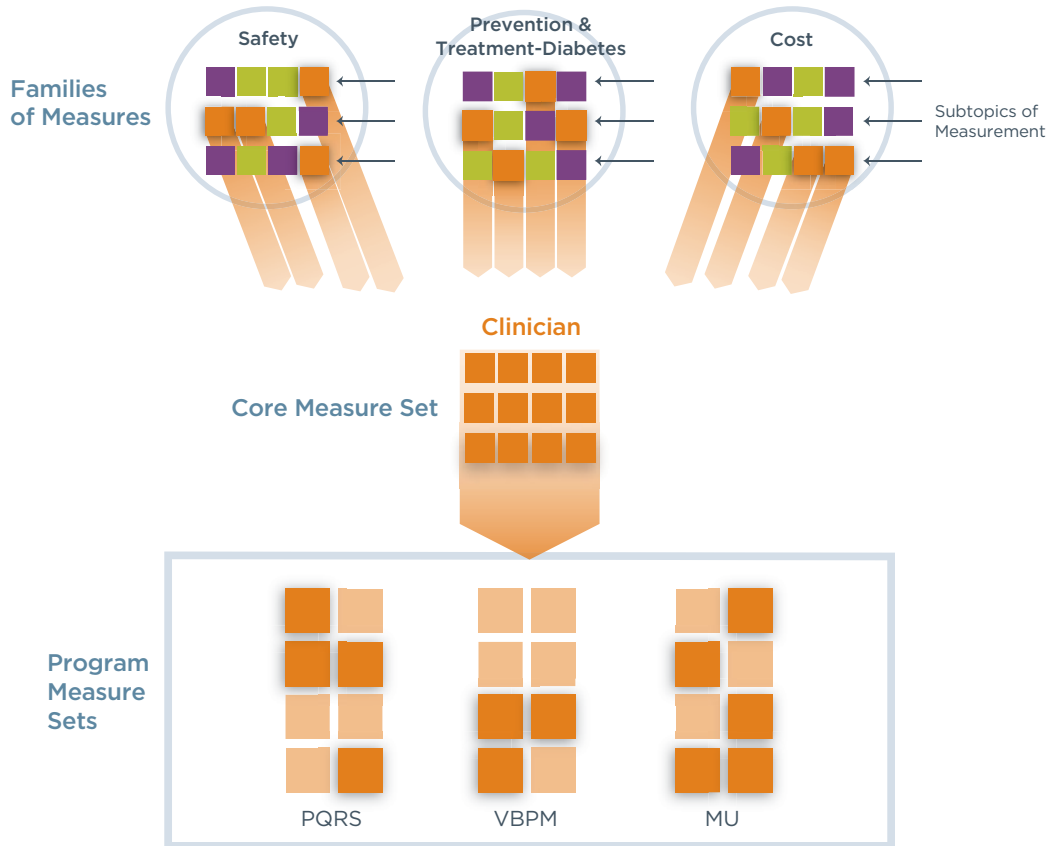
relies on the collection of specialized measures, each one targeted to a single type of potential harm (e.g., ventilator-associated pneumonia, surgical site infection, falls) and often specific to a single site of care. Granular information about safety assists in pinpointing opportunities for quality improvement.

### Alignment Promoted by MAP Families of Measures

In its Strategic Plan, MAP highlighted the use of Families of Measures as a tactic for making progress toward improved outcomes, consistent and meaningful information, and coordination of measurement efforts. MAP has used the Families of Measures to construct setting-specific core measure sets and to guide its pre-rulemaking input on the selection of measures for specific programs.

Figure 3, below, illustrates the relationship between Families of Measures, core measure sets, and program measure sets. In this example, each orange square represents a measure specified for the individual clinician or group practice levels of analysis. Clinician-level measures are found throughout each of the Families of Measures dedicated to a specific NQS priority area, such as patient safety, or prevention and treatment of a leading condition, such as diabetes. Taken together, all measures from families that can be applied to clinicians form the Clinician Core Measure Set. In turn, measures from that core can be applied in particular programs (e.g., the Physician Quality Reporting System (PQRS)). More detail regarding the purpose and application of the MAP Families of Measures can be found in the 2012 [report on Families of Measures](#).

**FIGURE 3: MAP’S FAMILIES OF MEASURES POPULATING A CORE MEASURE SET AND PROGRAM MEASURE SETS**

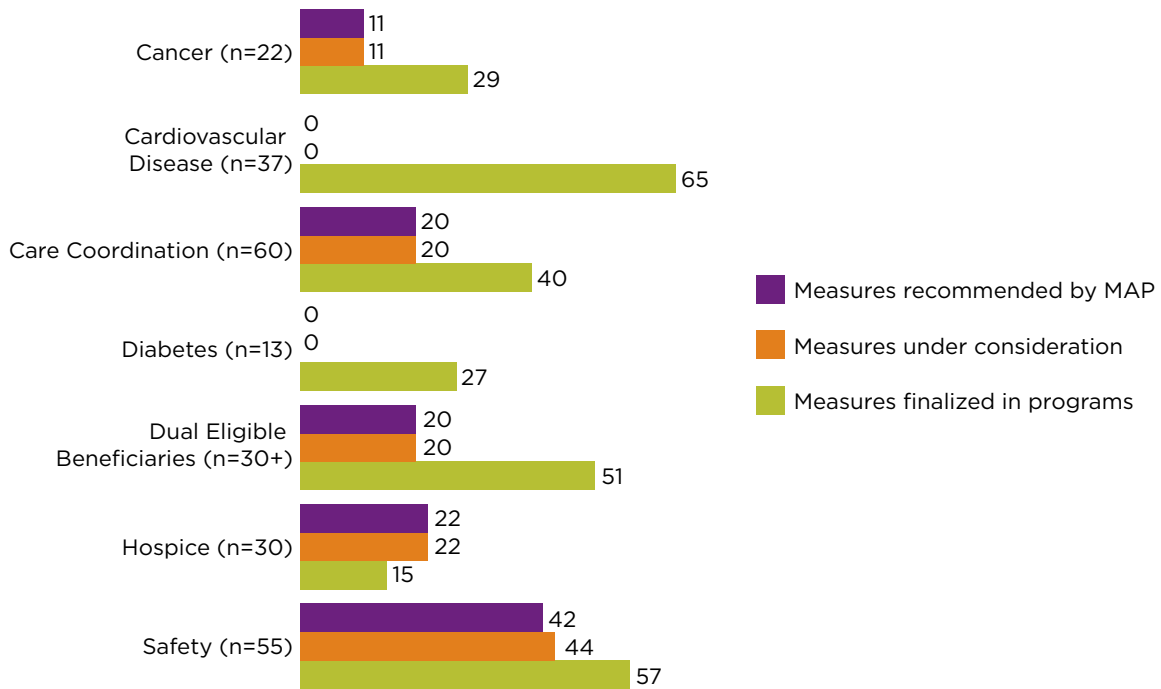


To date, MAP has developed seven sets of measures that can function as Families of Measures. They cover the topics of cancer care, cardiovascular disease, care coordination, diabetes, dual eligible beneficiaries, hospice care, and patient safety. Because families include high-leverage measures for important areas, they inform MAP’s decision-making about measures under consideration.

Figure 4, below, shows the total number of times a measure from a family is associated with a use in a federal program. Individual measures may be found in more than one family. Each measure

can also be associated with more than one program, and such instances increase alignment across programs. Green bars indicate the count of measures currently finalized for program use through rulemaking. Orange bars indicate the count of measures under consideration by HHS and MAP during the current cycle. Purple bars indicate the count of measures recommended by MAP with a decision of “support” or “support direction.” No measures from the cardiovascular disease or diabetes families were considered by MAP; however, a relatively large number of measures for those clinical conditions were previously finalized in programs.

**FIGURE 4: USE OF MEASURES FROM MAP FAMILIES IN PURSUIT OF ALIGNMENT**

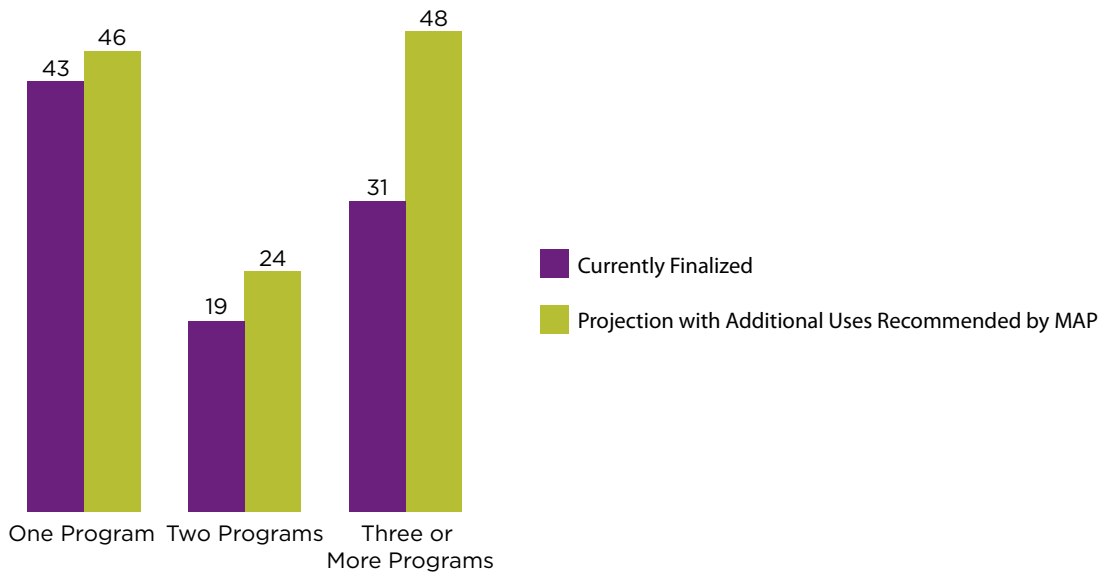


Alignment between measures from MAP families that were under consideration and MAP’s pre-rulemaking recommendations is illustrated by the orange and purple bars being of equal, or near-equal, length. Because Families of Measures are designed to identify the best available measures for application in NQS priority areas, MAP uses them to rapidly evaluate a large volume of measures and ensure that the best measures are recommended for use. MAP fully supported 67 percent of measures from families that were under consideration and supported the direction of an additional 30 percent. Overall, MAP was 98 percent consistent in moving measures from families forward for implementation or further development. In the case of cancer, care coordination, dual eligible beneficiaries, and hospice Families of Measures, MAP was 100 percent consistent in pushing measures toward use in programs. Uptake of measures from these

families should increase attention to important issues, including treatment preferences, pain control, healthcare-acquired infections, and follow-up communication after hospitalization. Moreover, measures that appear in multiple families and/or multiple programs help to amplify knowledge and synchronize action in priority areas.

MAP’s seven Families of Measures contain a total of 193 unique measures; about half are already finalized in one or more HHS programs as pictured in Figure 5, below. If HHS were to add all of the measures from families supported or supported in direction by MAP in this report, then use of important measures would increase. Twenty-five measures from families not previously in use would be incorporated into programs. Similarly, measures’ alignment across multiple programs would improve as the total number of measures reported in three or more programs would jump from 31 to 48.

**FIGURE 5: CURRENT AND PROJECTED USE ACROSS MULTIPLE PROGRAMS OF MEASURES FROM MAP FAMILIES**



Several public commenters noted the progress MAP has made in pursuing alignment and voiced support for the continued use of Families of Measures to synchronize measures and reduce frontline reporting burden. Further, Families of Measures help to organize measures within multiple programs around the NQS priority areas. Commenters also stated that alignment of system-wide goals is crucial to improvement.

### Alignment of Measures in Support of Higher-Quality Care for Dual Eligible Beneficiaries

In providing input to HHS regarding the selection of measures for federal payment and public reporting programs, MAP considered how the programs may impact the quality of care delivered to Medicare-Medicaid dual eligible beneficiaries. More than 9 million Americans eligible for both Medicare and Medicaid comprise a heterogeneous group that includes many of the poorest and sickest individuals covered by either program. Despite their particularly intense and complex service needs, the healthcare and supportive services accessed by these individuals are often highly fragmented.

The MAP Dual Eligible Beneficiaries Workgroup has identified the areas in which performance measurement can provide the most leverage in improving the quality of healthcare for dual eligible beneficiaries: quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. [Appendix E](#) provides a list of the Evolving Core Set of Measures for Dual Eligible Beneficiaries. This measure set was **updated in 2012** to reflect current priorities and the best available measures.

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#### Current Pre-Rulemaking Input

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Liaisons from the Dual Eligible Beneficiaries Workgroup participated in pre-rulemaking meetings across MAP to add the dual eligible perspective to the discussions of measures under consideration. The perspective integrated

well into MAP deliberations, especially when measure alignment was the topic. Different facets of alignment were considered, including across programs and across the episode of care. In addition, alignment between Medicare and Medicaid program requirements is a leading issue in improving care coordination for dual eligible beneficiaries.

In all cases where measures from the Evolving Core Set for Dual Eligible Beneficiaries were under consideration for addition to one or more programs, MAP workgroups supported them for inclusion or supported their direction for further development, testing, or endorsement. This should increase the adoption of high-value measures for vulnerable beneficiaries. New recommendations will add to the 12 core measures previously finalized for use in two or more federal programs and six core measures previously finalized for use in one program. If HHS were to add all of the measures from the core supported or supported in direction by MAP in this report, 5 core measures would be put into use for the first time, 4 additional measures would continue to be used in one program, and 18 measures would be used in multiple programs.

Despite early successes in alignment, much work remains in configuring systems of healthcare delivery and performance measurement to adequately serve vulnerable individuals. Examining measures from the perspective of a single population highlights the fragmentation experienced by beneficiaries. MAP discussed the need for a shared accountability framework to allow for more effective measurement of important issues such as preventable hospitalizations and care coordination.

MAP strongly encourages the fostering and propagation of creative methods for engaging beneficiaries and their social support systems in person-centered, goal-directed care. Significant quality improvements could be made if the outcomes important to individuals were identified and care and supports were provided

with those outcomes in mind. Most measures currently available are lacking the person-centered orientation, creating situations in which clinical measures may conflict with individuals' preferences for managing their health and health care. Measurement of goal attainment and/or fidelity to a shared plan of care are important indicators of high-quality care in medically complex and vulnerable populations.

When discussing the measurement needs presented by the population of dual eligible beneficiaries, MAP emphasized previously identified measure gap areas, including: shared accountability for care coordination through transitions, functional status, advanced care planning, mental/behavioral health, and structural measures as they apply to providers and health plans integrating with community organizations or other providers of long-term supports and services (LTSS). Public commenters also urged prompt action in addressing these gaps, particularly measurement of changes in functional status, a topic that is meaningful for both beneficiaries and their care providers.

MAP urged that more attention be paid to reflecting population diversity in measurement (e.g., socioeconomic, racial/ethnic, disability status) and the disparities in care that may be associated with these factors. Program implementers should explore appropriate risk adjustment and stratification methodologies to better understand the relationships between demographic factors and health outcomes. Public commenters indicated that this is an area of high interest, but caution is warranted. For example, one commenter noted that standard risk adjustment methods such as the Hierarchical Condition Categories (HCCs) have been found to bias quality measures to reward more intensive healthcare systems.<sup>1</sup> Commenters also urged more standardization in risk adjustment methods but were split on whether such methods should account for socioeconomic status. One commenter noted that risk adjustment must be constructed

in a way that does not mask disparities in care experienced by patients with low socioeconomic status.

## Affordability

One of the three aims of the NQS is making health care more affordable by reducing the cost of care for individuals, families, employers, and government.<sup>2</sup> As noted above, affordability is also a target area for increasing the use of relevant measures. The NQS establishes two goals for making care more affordable: ensuring affordable and accessible high-quality health care for people, families, employers, and governments; and supporting and enabling communities to ensure accessible, high-quality care while reducing waste and fraud. The IOM has identified several excess cost domains: unnecessary services, inefficiently delivered services, excessive administrative costs, prices that are too high, missed prevention opportunities, and fraud. Accordingly, affordability can be assessed through a variety of measure types, such as overuse, appropriateness, resource use, and efficiency. Price transparency through consistent price measures and patients' out-of-pocket costs are also critical aspects of affordability.

MAP intends to identify an Affordability Family of Measures to promote alignment of measurement efforts. The Affordability Family of Measures will define high-leverage opportunities for measurement and identify available measures (specifically, the measure types noted above) and measure gaps that address the high-leverage opportunities. MAP will look to private-sector efforts to measure cost and resource use, which are becoming more widely available, to determine high-leverage opportunities and measures that could be applied to federal programs. For example, several private-sector initiatives have developed appropriateness methods to determine when care that is typically assessed for underuse (e.g., cervical cancer screening, prostate cancer screening) is overused in certain populations.

Several public commenters supported MAP's plan to identify an Affordability Family of Measures. Additionally, commenters suggested several topics that should be explored while identifying the family, such as linking functional outcome measures and patient management measures to resource use measures, assessing patient/family/caregiver financial burden, and considering how benefit design could be reflected in cost and resource use.

Resource use and efficiency are types of affordability measures that MAP has continually cited as critical measure gaps. Additionally, several federal public reporting programs (e.g., Hospital Inpatient Quality Reporting, Hospital Outpatient Quality Reporting) and value-based purchasing initiatives (e.g., Hospital Value-Based Purchasing, Physician Value-Based Payment Modifier, Medicare Shared Savings Program) have statutory requirements to include measures of cost, resource use, or efficiency. This year, MAP was able to consider how to make progress toward aligned affordability measurement when reviewing several resource use and efficiency measures under consideration across settings.

Resource use and efficiency are building blocks for understanding value (see Figure 6). NQF's **Cost and Resource Use Consensus Development Project** (RU-CDP) is an ongoing effort to evaluate resource use measures for NQF endorsement. The initial phase of the project sought to understand resource use measures and identify the important attributes to consider in their evaluation. This project generated the **NQF Resource Use Measure Evaluation Criteria** and endorsed eight resource use measures that are used in private-sector efforts; all of the measures evaluate systems and individual conditions, six measures are condition-specific and two are total cost/resource use.

Additionally, the RU-CDP established definitions for the key concepts of resource use and efficiency:

**Resource Use:** Broadly applicable and comparable measures of health services counts (in terms of

units or dollars) that are applied to a population or event (may include diagnoses, procedures, or encounters). A resource use measure counts the frequency of defined health system resources; some further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource.

**Efficiency:** The resource use (or cost) associated with a specific level of performance with respect to the other five Institute of Medicine (IOM) aims of quality: safety, timeliness, effectiveness, equity, and patient-centeredness. Time is sometimes used to define efficiency when determining efficiency of throughput processes or applying time-driven activity based costing methods.

**FIGURE 6: RELATIONSHIP OF EFFICIENCY AND VALUE**



Finally, this project highlighted key considerations for resource use and cost measures:

- NQF supports using and reporting resource use measures in the context of quality performance, preferably outcome measures. Using resource use measures independent of quality measures does not provide an accurate assessment of efficiency or value and may lead to adverse unintended consequences.
- Efficiency measurement approaches should be patient-centered, building on previous efforts such as the NQF Patient-Centered Episodes of Care (EOC) Efficiency Framework.

- Given the diverse perspectives on cost and resource use measurement, it is important to know the purpose and perspectives these measures represent when evaluating the measures for endorsement.

During this pre-rulemaking cycle, MAP was asked to consider whether several resource use and efficiency measures would add value to the program measure sets of specific federal programs. None of the measures under consideration has been submitted for NQF endorsement, so they have not been assessed against the endorsement criteria of importance, scientific acceptability, usability, and feasibility. Despite the absence of such information, MAP determined that the measures under consideration could add value to the programs (see Appendix A; Tables [A4](#), [A8](#), [A10](#), [A16](#), and [A21](#)). NQF is committed to working with measure stewards to bring these measures into the endorsement process.

Additionally, MAP elaborated on the key findings of the RU-CDP, providing additional guidance on the application of resource use measures:

- Resource use measures ideally should be linked with outcome measures. A future MAP Affordability Family of Measures will consider the linkage of quality measures to resource use measures, and will provide additional guidance for monitoring unintended consequences and mitigating risks.
- To be patient-centered, resource use and efficiency measurement approaches should address individuals with multiple chronic conditions. For example, emerging methods of assessing resource use for patients with multiple chronic conditions may include methods for rolling up procedural episodes into acute episodes, or acute episodes into chronic episodes, to gain a better understanding of the total cost for a patient. MAP requests that the RU-CDP Steering Committee consider how condition-specific measures address multiple chronic conditions when evaluating

measures for endorsement. Public commenters concurred with the need to consider how individuals with multiple chronic conditions are addressed by affordability measures.

- Resource use approaches should align across populations and settings, using the same measure when feasible. When developing an Affordability Family of Measures, MAP will consider the potential for broader applicability for private-sector resource use measures, which are becoming more widely used, and determine the best uses for various resource use approaches (e.g., episode-based approaches versus per-capita approaches). To support alignment across settings, MAP requests that the RU-CDP Steering Committee consider how risk-adjustment and attribution methodologies could align across populations and settings.

## Additional Efforts Driving Alignment

MAP Families of Measures and core measure sets are being incorporated into activities beyond HHS programs, including a healthcare purchaser and payer initiative known as [Buying Value](#) and IOM's workshop on [Core Metrics for Better Care, Lower Costs, and Better Health](#). Buying Value will supply healthcare purchasers with the information they need to engage in value-based purchasing and the pursuit of quality improvement. Drawing from existing resources such as MAP Families of Measures, a national survey of health plans, and requirements for Stage Two of the Meaningful Use program, the initiative is identifying aligned performance measures to be used more consistently by purchasers. MAP's concept of measure families and how they populate core measure sets also contributed to national leaders' dialogue at a recent IOM workshop on identifying core population-level metrics within the complex, multilevel, and adaptive healthcare delivery system. The IOM workshop illuminated many perspectives about the application of performance measures and how to achieve alignment.

### III. HIGH-PRIORITY MEASURE GAPS AND NQF'S COLLABORATIVE INITIATIVE FOR GAP-FILLING

Performance measure gaps are a vital issue for a wide variety of stakeholders, as highlighted in the 2012 MAP Families of Measures report. MAP has played a key role in identifying measure gaps through its various activities. In addition, MAP has taken initial steps to encourage gap-filling by moving toward prioritization of high-leverage opportunities, offering more discrete suggestions for measure development, and involving measure developers in discussions about gaps. However, much work remains to be done by measure developers, NQF, MAP, and many other entities to accelerate closing the gaps.

#### MAP's Identification of High-Priority Measure Gaps

The 2012 MAP Families of Measures report described common gap themes and barriers to gap-filling. It detailed how MAP can work to better characterize gaps, provide more granular recommendations, and clarify which gaps are most important. Inherent in this process is the need to consider the anticipated benefit of addressing a specific gap weighed against the costs (financial, time, and potential unintended consequences). In addition, the report pointed to gaps at various stages along the measure lifecycle—from conceptualization, to development and testing, and then on to endorsement, implementation, and monitoring. Key entities that play essential roles in gap-filling may be able to influence some of these steps more readily than others.

In creating the initial Families of Measures, MAP set the stage for building a repository of measures that target the most important opportunities for improvement, in many cases across multiple settings and populations. MAP Families of

Measures identify high-priority gaps, in addition to the best available measures for a priority topic or condition. Measure developers attended and participated in the MAP meetings held to create the measure families. During the dialogue between MAP members and measure developers, developers shared plans for new measures in the development pipeline, and MAP members provided developers with a better understanding of the gaps MAP identified as highest priority to address.

During the 2012-2013 MAP pre-rulemaking meetings, a synthesized list of measure gaps was provided to support deliberations (see [Appendix F](#)). The MAP list of measure gaps is composed of gaps collated from all previous [MAP reports](#), representing cumulative findings over the past two years. The MAP list categorizes gaps according to the NQS priority areas. Using the list as a guide, MAP members were able to build off their prior efforts by affirming persistent gaps and also identifying additional priority gap areas.

#### MAP's Pre-Rulemaking Findings on Gaps

The MAP pre-rulemaking process includes review of currently finalized program measure sets to identify gaps to be filled by available measures (i.e., an implementation gap) or by measures that need to be created (i.e., a development gap). MAP's iterative review of the program measure sets and its list of previously identified measure gaps facilitate identification of both measure implementation and measure development gaps. In some cases, measures supported by MAP address multiple gap areas.



A current example of MAP recommending a measure under consideration for a program to fill a previously identified gap is NQF #0209 (Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment) for the PQRS program. This measure is included in the MAP Cancer, Duals, Hospice, and Safety Families of Measures; incorporates a patient-reported outcome (PRO); and is currently finalized for the Hospice Quality Reporting Program. Expanding its use to PQRS would help address a previously identified gap in implementation of measures concerning comfort at the end of life. Other measures that utilize a PRO were also supported by MAP. These measures help fill gaps in assessing the patient's perspective of the care experience in addition to focusing on outcomes. MAP supported NQF #0228 (CTM-3), a PRO measure that addresses a gap in measuring care transitions, for the Hospital Value-Based Purchasing Program. Similarly, NQF #0258 (CAHPS In-Center Hemodialysis Survey) is a PRO measure MAP supported for inclusion in the ESRD Quality Incentive program that assesses person-centered communication, a separate but related gap area. Both the CTM-3 measure and the CAHPS measures are in the MAP Care Coordination and Dual Eligible Beneficiaries Families of Measures.

Despite the relatively large number of measures under consideration by MAP, members indicated that many measure gaps remain. In general, the types of gaps raised were consistent with those that MAP has previously identified and include: a need for more outcome measures; insufficient coverage of certain populations, such as children and the underserved; measures that are not specified at the desired level of analysis and/or setting (e.g., HCAHPS being tested only in the hospital inpatient setting creating a gap in patient experience measurement in the hospital outpatient, ambulatory surgical center, and long-term care hospital settings); measures that go beyond a "checkbox" approach to assess whether high standards of care are being met; a lack of composite measures for multifaceted topics; and

a relative dearth of measures addressing certain specialty areas, such as mental and behavioral health. Each of the NQS priority areas remains affected to some degree by persistent measure gaps.

During this year's pre-rulemaking process, the areas on MAP's list of previously identified gaps were validated and some nuances were added. For instance, the Clinician Workgroup indicated that measures need to reflect a more diverse set of outpatient conditions, and the group struggled to find available measures that adequately balance issues under the control of individual clinicians versus the larger health system. Public commenters generally agreed with the gap areas identified on the list, and multiple organizations conveyed a need for better measures on diverse topics including care coordination, functional status, medication management, and palliative care. Some public commenters offered specific recommendations for additional priority gap areas, such as prevention and treatment of osteoporosis, and made suggestions for updates to the list of previously identified gaps.

Since implementation gaps also endure, MAP continues to seek opportunities to recommend use of the best available measures where feasible. One member of the Hospital Workgroup advocated that MAP Families of Measures should be used to fill some implementation gaps even when those measures are not on HHS' list of measures under consideration for certain programs. An example provided for this point was NQF #0646 (Reconciled Medication List Received by Discharged Patients), which is in the MAP Safety Family of Measures and addresses a gap in medication safety, but was not under consideration for any acute care hospital programs. Although this measure assesses a basic process rather than an outcome, MAP in some cases has expressed willingness to support process measures for important issues until outcome measures are available.

## NQF's Collaborative Initiative for Gap-Filling

NQF has determined that a coordinated strategy for addressing measure gaps will be an area of focus for the organization in 2013, and has been planning a collaborative initiative for gap-filling. This initiative will build on findings from the 2012 NQF Measure Gap Analysis and Recommendations for Action Report, which includes a summary and analysis of measure gaps identified across the National Priorities Partnership (NPP), MAP, and NQF measure endorsement projects, and lays out a path for NQF's work on gap-filling for this year and next year.

The Gaps Report's first major recommendation emphasizes using existing measures wisely. While all stakeholders agree that both measure development and implementation gaps persist and many are crucial, the ultimate goal should be achieving high-value, parsimonious sets of measures. Excessive numbers of measures, measures that overlap, and measures that have low net benefit lead to data collection and reporting burden, as well as confusing signals about healthcare quality. Reducing measure use burden is a priority within NQF 2013 planning efforts. Aligning use of existing measures that meet the most important needs and are effective at driving improvement across settings and populations will help draw attention to the remaining highest priority needs for efficient gap-filling.

The second recommendation from NQF's Gaps Report and part of NQF 2013 planning is to accelerate progress on the "next generation" of measures. The newer types of measures are often complex but may be able to address multiple priority gap areas. Examples of these measures include composites, PRO measures, resource use measures, and eMeasures. NQF 2013 planning has placed a particular emphasis on the latter, because work on eMeasures has been limited thus far but holds much promise to reduce burden and improve timeliness of quality reporting in the future. All of these measures will still need to meet

the NQF endorsement criteria to ensure they are suitable for widespread use. NQF is considering the possibility of graded endorsement—alogous to a bond rating—to provide more granular guidance for the selection of measures for specific types of programs.

The third recommendation in the Gaps Report is that collaboration must be stronger to make optimal progress on closing measure gaps, which is also an integral component of NQF's 2013 plan for a more coordinated initiative on gap-filling. The resources available to fund measure development, testing, and endorsement are finite, so stakeholders need to establish agreement on the highest priority measurement issues and how to overcome barriers to address them. Duplicative measure development efforts should be discouraged through greater information sharing and harmonization. Emphasis on improved collaboration should include stronger partnerships between stakeholders focused on gaps and those who fund, develop, test, endorse, and implement measures. The work includes proactive outreach to developers and connecting developers to test beds, including electronic health record (EHR) vendors. Regularly convening measure developers for discussions with those who can elucidate the highest priority gaps can provide real-time feedback as measures are identified, developed, and implemented. NQF is also exploring ways to heighten collaboration through creation of a virtual "measure incubator," which would allow stakeholders interested in addressing measurement gaps to collaborate with measure funders, developers, EHR vendors, healthcare systems with advanced measures, and local/regional collaboratives.

MAP members expressed strong support for NQF playing a coordination role in gap-filling and working closely with measure developers early in the development process in the role of "coach" to address gaps, rather than only as "referee" during endorsement. One MAP member expressed a collective need to better

understand the development pipeline and the cost of stewarding a measure to assess barriers to measure development. Subsequent discussion touched on the need to create a business case for measure development. Another MAP member indicated that the lack of shared knowledge about which measure developers are already working on certain topics can lead to duplicative efforts and inefficient use of resources. The concept of a measure incubator was also met with much enthusiasm by MAP. MAP members pointed out that such a mechanism could focus developers on high-priority gap areas upstream, reduce the cost of and the timeline for development, and would also be an excellent forum for training inexperienced developers.

Public commenters broadly supported NQF's initiative for making headway on gap-filling. Several of the public commenters mentioned that the measure incubator concept in particular is a promising step to increase collaboration and further progress. Some public commenters offered recommendations for new directions to take in measure development, such as making better use of alternate data sources and increasing research in important areas where evidence is limited. Several organizations stated an explicit desire to assist NQF in its ongoing efforts to address measure gaps.

MAP plays an important role in identifying and filling gaps in measure use. MAP's work on identifying Families of Measures is already paying dividends by establishing agreement on high-value measures for parsimonious and aligned measure sets. To date, MAP has identified measure families for safety, care coordination, cardiovascular disease, diabetes, cancer, hospice, and dual eligible beneficiaries. In 2013, MAP has proposed identifying additional measure families for affordability, population health, patient and family engagement, and behavioral/mental health. Also during 2013, MAP will engage with stakeholders in new ways. MAP will put feedback loops in place to gather input on measure implementation experience. For example, MAP may learn that measures it has recommended to address gaps may subsequently be found to need modifications to be feasible for particular applications, or to avoid unintended consequences.

Although MAP's work to date on measure gaps is starting to bear fruit, persistent gaps continue to frustrate measurement efforts. MAP has the capability, in coordination with NQF's larger initiative, to influence ongoing progress in filling measure gaps through its specific recommendations and by enhanced collaboration with other stakeholders.

## IV. MAP PRE-RULEMAKING RECOMMENDATIONS

### Approach to MAP Pre-Rulemaking

MAP enhanced its 2013 pre-rulemaking process by utilizing the following step-wise approach (see [Appendix G](#)):

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#### 1. Build on MAP's Prior Recommendations

MAP's strategic input and pre-rulemaking decisions to date informed MAP's deliberations during this pre-rulemaking cycle.

- **Coordination Strategies** elucidated opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives. The recommendations in the MAP performance measurement coordination strategies served as setting-specific background for MAP pre-rulemaking.
- **2012 Pre-Rulemaking Report** provided program-specific input that included MAP's recommendations about measures previously finalized for federal performance measurement programs and about measures on HHS' list of measures under consideration. HHS' uptake of MAP's prior recommendations was provided as background for MAP pre-rulemaking.
- **Families of Measures** served as an initial starting place for evaluation of program measure sets, identifying measures that should be added to a program measure set or measures that should replace previously finalized measures in a program measure set.
- **Measure Gaps** were identified across all MAP reports (see [Appendix F](#)). When reviewing program measure sets, MAP re-evaluated the previously identified gaps, noting where gaps persist. Additionally, specific program measure

gaps are highlighted in the discussion of each program.

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#### 2. Evaluate Currently Finalized Program Measure Sets

Next, MAP used the MAP Measure Selection Criteria to evaluate each finalized program measure set (see [Appendix D](#)). Information relevant to assessing the adequacy of the finalized program measure sets was provided to MAP workgroup members. This assessment led to the identification of measure gaps, potential measures for inclusion, potential measures for removal, and other issues regarding program structure.

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#### 3. Evaluate Individual Measures Under Consideration

Building off the program measure set evaluation, MAP determined whether, and, if so, how the measures on HHS' list of measures under consideration enhanced the program measure sets. In reviewing individual measures under consideration, the MAP Clinician and Hospital Workgroups developed guiding principles to aid their decision-making. Several public commenters concurred with using the guiding principles to inform refinement of the Measure Selection Criteria; several commenters suggested revisions to the guiding principles and the Measure Selection Criteria; and one commenter voiced that the guiding principles should not be used in future deliberations.

For each measure under consideration, MAP provided rationale for one of the following recommendations:

- **Support** indicates measures for immediate inclusion in the program measure set, or for

continued inclusion in the program measure set in the case of measures that have previously been finalized for the program.

- **Support Direction** indicates measures, measure concepts, or measure ideas that should be phased into the program measure set over time, after specific issues are addressed.
- **Phased Removal** indicates measures that should be phased out of the program measure set.
- **Do Not Support** indicates measures or measure concepts that are not recommended for inclusion in the program measure set.
- **Insufficient Information** indicates measures, measure concepts, or measure ideas for which MAP does not have sufficient information (e.g., measure description, numerator or denominator specifications, exclusions) to determine what recommendation to make.

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#### 4. Identify High-Priority Measure Gaps

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After reviewing the measures under consideration, MAP reassessed the program measure sets for remaining high-priority gaps.

Public commenters were supportive of MAP's enhancements to its pre-rulemaking approach and suggested additional improvements for future years. For example, several commenters suggested that MAP collaborate with CMS to review measures under consideration earlier in the year or on an ongoing basis, while other commenters suggested that MAP capture additional details about Coordinating Committee and workgroup individual measure discussions. MAP will address these suggestions as it works to continually enhance the pre-rulemaking process.

### System Performance Measurement Programs

While providing input on the finalized measure set for the Medicare Shared Savings Program (MSSP),

MAP also identified key issues for system-level performance measurement.

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#### Key Issues

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System-level measurement provides an opportunity for a truly patient-centered approach to measurement because performance can be assessed across the settings where patients receive care. Additionally, system-level measurement provides an opportunity to assess topics that may be difficult to measure at setting-specific levels of analyses because of small numbers or difficulty attributing patients to providers. MAP recommends that system-level (e.g., health plans, accountable care organizations, integrated delivery systems) measure sets align with the measures used for setting-specific performance measurement programs to leverage measurement data, decrease provider data collection burden, and align care delivery goals across programs.

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#### Medicare Shared Savings Program Measure Set

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MAP considered the MSSP measure set to be a comprehensive set because it addresses patient experience, other cross-cutting measurement priorities, high-impact conditions, and key quality outcomes. However, MAP noted that the measure set has a heavy emphasis on ambulatory care and could be enhanced with additional acute and post-acute care measures, and measures more relevant to patients with complex medical needs. Two public commenters agreed with the addition of acute and post-acute measures to the MSSP measure set. Additionally, MAP recognized that the measure set currently has a mix of process, outcome, and patient experience measures. Although these measures are important, to make the most impact, MAP would prefer to move to outcome measures (e.g., clinical depression improvement, rather than only screening) where available, or process measures proximal to outcomes. MAP also recommends that adding

measures of patient identification of a usual source of care and health information exchange to understand access to care and coordination of services across the system.

Although MAP recognized that the shared savings aspect of the MSSP is designed to generate cost savings and that the per-capita cost benchmarks included in the MSSP provide comprehensive cost measures, the measure set should incorporate further cost measures to assess value and encourage transparency. From a program implementation perspective, MAP suggested that calculations for the benchmark and performance periods could be based on a longer periods of time to strengthen the shared savings incentives.

MAP previously recommended that the MSSP measure set and the Medicare Advantage 5-Star Quality Rating System measure set should be aligned. MAP strongly reiterated this recommendation during this pre-rulemaking cycle. In support of this goal, MAP identified five NQF-endorsed measures used in the 5-Star program that would enhance the MSSP measure set and alignment across the two programs: NQF #0576 Follow-up After Hospitalization for Mental Illness, NQF #0037 Osteoporosis Testing in Older Women, NQF #0040 Flu Shot for Older Adults, NQF #0053 Osteoporosis Management in Women Who Had a Fracture, and NQF #0553 Care for Older Adults—Medication Review. Public commenters supported alignment of the MSSP measure set and the Medicare Advantage 5-Star Quality Rating System. Additionally, three commenters suggested inclusion of a measure that would address post-fracture care coordination—NQF #0048 Osteoporosis: Management Following Fracture of Hip, Spine, or Distal Radius for Men and Women Aged 50 Years and Older.

MAP also recommends alignment of MSSP and Meaningful Use measures, because integrated systems are increasingly adopting health information technology (HIT) and should have aligned incentives across programs. Although most measures in MSSP are also finalized for

Meaningful Use, some that are not could be revised for electronic reporting and incorporated. For example, NQF #0066 Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%), NQF #0097 Medication Reconciliation, and NQF #0729 Optimal Diabetes Care are all finalized for MSSP and could enhance the Meaningful Use clinical quality measure set. One public commenter emphasized that levels of analysis should be considered when aligning measures across programs, as measures should not be used outside their specified levels of analysis without further evaluation (i.e., development, testing).

Finally, MAP reviewed several measures in the MSSP measure set that are not NQF-endorsed<sup>®</sup> and recommends that one measure be submitted for NQF-endorsement, one measure be removed from the measure set because it overlaps with another NQF-endorsed measure in the set, and one measure be supported in direction until the measure is updated to reflect current guidelines and then resubmitted for endorsement (see Appendix A; [Table A1](#)).

## Clinician Performance Measurement Programs

In reviewing measures for use in PQRS, Physician Compare, the Value-Based Payment Modifier (VBPM), and the Medicare and Medicaid EHR Incentive Program for Eligible Professionals (Meaningful Use), MAP discussed key issues related to clinician performance measurement. To address the key issues, the Clinician Workgroup developed Guiding Principles for Applying Measures to Clinician Programs and then applied those principles to the programs (see [Appendix H](#)). The key issues, guiding principles, and an overview of MAP's recommendations for the clinician programs are presented below.

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### Key Issues

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An overarching goal for all federal clinician

performance measurement programs is engaging clinician participation in meaningful quality reporting to drive improvement in care. To date, participation has been low; in 2010, only 25 percent of eligible clinicians participated in PQRS.<sup>3</sup> Encouraging clinician participation is imperative as the significance of performance measurement increases over time: clinicians who do not participate in PQRS will begin to receive payment penalties in 2015; clinician performance data will be publicly available on Physician Compare in 2015; and the VBPM will be applicable to all clinicians in 2017. Additionally, increased clinician participation will provide consumers and purchasers with publicly reported information to inform their health care choices. MAP seeks to encourage clinician participation in these programs by identifying measures that are considered clinically relevant for all clinician specialties.

To encourage participation, MAP also aims to reduce clinician reporting burden resulting from a lack of alignment across federal programs and between public- and private-sector programs. Improving alignment would also help alleviate the burden experienced by consumers and purchasers who currently do not have easy access to publicly reported information they need to identify high and low performing providers. MAP recommends leveraging measurement data for multiple purposes to decrease reporting burden. For example, Board Maintenance of Certification (MOC) programs (e.g., American Board of Internal Medicine) represent a significant contribution to quality improvement, and their measures, particularly patient-reported survey measures and composites, would be valuable for clinician public reporting and payment incentive programs. Clinicians are also increasingly participating in health plan performance measurement programs (e.g., Integrated Healthcare Association Pay for Performance Program, Massachusetts Blue Cross Blue Shield Alternative Quality Contract), creating opportunity for alignment of measures used in public- and private-sector programs. Public commenters supported MAP's efforts to align

measurement, and one commenter suggested that MAP explore aligning with MOC programs for disciplines other than physicians.

To support alignment, MAP recommends identifying a set of measures that all clinicians could report across programs, regardless of specialty. MAP specifically highlighted the importance of consistent patient experience and engagement measures being available for all clinicians, and it also encouraged consistent or complementary measures for coordination of care, population health (e.g., health risk assessment, prevention), and health disparities. All of these are cross-cutting NQS priorities; future MAP Families of Measures addressing these priorities will support identification of measures that could be reported by all clinicians. Additionally, these areas of measurement reflect a patient's perspective of comprehensive care, which will enable consistent measurement across varying types of systems, whether integrated delivery systems or independent practices. Several public commenters disagreed with MAP's recommendation to identify a set of measures that all clinicians could report, noting that this approach would not adequately assess care provided by subspecialists. Conversely, other commenters stated that utilizing cross-cutting and patient-centered measures would increase clinician participation in PQRS.

Selecting measures that are in use in other settings (e.g., Inpatient Quality Reporting) or levels of analysis (e.g., MSPP) presents opportunities for alignment; however, measures must be tested at the appropriate level of analysis prior to inclusion in clinician public reporting and payment programs. Several public commenters reiterated the need to ensure that measures are tested for individual clinician-level reporting to ensure attribution and accountability issues have been addressed. MAP also recognizes the need to continue to drive toward greater adoption of HIT to build capacity for more sophisticated measurement with less burdensome data collection and reporting.

Further, MAP aims to balance encouraging clinician participation and reducing clinician reporting burden with identifying measures that drive performance improvement and result in greater value. To this end, MAP recommends that measures for clinician public reporting and payment incentive programs focus on outcomes most relevant to patients and to those who purchase care on behalf of patients. To capture value for the VBPM, outcome measures should ideally be associated with related cost or resource use measures (i.e., efficiency measures).

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### Clinician Workgroup's Guiding Principles for Applying Measures to Clinician Programs

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To stimulate broad clinician participation, HHS asked MAP to consider a large number of measures—731 in total—for inclusion in federal clinician programs. Specifically:

- For PQRS, MAP reviewed more than 200 measures under consideration that would be new to federal clinician measurement programs. In addition, all existing measures and measures under consideration for the Hospital Inpatient Quality Reporting (IQR) Program and the Hospital Outpatient Quality Reporting (OQR) Program—113 measures—were submitted for consideration for use in PQRS to accommodate hospital-based physicians. The hospital performance rates for these measures would be applied to individual clinicians.
- For Physician Compare and VBPM, all measures under consideration and existing measures for PQRS—618 measures total—are also under consideration for use in these programs. The recent final rule, Revisions to Payment Policies Under the Physician Fee Schedule, released on November 1, 2012, included all currently finalized PQRS measures in the VBPM.

MAP reviewed the measures under consideration by condition, based on the qualities that make a measure suitable for payment incentives (i.e.,

VBPM), public reporting (i.e., Physician Compare), only for quality reporting (i.e., PQRS) at this time, or not for any of these purposes. MAP's rationale regarding the measures' fit for the programs' purposes will support MAP's future efforts to refine the MAP Measure Selection Criteria and, to meet immediate needs for MAP decision-making, led the Clinician Workgroup to develop the Guiding Principles for Applying Measures to Clinician Programs (see [Appendix H](#)). The principles are not absolute rules; rather, they are meant to be used in conjunction with program-specific statutory and regulatory requirements and the MAP Measure Selection Criteria. The principles will inform future revisions to the Measure Selection Criteria.

### PQRS

Under the guiding principles, measures should first be used in PQRS to obtain measure implementation experience before being used in public reporting and payment incentive programs. Recognizing that performance results do not effect payment for reporting, the Clinician Workgroup concluded that PQRS should be more broadly inclusive of measures to encourage clinician participation while still striving for measures that drive performance improvement. Specifically, the Clinician Workgroup supported the following:

- Including NQF-endorsed measures relevant to clinician reporting to encourage clinician participation, noting that the endorsement process addresses harmonization of competing measures.
- Including a measure that is not NQF-endorsed if it supports alignment (e.g., outcome measures also used in MOC programs), is an outcome measure for a topic not already addressed by an outcome measure included in the program, or is clinically relevant to specialties that do not currently have clinically relevant measures. To be recommended by MAP for PQRS, measures that are not



NQF-endorsed must be fully specified. Some measures that are not NQF-endorsed may not yet be fully tested, and PQRS could serve as a vehicle for gaining access to data for testing and provide implementation experience with these measures.

- Submitting for endorsement measures that are not NQF-endorsed, whether currently finalized in the program or recommended for inclusion in the program. NQF is committed to working with measure stewards to bring promising measures into the endorsement process. Subsequently, if a measure is submitted for endorsement but is not endorsed, then it should be removed from the program. Additionally, measures with NQF endorsement in reserve status (i.e., performance is topped out) should be removed from the program unless they are clinically relevant to specialties that do not currently have clinically relevant measures in the program.

Several public commenters emphasized that PQRS should contain measures that are clinically relevant to all clinicians. Accordingly, commenters recommended including measures that are not NQF-endorsed to allow for more clinician specialties to participate in PQRS. Similarly, commenters suggested that MAP should specify time periods when recommending phased removal for measures that have had NQF endorsement removed, because these may be the only clinically relevant measures for a particular specialty and should remain in PQRS until better measures are available. Finally, public commenters suggested that MAP identify measures that should be used in lieu of the measures MAP recommended for removal or measures under consideration that MAP did not support.

### Physician Compare

The Clinician Workgroup supported including NQF-endorsed measures in Physician Compare that are meaningful to consumers (i.e., have face validity) and purchasers, to meet the public

reporting purpose of supporting consumer and purchaser decision-making. MAP noted that a parsimonious set of measures that all clinicians could report would best support meaningful comparisons for consumers and purchasers. Additionally, measures included in Physician Compare should:

- Focus on patient experience, patient-reported outcomes (e.g., functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care.
- Be aggregated (e.g., composite measures), with drill-down capability for specific measure results to generate a comprehensive picture of quality.

### VBPM

Although the recent Physician Fee Schedule final rule signaled CMS' intent to include all measures used in PQRS for VBPM, the Clinician Workgroup recommended a more targeted approach for measures to be used in this program. Specifically, measures used for VBPM should ideally drive toward value by linking the outcomes most important to patients with measures of cost of care. For payment incentive programs, NQF-endorsed measures are strongly preferred and measures should have been reported in a national program, such as PQRS, for a year. Additionally, measures used in VBPM should:

- Focus on outcomes, composites, process measures that are proximal to outcomes, appropriate care, and care coordination measures (measures included in the MAP Family of Measures generally reflect these characteristics).
- Monitor for unintended consequences to vulnerable populations, such as through the use of stratification methodologies.

Public commenters supported a focus on outcomes for Physician Compare and VBPM; however, one commenter cautioned that there is a lack of evidence for developing outcome measures for many conditions treated by specialists.

## Meaningful Use

The goal of the Meaningful Use program is to encourage quality improvement and information exchange through clinician adoption and use of EHRs. Similar to PQRS, the Clinician Workgroup's initial recommendation is to balance broad inclusion of measures applicable to a variety of clinician specialties with identifying measures that drive performance improvement. Specifically, the workgroup recommends including endorsed measures that have eMeasure specifications available. However, MAP members noted that having eMeasure specifications does not necessarily mean that a measure will improve care and provide information about whether a provider is a meaningful user of HIT; thus, the availability of eMeasure specifications should be just one element in considering measures.

As health IT becomes more effective and interoperable, measures should focus on a demonstrated and meaningful impact on care, such as:

- Measures that reflect efficiency in data collection and reporting through the use of health IT.
- Measures that leverage health IT capabilities (e.g., measures that require data from multiple settings/providers, longitudinal data, patient-reported data, or connectivity across platforms to be fully operational).
- Innovative measures made possible by the use of health IT.

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## Overview of Recommendations for Clinician Programs

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Given the large number of measures under consideration and the complexity of the task, MAP identified specific measures for PQRS and Meaningful Use, but did not identify specific measures for inclusion in Physician Compare or VBPM. As an essential partner in the pre-rulemaking process, CMS encouraged MAP to develop the guiding principles in lieu of individual

measure recommendations for Physician Compare and VBPM, and indicated that having the principles will provide a valuable foundation for measure selection for clinician programs. Illustrations of measures MAP would likely support for inclusion in Physician Compare and VBPM based on the guiding principles are provided below.

To allow for more thorough review, MAP proposes that CMS prioritize the measures under consideration by pre-screening them against the Measure Selection Criteria. In addition, MAP proposes that CMS make the clinician measures under consideration available earlier in the year. With more time and more detailed measure specifications, MAP could convene clinical panels to provide further input on condition-specific measures prior to convening the MAP Clinician Workgroup. MAP will collaborate with CMS to determine a more feasible review process prior to the next pre-rulemaking cycle. Several public commenters reiterated the need for a more thorough review of individual measures under consideration for clinician programs and supported MAP's suggestions for enhancing its processes. Further, commenters suggested that MAP consult with measure developers or other experts to support MAP deliberations.

In addition to reviewing individual measures under consideration, MAP identified four high-priority gaps that when addressed would contribute to a set of measures that could be reported by all clinicians, regardless of specialty:

- Patient and family engagement
- Population health
- Appropriateness, in particular measures that align with the American Board of Internal Medicine (ABIM) Choosing Wisely campaign
- Vulnerable populations (e.g., individuals with multiple chronic conditions, dual eligible beneficiaries) and disparities. MAP favored measures included in the Dual Eligible

Beneficiaries Family of Measures and measures that are identified as disparities-sensitive according to NQF's criteria.

### PQRS

To encourage broad clinician participation, MAP recommends including 54 NQF-endorsed measures under consideration in PQRS. MAP also recommends including 2 measures under consideration that are not NQF-endorsed because they are composites that support alignment: the Diabetes Composite and the Hypertension Composite are used in ABIM's maintenance of certification program. MAP supports the direction of 87 measures; of these, more than half facilitate alignment because they are used in the American College of Surgeons' Surgeon Specific Registry (SSR) and the National Surgical Quality Improvement Program (NSQIP).

MAP did not support the inclusion of 139 measures. Several public commenters opposed MAP's do not support recommendations for specific measures and identified measures that would allow a particular subspecialty to participate in PQRS (see Appendix A; [Table A2](#)). For example, ACS pointed out the need for the bariatric surgery measures under consideration to address clinicians who primary provide bariatric surgery, while the College of American Pathologists (CAP), American Society of Cytopathology (ASC), and Association of Pathology Chairs pointed out the need for measures under consideration that address pathology.

Finally, MAP recommends phased removal of 56 measures currently finalized for PQRS that have been previously submitted for endorsement and were not endorsed. Several public commenters opposed MAP's recommendations for removal, indicating that removing measures will prevent some specialties from participating in PQRS (see Appendix A; [Table A3](#)).

### Physician Compare

When applying the guiding principles, MAP would likely support the following measures for Physician Compare:

- CG CAHPS, while not finalized for use in any federal clinician measurement program, is an NQF-endorsed patient experience measure that MAP recommends for incorporation into all clinician programs. MAP viewed this measure as a high priority that should be implemented quickly.
- NQF #0576 Follow-up after Hospitalization for Mental Illness is an NQF-endorsed care coordination measure that is included in the MAP Care Coordination and Dual Eligible Beneficiaries Families of Measures and also addresses vulnerable populations.
- Two diabetes measures (NQF #0575, 0729) and several cardiac imaging measures (NQF #0670, 0671, and 0672) are NQF-endorsed outcome measures related to prevention and treatment, are currently reported in PQRS, and are included in a MAP Family of Measures.

### VBPM

Currently, the Physician Feedback program, which provides confidential feedback reports to clinicians, serves as a pilot for VBPM. MAP supported the direction of six episode grouper-based resource use measures under consideration for use in the Physician Feedback program (see Appendix A; [Table A4](#)). MAP recommends that these measures be submitted for NQF endorsement and ideally be linked with clinical outcome measures before being used in the VBPM. For example, Episode Grouper: Acute Myocardial Infarction (AMI) could be linked with NQF #0018 Controlling High Blood Pressure, which is an outcome measure currently finalized for use in PQRS and is also included in the MAP Cardiovascular Family of Measures. MAP may also identify outcome measures related to follow-up care and additional clinical outcome measures to link to episode grouper measures in

the program. MAP also supported the direction of two resource use measures that are currently finalized in the program measure set, noting that the measures should be submitted for and receive NQF endorsement before implementation in the program (see Appendix A; [Table A5](#)). Several public commenters urged caution regarding the resource use measures, raising attribution and testing concerns, and highlighting issues experienced when using the M2147 Total Per Capital Cost Measure in CMS' Quality and Resource Use Reports.

MAP also supported the CG-CAHPS patient experience survey for VBPM. Several public commenters agreed with this recommendation, while others raised concerns about the feasibility of implementation. MAP has previously noted that the lack of infrastructure in clinician practices may be a barrier to broad application of CG-CAHPS and suggested exploring alternative methods for supporting implementation.

### Meaningful Use

MAP supported the direction of two measures under consideration for the clinician Meaningful Use program that are not NQF-endorsed, because the measures are tied to an annual wellness visit and the concepts of these measures overlap with endorsed measures currently finalized in the measure set (see Appendix A; [Table A6](#)). Both measures assess care provided during an annual wellness visit—whether patients received a variety of age-appropriate screenings and whether patients received management of identified risks. MAP supports the concept of preventive care composite measures; however, these measures overlap with several individual NQF-endorsed measures that are currently finalized in the set and are not limited to the context of an annual visit. More generally, MAP would strongly prefer measures that reflect the use of HIT to coordinate care, support improved workflow, and drive improved outcomes. Additionally MAP recommended removing measures that have had NQF-endorsement removed (see Appendix A; [Table A7](#)).

## Hospital Performance Measurement Programs

MAP reviewed measures in currently finalized program measure sets and measures under consideration for nine hospital programs that have varying purposes and constructs. As the Hospital Workgroup deliberated about the relationships among these programs, the workgroup identified key issues that led to the development of Guiding Principles for Applying Measures to Hospital Programs. These guiding principles were then used in conjunction with MAP's Measure Selection Criteria to inform decision-making regarding the measures under consideration for each hospital program. The following section covers the key issues and guiding principles and reviews MAP's recommendations for each hospital program.

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### Key Issues

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As MAP began to work through the decision-making process for determining which measures should be included in federal programs, two major challenges arose. The first challenge centered on the overlapping nature of the hospital programs and individual measures within the programs. A large number of the measures on HHS' list were under consideration for more than one program or previously finalized in another program. This highlighted the need to differentiate valuable measure alignment from unnecessary measurement duplication. The second challenge focused on the evolution of hospital quality measurement programs and its relationship to the rigor of performance measures. As these programs move from pay-for-reporting to pay-for-performance approaches, performance measures selected for the programs should also be more rigorous to match the increasing level of accountability.

MAP worked to distinguish effective alignment across programs from potentially unproductive overlap of measures. Some MAP members voiced concern regarding double payment adjustments for hospitals, especially those hospitals serving

large proportions of vulnerable populations. Other members acknowledged that for certain areas of quality measurement, tying significant dollars to performance would send a strong signal to providers about the need to improve and to adequately reward improvement. Public commenters further emphasized both of these viewpoints. Some commenters did not support the use of measures in more than one payment incentive program simultaneously noting that the potential compounded reductions in hospital resources may hinder investment in improvement initiatives to achieve better care. Other commenters stated that the inclusion of certain measures within more than one pay-for-performance program helps to convey the gravity of the problem and urgency to improve, and that including measures in multiple programs is a way of approaching an area for improvement from multiple directions.

MAP members also raised issues regarding clarity of message. While some MAP members pointed out that measuring the same or very similar concepts within multiple programs may cause confusion for consumers, purchasers, and providers, others disagreed. Displaying related, but differing, performance scores for a single provider may be confusing if the differences in scores are not well explained, requiring attention to effective presentation. Likewise, conflicting performance scores for similar measures across programs may send mixed signals to providers about where to focus their improvement efforts. Given the programmatic structures of the Hospital Value-Based Purchasing Program (HVBP) and the Hospital-Acquired Condition Payment Reduction Program, it is possible for a provider to receive a positive score for improving on a hospital-acquired condition (HAC) measure in the HVBP program while receiving a negative payment adjustment for the Hospital-Acquired Condition Payment Reduction Program as a result of performance on the same measure. A number of public commenters reinforced that the designs of the multiple payment incentive

programs are inherently different and may cause confusion when the same measure results in reward for improvement in one case and penalty for performance in another. Conversely, other public commenters indicated potential differences in results are not confusing to consumers when accompanied by clear messaging. Further, some commenters stated that the importance of having certain measures implemented in more than one program to improve outcomes and reduce unnecessary errors and deaths takes precedence over the potential for confusion in public reporting.

The differing types and structures of the hospital performance measurement programs under review also have implications for the measures used within those programs. Some MAP members were concerned about applying measures directly to pay-for-performance programs without first having the opportunity to gain experience collecting and reporting the measures to uncover any measure implementation issues. MAP members expressed concern that potential unintended consequences related to the broad use of a measure should be identified and addressed prior to implementing the measure in a pay-for-performance program. Additionally, a few MAP members stated that implementing measures differently than originally specified and tested can impact the reliability and validity of those measures. For example, a measure specified and tested for a population aged 18-64 may not be reliable and/or valid when applied to a population aged 65 and older. Currently, under statute, measures must first be reported for one year in the IQR program prior to implementation in the HVBP program. MAP agreed with this staged approach, implementing measures in pay-for-reporting programs first, and believed it could be applied to other pay-for-performance programs. However, MAP noted that a staged approach should include a discrete period of time to uncover implementation issues so the use of measures in pay-for-performance programs is not unduly delayed.

MAP determined that the complex relationships among hospital programs must be considered when applying measures to the various programs. Although the MAP Measure Selection Criteria are useful to evaluate the adequacy of program measure sets, the Hospital Workgroup found that further guidance in the form of guiding principles was needed to determine that individual measures are fit for specific program purposes and structures.

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### Hospital Workgroup's Guiding Principles for Applying Measures to Hospital Programs

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The Hospital Workgroup developed the following Guiding Principles for Applying Measures to Hospital Programs (see [Appendix I](#)) to support pre-rulemaking decisions for specific types of programs. The principles are not absolute rules; rather, they are meant to be used in conjunction with program-specific statutory and regulatory requirements and the MAP Measure Selection Criteria. The principles will inform future revisions to the Measure Selection Criteria. The majority of public commenters agreed that the Hospital Workgroup's guiding principles should be taken into account when MAP's Measure Selection Criteria is next revised, though one commenter voiced that the guiding principles should not be used in future deliberations. Comments received offered suggestions for integration of the Hospital Workgroup guiding principles with the Measure Selection Criteria that will be included in this future work.

#### Pay-for-Reporting Programs

The Hospital Workgroup emphasized the importance of gaining experience with measures in a public reporting program before applying them to pay-for-performance programs. Through a public reporting program, such as the IQR program, program implementers can determine that measures accurately and fairly reflect hospital performance. Measures for public reporting should generate useful information to support consumer and purchaser decision-making and

also guide provider improvement efforts. Further, a public reporting period allows hospitals to hone data collection practices and provide feedback regarding the feasibility, usability, and unintended consequences of the data collection methodology. Initially implementing measures in pay-for-reporting programs should not delay their timely use in pay-for-performance programs. If compelling reasons exist to support the immediate inclusion of measures within a pay-for-performance program, then the measures should be applied to those programs more rapidly. Public commenters largely agreed with a staged approach to hospital measure implementation. Some commenters stressed that this approach should not unnecessarily delay measure application to pay-for-performance programs when there is ample opportunity to significantly improve patient care.

#### Pay-for-Performance Programs

Certain measures are more appropriate for pay-for-performance programs that include an improvement component in the payment structure, such as the HVBP program than for programs without an improvement incentive. Measures should address areas of known variation with opportunities for improvement. Topics for which hospitals are less sophisticated in their understanding of how best to make improvements in care are particularly appropriate for application to a program with an improvement incentive. Where unintended consequences and gaming from use of a measure are concerns, monitoring should be established to identify and mitigate those concerns. For example, tracking performance on measures of average length of stay and observation days may provide a signal of potential unintended consequences from the application of readmissions measures. Measures for which the benchmark is uncertain, and may not be zero, may also be more appropriate for programs with an improvement incentive, rather than for other types of payment adjustment programs. To capture the value aspect of

value-based purchasing, measures of clinical quality, particularly outcomes, should be linked to cost of care measures.

Pay-for-performance programs that include only reductions in their payment structures, such as the Hospital Readmission Reduction Program (HRRP) and the Hospital-Acquired Condition Payment Reduction Program, send strong incentive signals to avoid readmissions and HACs. Measures for these programs should address high incidence, severity, or cost areas where there is variation in quality with opportunities for improvement. When selecting measures for these programs, program implementers should consider whether a measure is used within other pay-for-performance programs. Some MAP members expressed concern that measures implemented in more than one pay-for-performance program may result in potential unintended consequences related to overlapping incentives, such as overuse of antibiotics to prevent any patient from contracting a healthcare-acquired infection. Other MAP members noted that to protect vulnerable populations, appropriate adjustments to payment, such as through data stratification, are particularly important for pay-for-performance programs without improvement incentives.

As noted earlier, public commenters expressed divergent viewpoints regarding the inclusion of measures in more than one pay-for-performance program. Multiple commenters stated that this should not be done because it may create confusion regarding provider performance. Other commenters indicated this would be an effective way to further incentivize providers in their performance improvement efforts.

### General Considerations

General considerations included in the Hospital Workgroup's Guiding Principles for Applying Measures to Hospital Programs relate to program monitoring, composite measures, and measure testing. All hospital programs should be monitored for overall impact and unintended consequences that could result from the use of performance

measures. Program implementers should be particularly sensitive to providers serving low patient volumes when applying program measure sets and incentive structures. If composite measures are selected for hospital programs, then individual measures contained within those composites should not be included. Finally, prior to application, measures should be tested for reliability and validity using data from the relevant population for that program. One public commenter noted that program implementers should be sensitive to the quality of health care and information needs of all patients, regardless of volume of events or procedures, and suggested adding another general consideration for hospital programs urging program implementers to be sensitive to consumers' needs for safe, efficient, patient-centered, high quality care.

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## Overview of Recommendations for Hospital Programs

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MAP reviewed program measure sets and measures under consideration for these nine hospital programs: Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Meaningful Use for Hospitals and Critical Access Hospitals, Hospital Readmissions Reduction Program, Hospital-Acquired Condition Payment Reduction Program, PPS-Exempt Cancer Hospital Quality Reporting (PCHQR), Inpatient Psychiatric Facility Quality Reporting (IPFQR), Hospital Outpatient Quality Reporting, and Ambulatory Surgical Center Quality Reporting (ASCQR). MAP's pre-rulemaking recommendations for measures for these hospital programs reflect the guiding principles outlined above.

### Hospital Inpatient Quality Reporting

MAP reviewed 21 measures under consideration for the IQR program, a pay-for-reporting program for acute care hospitals (see Appendix A; [Table A8](#)). As reflected in the guiding principles, measures should initially be included in IQR so hospitals can gain experience with data collection and reporting of performance scores.

A few points from MAP's Measure Selection Criteria are particularly salient for selecting measures for public reporting. NQF-endorsed measures are preferred over measures that are not endorsed or endorsed in reserve status. Similarly, measures that are not NQF-endorsed, are topped out, or no longer represent the standard of care should be removed or suspended from IQR reporting. One public commenter disagreed that good measures that are topped out should automatically be removed from reporting to avoid degradation of performance. Measures selected should be meaningful to consumers, purchasers, and providers and address the NQS aims and priorities, as well as high-impact conditions. The program measure set should be parsimonious, balancing conciseness and comprehensiveness.

MAP supported including updated methodologies for the readmissions measures in IQR to better exclude planned readmissions. Some members noted that further measure development is needed to exclude unrelated admissions for conditions such as traumatic injury or burn. Public commenters agreed with MAP's recommendations stating that the updated methodologies are an improvement and that further exploration of how to measure other unrelated admissions is warranted. Some commenters stressed that more development is needed to determine how readmission measures can be risk adjusted for socioeconomic status and exclude certain patient populations whose conditions may require multiple hospitalizations in a short timeframe. MAP also supported updated Centers for Disease Control and Prevention (CDC)-National Healthcare Safety Network (NHSN) measures under consideration with additional risk adjustment for volume of exposure within a facility, contingent on NQF endorsement of the new methodology. In all, MAP reviewed seven readmission measures, five safety measures, and two mortality measures for the IQR program.

Recognizing the need for more measures addressing affordability, MAP agreed that

additional cost measures should be included in the program measure set. MAP supported the Medicare Spending per Beneficiary measure, noting the statutory requirement for this measure and that this measure is expected to be submitted for NQF-endorsement this year. MAP supported the direction of the AMI Episode of Care measure, recognizing the need for further development of the episode methodology.

Using the MAP Previously Identified Measure Gaps (see [Appendix F](#)), MAP highlighted priority gaps in the IQR program measure set. To expand the populations covered by the IQR program, MAP supported additional pediatric and maternal/child health measures for this set. Additionally, MAP recommended a measure that was not on the list of measures under consideration, NQF #0471 PC-02 Cesarean Section, to address high rates of elective C-sections. Public commenters agreed with MAP's conclusion to support these measures and noted that additional pediatric and maternal/child health measures are needed to address significant gaps in these areas. One commenter raised concerns about the feasibility of implementing NQF #0471 in a federal program as differing state reporting requirements on the parity of the mother could lead to data collection challenges. MAP also suggested including cancer and behavioral health measures from the PCHQR and IPFQR programs in the IQR program to better align measurement for these populations. While MAP did not support two measures under consideration addressing stroke readmissions and mortality because they are not NQF endorsed, these remain important measure gaps for this program. Public commenters agreed that stroke mortality and readmissions should be addressed but shared concerns about the specifications of the measures under consideration. MAP stressed the need for additional safety measures, especially in the areas of medication reconciliation and culture of patient safety. One public commenter suggested that questions regarding medical harm could be added to HCAHPS to provide information about the patient perspective of safety. Other IQR



measure gaps noted include affordability, especially overall costs, and measures that drive toward system-wide improvement in care transitions. Public commenters noted additional gaps in the IQR program including diagnosis and follow-up care for osteoporosis as well as palliative care.

To keep the IQR measure set parsimonious, MAP identified six currently finalized measures within the program for phased removal (see Appendix A; [Table A9](#)). MAP focused on removing measures that are no longer NQF-endorsed or endorsed in reserve status. Three measures were identified for phased removal because NQF endorsement has been removed. An additional three measures were recommended for phased removal because they are NQF-endorsed in reserve status, indicating that performance is topped out. One additional measure was identified for phased removal because MAP believed performance was topped out, although the measure has not yet been moved to reserve status.

### Hospital Value-Based Purchasing

MAP reviewed 17 measures under consideration for the HVBP program, a pay-for-performance program in which hospitals receive the higher of two scores, one based on their performance relative to other hospitals and the other reflecting their improvement over time, with a payment consequence (see Appendix A; [Table A10](#)). Measures within this program should emphasize areas of critical importance for high performance and quality improvement, and ideally, link clinical quality and cost measures to capture value. For the HVBP program, NQF-endorsed measures are strongly preferred and the program measure set should be parsimonious to avoid diluting the payment incentives.

MAP supported including outcome measures and process measures strongly tied to positive outcomes for the HVBP program measure set. Measures under consideration for the HVBP program and supported by MAP addressed safety, prevention, affordability, and care transitions. Additionally, MAP strongly supported

the direction of emergency department (ED) throughput measures, recognizing the significance of ED overcrowding and improving wait times, but noting validity concerns regarding the ED measures under consideration. One public commenter shared the concern that these measures may be subject to bias. Further, MAP identified a number of key gap areas that should be addressed within the HVBP program measure set, including medication errors, mental and behavioral health, and patient and family engagement. One public commenter reinforced the importance of additional safety measures, especially in the areas of medication reconciliation and a culture of patient safety.

MAP recommended phased removal of two measures that are no longer NQF-endorsed to maintain a more parsimonious measure set (see Appendix A; [Table A11](#)). Because HVBP measures are a subset of the IQR program measure set, the two measures identified for phased removal from the HVBP program were also recommended for removal from the IQR program.

### Hospital Meaningful Use

MAP supported the direction of the one measure under consideration for the Meaningful Use for Hospitals and Critical Access Hospitals program, a pay-for-reporting program (see Appendix A; [Table A12](#)). MAP received numerous public comments regarding the one measure under consideration, M3040 Appropriate Monitoring of Patients Receiving PCA. Fifteen commenters urged that the measure specifications be modified to require continuous respiratory monitoring for the first 24 hours rather than the current specification of a maximum period not to exceed 2.5 hours between documented respiratory rate, sedation score, and pulse oximetry. A few commenters further indicated specific support for continuous monitoring through one or more of the respiratory monitoring techniques of respiratory rate, ventilation with capnography, and/or oxygenation with oximetry. Conversely, three commenters did not support inclusion of the measure in Hospital

Meaningful Use, citing alarm fatigue, inaccuracy of current respiratory monitoring devices, and the need for personalized care for patients nearing the end of life.

Overall, MAP noted that the Hospital Meaningful Use program is quite complex, and hospitals have had difficulty understanding and implementing the program requirements. At this time, many hospitals are undergoing initial implementation of electronic health records and are struggling to ensure that all clinicians practicing within the facility can access and operate the systems effectively, with the future expectation of demonstrating meaningful use. One MAP member also raised concerns about the comparability of performance scores calculated for a measure using data collected through manual chart abstraction versus through automated electronic data collection.

MAP identified five measures for phased removal from the Hospital Meaningful Use program (see Appendix A; [Table A13](#)). Two measures related to heart disease were also identified for removal from the IQR program because their NQF endorsement status has been changed to reserve status. Two additional measures have lost their NQF endorsement and were not supported for inclusion in other hospital programs. A measure related to healthy term newborns was identified for phased removal at this time due to measure implementation concerns. MAP strongly supports this measure concept for inclusion in the program once the technical issues are resolved by the measure developer.

### **Hospital Readmissions Reduction Program**

The Hospital Readmissions Reduction Program is a pay-for-performance program that adjusts payments for hospitals found to have an excessive number of readmissions. MAP reviewed six measures under consideration for this program (see Appendix A; [Table A14](#)). MAP supported three measures under consideration that are updated versions of currently finalized measures with new methodology excluding planned readmissions.

Public commenters echoed MAP's support for the inclusion of updated methodologies that account for planned readmissions. Additionally, MAP supported two measures under consideration addressing high-volume elective hip and knee surgeries and supported the direction of a chronic obstructive pulmonary disease (COPD) readmission measure.

MAP considered the balance between all-cause, all-condition measures and condition-specific measures of readmissions. MAP recognized that condition-specific measures highlight opportunities to improve workflow and processes specific to a particular condition, while all-condition measures uncover system-wide issues. One public commenter supported the use of both all-cause, all-condition as well as condition-specific readmission measures. MAP encouraged the development of additional condition-specific readmission measures to address high-impact conditions, such as diabetes and cancer, behavioral health conditions, and conditions particularly relevant to the adult commercially insured population (individuals aged 18-64). Public commenters noted the importance of readmissions for stroke, while sharing MAP's concerns about the specifications of the measures under consideration. Additionally, some MAP members noted the need to exclude unrelated readmissions, beyond planned readmissions, such as readmissions related to traumatic injury or burn. Further, MAP recognized that readmissions are multi-factorial and are often related to broader issues, such as access to care, socioeconomic status, presence of community supports, and other psychosocial factors. Concurrent implementation of measures to monitor patient experience and post-discharge follow-up are important, and risk-stratification methodologies related to race, gender, and socioeconomic status may be needed. Public commenters encouraged the development of risk adjustment methodologies to account for socioeconomic status, community infrastructure, and social determinants of health as these factors have been shown to have an impact on patient

outcomes and readmission rates.

### Hospital-Acquired Condition Payment Reduction Program

The Hospital-Acquired Condition Payment Reduction Program is a pay-for-performance program. There are no currently finalized measures for this program, so HHS asked MAP to review 25 measures under consideration to help shape the initial program measure set (see Appendix A; [Table A15](#)).

When considering measures for the HAC program, MAP's deliberations were particularly focused on potential unintended consequences that could result from overlapping incentives. MAP recognized the fine balance between using high-impact measures in multiple programs to sharpen providers' focus on priority improvement areas and avoiding unintended consequences. For example, while MAP supported the inclusion of NQF #0138, NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure in the HAC and HVBP programs, a MAP member voiced concern that there could be an increase in inappropriate antibiotic use as providers strive to avoid multiple payment adjustments related to infections such as CAUTI. MAP also expressed a preference that measures be publicly reported prior to adoption for this program, in light of concerns regarding potential unintended consequences. Given the program structure, MAP carefully considered the implications of including some serious reportable events, because the occurrence of one of these events during a year could potentially put a hospital in the bottom 25th percentile to receive the payment adjustment. While some MAP members raised concerns about the impact of this program on low-volume and safety-net providers, others emphasized the importance of holding all providers to the same standard of safety.

When discussing the possible inclusion of composite measures in the program, MAP cautioned that composites require careful testing and weighting of all individual components to

ensure a scientifically rigorous measure. Public commenters reinforced these concerns about composite measures. MAP concluded that if composites were applied to this program, then individual measures that are part of the composite should not be included in the program. Consistent with previous recommendations, MAP preferred the CDC-NHSN methodology for data collection and measurement, because this approach does not use administrative claims data and the measures have been well tested, vetted, and publicly reported. Public commenters affirmed this preference for the CDC-NHSN methodology and cautioned against using claims-based measures. One public commenter voiced concern that the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) measures supported by MAP are claims-based and dependent on provider documentation and coder interpretation. Finally, MAP named several measure gaps for this program, including adverse drug events (e.g., wrong dose, wrong patient, drug-drug interactions, drug-allergy interactions), ventilator-associated events (VAEs), sepsis, and an obstetric complications composite measure.

### PPS-Exempt Cancer Hospital Quality Reporting

MAP reviewed 19 measures under consideration for the PCHQR program, a pay-for-reporting program (see Appendix A; [Table A16](#)). This program provides the first opportunity for the 11 PPS-exempt cancer hospitals to gain experience with federal reporting of quality measures.

Consistent with prior recommendations, MAP reinforced the need for alignment of measures for this cancer hospital-specific program with IQR and OQR measures where appropriate for the cancer population. Public commenters noted that care processes for cancer patients may be different and some measures may need additional risk adjustment for this care setting. For example, commenters stated that immunizations would not be appropriate for immuno-suppressed cancer patients who are unable to mount an immune response. The quality of care for other medical

conditions, beyond cancer, should be as high in a PPS-exempt cancer hospital as in a general acute care hospital. While some of the measures under consideration for the PCHQR program may be considered “topped out” in other programs, MAP noted that potential performance variation or disparities in care quality within these facilities are not known. For example, a measure with high performance in the IQR program, such as NQF #0528 Prophylactic Antibiotic Selection for Surgical Patients which had performance scores of 98 percent in 2010 and 2011, should be reported in the PCHQR program to determine whether there is a need for improvement in PPS-exempt cancer hospitals.

Given the unique nature of cancer care and its overall effect on cancer patients and their families and caregivers, MAP placed a high priority on measures of patient and family/caregiver experience as well as other patient-reported outcome measures. To address this, MAP supported the direction of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure and encouraged the completion, NQF endorsement review, and rapid implementation of the cancer-specific CAHPS module currently in development. Public commenters noted measures of patient and family/caregiver experience applied to PPS-exempt cancer hospitals should be applicable across the continuum of cancer care; however, another commenter cautioned against overburdening patients and family/caregivers through administration of multiple surveys. Other measure gaps MAP identified for this program include measures of survival, patient-reported symptoms and clinical outcomes, palliative and hospice care, and psychosocial/supportive services for the patient and family or caregiver. Two public commenters reinforced palliative and hospice care quality measures as priority gaps in the PCHQR program.

### **Inpatient Psychiatric Facility Quality Reporting**

MAP reviewed five measures under consideration for the IPFQR program, a pay-for-reporting program (see Appendix A; [Table A17](#)). This program provides the first opportunity for psychiatric care providers to gain experience with federal reporting of quality measures.

Consistent with prior recommendations, MAP encouraged alignment, as appropriate, of measures for this psychiatric care-specific program with IQR measures to ensure that the quality of care for other medical conditions remains high for patients treated in these facilities and units. Further, MAP supported the extension of psychiatric care quality measurement to outpatient settings, particularly EDs, and inpatient hospitals without psychiatric units. MAP supported measures related to patient follow-up after hospitalization, signaling the broader responsibility of hospitals for patient outcomes even after discharge from the facility. One public commenter supported measures of follow-up after hospitalization for mental illness due to the importance of care coordination for psychiatric patients; however, another commenter stated concern that this practice could be burdensome for facilities not connected with outpatient care settings.

Efforts by hospitals to improve person-centered psychiatric care, such as assessing patient and family/caregiver experience and engagement and establishing relationships with community resources, are priority measure gap areas. As a starting place, MAP supported the Inpatient Consumer Survey (ICS) measure for inclusion in this program. One public commenter expressed concern that this survey includes too many items for general use and has not been formally tested in non-state hospital settings. Additional measure gaps in the IPFQR program include behavioral health assessments and care in the ED, readmissions, identification and management of

general medical conditions, partial hospitalization or day programs, and a psychiatric care module for CAHPS.

### Hospital Outpatient Quality Reporting

MAP reviewed seven measures under consideration for the OQR program, a pay-for-reporting program (see Appendix A; [Table A18](#)). MAP noted that measures for outpatient hospital programs should be aligned with ambulatory measures in programs such as PQRS and Physician Compare. MAP supports measures for the OQR program related to fostering important ties to community resources to enhance care coordination efforts, increasing patient follow-up after procedures, and tracking patients longitudinally. One public commenter noted that measures of follow-up intervals, such as the proposed colonoscopy measures, would be very difficult for hospitals to manage because patients are often not tracked by hospitals after procedures.

Specific gap areas for the OQR program measure set include measures of ED overcrowding, wait-times, and disparities in care, specifically disproportionate use of EDs by vulnerable populations. Additional gaps include measures of cost, patient-reported outcomes, patient and family engagement, and an outpatient CAHPS module. One ED measure was identified for phased removal from the OQR program because it lost NQF endorsement (see Appendix A; [Table A19](#)).

### Ambulatory Surgical Center Quality Reporting

MAP reviewed five measures under consideration for the ASCQR program, a pay-for-reporting program (see Appendix A; [Table A20](#)). These five measures also were under consideration for the OQR program, and MAP supported HHS' efforts to move toward greater alignment across these two programs. One member expressed a concern that these measures are specified for the individual clinician or group practice level of analysis and not for the facility level. MAP supports the inclusion of ambulatory surgical centers (ASC) within a broader system-wide approach

to measuring performance and improving care; however, measures should be tested, endorsed, and implemented for the intended level of analysis. Public commenters reinforced the concerns raised regarding level of analysis for these measures stating that they have never been tested as ASC-level measures. Commenters emphasized that outcome measures applied to the ASCQR program should relate to the ASC episode and measure what the facility controls. Moreover, commenters noted that the ASC would not be able to efficiently collect and report the data required for some of these measures because it would be located in medical records housed in the surgeon's office. Public commenters also noted that two of the measures under consideration are specified for registry-based reporting only and this type of reporting is currently not an option for reporting in the ASCQR program.

MAP found the ASCQR program measure set to be inadequate. The measures under consideration were limited to cataract surgery and endoscopy/polyp surveillance in contrast to the wide variety of procedures now being performed in this setting. MAP encourages swift progress in developing, testing, and endorsing applicable measures to address the quality of care for these additional procedures. Priority measure gap areas for the ASCQR program include follow-up after procedures, complications, cost, patient and family engagement, an ASC-specific CAHPS module, and patient-reported outcome measures.

### Post-Acute Care and Long-Term Care Performance Measurement Programs

MAP utilized its prior coordination strategies for post-acute care/long-term care (PAC/LTC) and hospice performance measurement to guide its input on measures for use in these PAC/LTC programs: Long-Term Care Hospital (LTCH) Quality Reporting Program, Inpatient Rehabilitation Facility (IRF) Quality Reporting Program, End Stage Renal Disease Quality Incentive Program

(ESRD-QIP), Hospice Quality Reporting Program, Nursing Home (NH) Quality Initiative and Nursing Home Compare (NH Compare), and Home Health (HH) Quality Reporting Program. This section presents key issues related to performance measurement in PAC/LTC settings, applicable recommendations from MAP's prior coordination strategies, and an overview of MAP's pre-rulemaking recommendations for each PAC/LTC program.

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### Key Issues

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In reiterating the need to align performance measurement across PAC/LTC settings, MAP emphasized that measurement should also be aligned with other acute settings, such as hospitals. Alignment must be balanced with consideration for the heterogeneity of patient needs across settings. For example, treatment goals for patients in PAC settings focus on improvement while treatment goals for patients in LTC settings are more likely to focus on maintenance. MAP suggests robust risk adjustment methodologies to address the variability of patient populations across settings. For some programs, patient populations are distinguished as short-stay (i.e., patients who are recovering from an illness and are in a facility for less than 100 days) and long-stay (i.e., patients with chronic medical problems who reside in a facility or institution for more than 100 days). MAP suggests revisiting these measures to determine whether (1) there are opportunities to combine the long-stay and short-stay measures using risk adjustment and/or stratification to account for patient variations and (2) any of the measures could be applied to other PAC/LTC programs to align measures across settings.

Admission and readmission measures are also examples of measures that MAP recommends be standardized across settings, yet customized to address the unique needs of the heterogeneous PAC/LTC population. MAP has continually noted the need for care transition measures in PAC/LTC

performance measurement programs. Setting-specific admission and readmission measures under consideration would address this need. However, MAP would like a more parsimonious approach, utilizing fewer measures to address readmissions across settings. Attention would need to be given to defining the index event (e.g., acute hospital admission versus LTCH admission) so that the measure can serve multiple settings. Additionally, MAP suggests that shared accountability across settings be considered when utilizing results from admission and readmission measures so that providers are not unfairly penalized.

MAP suggests that measures besides readmission measures be expanded beyond addressing single settings or conditions. The majority of patients in PAC/LTC settings have multiple chronic conditions. For measures to drive performance, they must address the complexities of this population. Functional status, care coordination, and shared decision-making are measurement areas that address the complexities of multiple chronic conditions from a patient perspective. Public commenters noted that while alignment across settings is important, setting-specific readmission measures may allow more appropriate timeframes, risk adjustment, and data sources. Total cost of care is another type of measure that crosses multiple settings and conditions; MAP recommends that cost measures be included in all PAC/LTC programs.

While MAP emphasizes alignment across settings, MAP encourages parsimony by recommending measures that are most applicable to the population served in each specific setting. For example, MAP recognizes that assessing core safety issues across all settings will promote alignment; however, some safety issues may not reflect the highest-leverage opportunities for measurement in every setting. For example, central line-associated bloodstream infection (CLABSI) incidence is very low in inpatient rehabilitation facilities (IRFs) because patients in

that setting rarely have central lines, while falls are a particularly important safety issue for patients with impaired functional status. Several public commenters emphasized the need to focus on the safety issues that are most pertinent to each setting. These commenters cautioned against measuring healthcare-acquired conditions that have a low incidence in a particular setting, as doing so could divert resources from high-priority improvement efforts for that setting and create unnecessary burden without meaningful quality improvement.

Similarly, patient immunizations are important aspects of care that can promote alignment across settings but may not reflect a high-leverage opportunity for measurement in every setting. For example, influenza and pneumonia immunization are highly important in LTC settings, such as nursing homes, but may be of lesser importance in PAC settings, such as IRFs, where patients should have been immunized in the prior acute care setting. MAP supported the inclusion of several immunization measures across settings, but also called for further evidence regarding the impact of patient immunization measures in each setting. One public commenter supported including immunizations across all PAC and LTC settings, while other commenters noted that immunizations are not the highest priority for measurement in some settings such as IRFs.

MAP continues to recognize that the lack of an information infrastructure across PAC/LTC settings, which are not eligible for Meaningful Use incentives, remains an impediment to measurement. A robust HIT infrastructure is needed to reduce data collection and reporting burden for providers and to enhance care coordination and transmission of information essential to better patient care.

**Application of Prior Coordination Strategies to Pre-Rulemaking Decisions**

In addition to the MAP Measure Selection Criteria, MAP’s **Coordination Strategy for Post-Acute Care**

**and Long-Term Care Performance Measurement and Performance Measurement Coordination Strategy for Hospice and Palliative Care** served as guides for MAP’s pre-rulemaking decisions for the PAC/LTC programs.

In the PAC/LTC coordination strategy, MAP defined high-leverage areas for performance measurement and identified 13 core measure concepts to address each of the high-leverage areas.

**TABLE 1. PAC/LTC HIGHEST-LEVERAGE AREAS AND CORE MEASURE CONCEPTS**

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	<ul style="list-style-type: none"> <li>• Functional and cognitive status assessment</li> <li>• Mental health</li> </ul>
Goal Attainment	<ul style="list-style-type: none"> <li>• Establishment of patient/family/caregiver goals</li> <li>• Advanced care planning and treatment</li> </ul>
Patient Engagement	<ul style="list-style-type: none"> <li>• Experience of care</li> <li>• Shared decision making</li> </ul>
Care Coordination	<ul style="list-style-type: none"> <li>• Transition planning</li> </ul>
Safety	<ul style="list-style-type: none"> <li>• Falls</li> <li>• Pressure ulcers</li> <li>• Adverse drug events</li> </ul>
Cost/Access	<ul style="list-style-type: none"> <li>• Inappropriate medicine use</li> <li>• Infection rates</li> <li>• Avoidable admissions</li> </ul>

In the hospice coordination strategy, MAP identified 28 high-leverage measurement opportunities that are important for hospice and palliative care. Further, MAP prioritized 7 measurement opportunities for both hospice and palliative care, 3 specific to hospice care, and 3 specific to palliative care. The opportunities specific to hospice care reflect patients’ needs for increased access and communication and include

timeliness/responsiveness of care, access to the healthcare team on a 24-hour basis, and avoiding unwanted treatments.

This year when reviewing the program measure sets and measures under consideration for PAC/LTC programs, MAP determined that the following core measurement concepts represent the most critical gaps that when filled would greatly improve care across all PAC/LTC settings: goal attainment; medication management, medication reconciliation, and adverse drug events; functional and cognitive status; patient and family experience of care and engagement in care, and shared decision-making; and transitions in care. Two public commenters strongly supported the use of care transition measures in PAC and LTC settings.

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## Overview of Recommendations for Post-Acute Care and Long-Term Care Programs

### Long-Term Care Hospital Quality Reporting Program

MAP reviewed 5 measures currently finalized for the program measure set and 29 measures under consideration for the LTCH Quality Reporting Program (See Appendix A; [Table A21](#)). MAP noted that many measures under consideration would support alignment with other settings; however, measures should be tested in LTCHs to determine if they are feasible for implementation. Accordingly, MAP supported the direction of 24 measures that address the PAC/LTC core measure concepts but are not ready for implementation in the LTCH setting. MAP also supported the direction of one cost measure, noting that the measure under consideration would exclude LTCHs because the measure methodology excludes hospitals whose average inpatient length of stay exceeds 25 days. MAP recommends that additional measures be added to address cost. For example, assessing whether individuals are appropriately placed in LTCHs would help determine whether they could receive care in less costly settings. MAP did not support four measures under consideration that did not address PAC/LTC core concepts

or had lost NQF endorsement. Core measure concepts that remain as gaps include cognitive status assessment (e.g., dementia identification), advance directives, and medication management (e.g., use of antipsychotic medications).

### Inpatient Rehabilitation Facility Quality Reporting Program

MAP reviewed 2 measures currently finalized for the program measure set and 10 measures under consideration for the IRF Quality Reporting Program (See Appendix A; [Table A22](#)). MAP found the program measure set too limited and noted that it could be greatly enhanced by addressing the core measures concepts not addressed in the set—care coordination, functional status, and medication reconciliation—and the safety issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and *C. difficile*. Accordingly, MAP supported the direction of two measures that address CAUTI and *C. difficile*, in addition to supporting three immunization measures. MAP supported the direction of three functional status outcome measures and one avoidable admissions measure, noting that the measures are important but still in development. MAP did not support one CLABSI measure, which has a low incidence in this setting.

Several public commenters agreed with the MAP's decision to not support the CLABSI measure; however, they disagreed with the MAP's decision to support the direction of the other healthcare-associated condition measures because they did not consider these measures to be the most important areas for safety and quality improvement in this setting. Conversely, one commenter strongly supported the addition of healthcare-acquired condition measures for IRFs. Several commenters noted that measurement for IRFs should focus on patients' functional improvement and discharge to the community, particularly exploring the use of the existing functional outcomes tools such as the Functional Independence Measure (FIM). Lastly, several public commenters cautioned that immunization



measures should not be incorporated into the program because short lengths of stay make it difficult to obtain accurate and timely immunization histories resulting in low benefit-to-burden ratio.

### **End Stage Renal Dialysis Facility Quality Incentive Program**

MAP reviewed 12 measures currently finalized for the program measure set and 21 measures under consideration for the ESRD-QIP (See Appendix A; [Table A23](#)). MAP previously recommended that the measure set expand beyond dialysis procedures to include non-clinical aspects of care, such as care coordination. This issue persists because only one measure under consideration addresses a cross-cutting topic—NQF #0258 CAHPS In-Center Hemodialysis Survey; MAP supports the use of this measure. One public commenter agreed with the MAP’s decision to support the inclusion of CAHPS. Recognizing that the program is statutorily required to include measures of dialysis adequacy, MAP supported 11 measures under consideration that are clinically focused. Similarly, MAP supported the direction of an additional 9 clinically focused measures under consideration, because the measures would address statutory requirements but they are undergoing development and need to be brought forward for NQF endorsement. One public commenter agreed with MAP’s recommendation to support the direction of NQF #0226 Influenza Immunization in the ESRD Population (Facility Level), and another commenter recommended full support instead of support direction, citing evidence demonstrating that influenza vaccination in this population is highly effective and would improve health outcomes. MAP did not support 1 measure under consideration because its NQF endorsement has been removed. MAP recommends exploring whether the clinically focused measures could be combined in a composite measure for assessing optimal dialysis care. The core measure concepts not addressed in this measure set include advance care planning, care coordination, medication reconciliation,

functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression.

### **Hospice Quality Reporting Program**

MAP reviewed two measures currently finalized for the program measure set and seven measures under consideration for the Hospice Quality Reporting Program (See Appendix A; [Table A24](#)). Earlier in 2012, MAP’s [Hospice and Palliative Care Coordination Strategy](#) identified measures for inclusion in a MAP Hospice Family of Measures. All of the measures under consideration are included in the hospice family, so MAP supported them for the hospice program. Public commenters also supported these measures for inclusion in the Hospice Quality Reporting Program and expressed a desire to see an increased focus on hospice and palliative care across settings. Additionally, MAP recommends that other measures in the MAP Hospice Family of Measures be added to the measure set. Specifically, MAP recommends including NQF #1647 Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss. Overall, the measure set fails to address several core measure concepts including pain, goal attainment, patient engagement, care coordination, and depression. Additionally, the measure set would be enhanced with measures that address the caregiver’s role and timely referral to hospice. MAP notes that attribution would be an issue for a timely referral measure because hospice programs cannot control referrals; therefore, timely referral should be assessed in other settings.

### **Nursing Home Quality Initiative and Nursing Home Compare**

MAP reviewed 26 measures currently finalized for the program measure set and 5 measures under consideration for the NH Quality Initiative and NH Compare (See Appendix A; [Table A25](#)). MAP supported the direction of 2 measures that address the PAC/LTC core concept of

inappropriate antipsychotic medication use, noting that the measures should have as few diagnoses excluded as possible and monitoring should be incorporated into program implementation to detect unintended consequences. MAP noted the need for measures that address the overall improvement of dementia care and cautioned that focus on reducing inappropriate use of one class of medication may lead to inappropriate use of other medication classes. One public commenter suggested that the measure exclude FDA-approved diagnoses, particularly bipolar disorder, to reflect appropriate use of antipsychotics.

MAP also supported the direction of two measures addressing avoidable admissions, a core measure concept. MAP recognized the importance of measuring readmissions in the nursing home setting but, as noted earlier, would prefer fewer measures to address readmissions across settings. One public commenter noted that while alignment is important, a readmission measure should be tailored to the nursing home setting as it could have a more appropriate timeframe, risk adjustment methodology, and could be collected through the MDS. Lastly, MAP supported one measure that assesses whether short-stay residents are discharged to the community, noting that this is an important goal for short-stay residents and that additional measures should assess the quality of transition planning. One public commenter did not support MAP's

conclusion and indicated that the measure should be risk-adjusted. Additionally, one commenter stated the need for NQF-endorsed measures addressing nurse staffing rates, noting the impact of staffing ratios on improvement of patient care and outcomes.

### **Home Health Quality Reporting Program**

MAP reviewed 97 measures currently finalized for the program measure set and 2 measures under consideration for the Home Health Quality Reporting Program (See Appendix A; [Table A26](#)). MAP supported the direction of both measures under consideration because they address the PAC/LTC core concept of avoidable admissions. MAP recognized the importance of reducing rehospitalizations and ED visits but noted that these measures should replace or be harmonized with currently finalized measures addressing hospitalizations or ED visits to reduce redundancy in the set. Overall, MAP noted that the large measure set reflects the heterogeneity of home health population; however, the measure set could be more parsimonious. One public commenter supported MAP's recommendations and the need for a parsimonious set including the most salient home health measures. Additionally, one public commenter noted the need to add palliative care domains to the OASIS instrument.

## V. FEEDBACK LOOPS ABOUT MEASURE USE

The MAP Strategic Plan for 2012-2015 emphasizes the need to engage stakeholders more deeply in MAP's work. Specifically in 2013, MAP will establish feedback loops for two-way exchange of information about measure implementation, use, and impact, to inform MAP's recommendations and to determine how to better meet the measure selection needs of public- and private-sector performance measurement programs. This section presents important items to consider when constructing feedback loops, including essential characteristics, intended purposes, information sources, and channels for exchange of information.

The recent Institute of Medicine Report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*,<sup>4</sup> cites the creation of feedback loops as essential for continuous learning and system improvement. A continuously learning system uses information to change and improve its actions and outputs over time. Ideally, the exchange of information through feedback loops is systematic, standardized, real-time, two-way, occurs among all levels of the system, and takes best advantage of information technology.

Standardized information about measure implementation, use, and impact serves many purposes for MAP, other aspects of the work of NQF, HHS, and the broader field. For example, information about measure use across public- and private-sector programs will help MAP ensure that its recommendations for measure use are resulting in alignment. The NQF endorsement process collects information through measure maintenance about the implementation experience and intended and unintended effects of specific measures every three years. Measure developers want to understand unintended consequences from measurement so they can modify their measures where necessary. HHS and other program implementers need information about

measure impact to evaluate their programs. Measure end users are particularly interested in feasibility and data collection burden and in sharing their implementation experiences with program implementers.

Establishing feedback loops is an expensive endeavor, and in an era of constrained resources, it is practical to build on information sources that are already available. MAP has used HHS' uptake of MAP's recommendations from the first round of pre-rulemaking in its proposed and final rules as a feedback loop to assess the effectiveness of MAP's recommendations. The MAP strategic plan also calls for a formal evaluation of its processes and impact. Many other information sources could be developed into feedback loops, for example:

- Measure use and results from private health plans, purchaser coalitions, and regional alliances;
- Information from program implementers, such as CMS and The Joint Commission, about experience with the measures used in their programs;
- Information about maintenance of certification (MOC) from the medical specialty boards;
- Data and measurement results from clinical registries and medical specialty societies;
- NPP's recommendations on measures for the NQS, its action pathways, and its online action registry;
- Measure-specific information submitted through the NQF endorsement process for measure maintenance;
- Structured input about measure properties and implementation experience received through the NQF Quality Positioning System (QPS);
- Barriers to the use of measures raised through the NQF Councils;
- Agency for Healthcare Research and Quality's

(AHRQ's) National Healthcare Quality and Disparities Reports and Medical Expenditure Panel Survey (MEPS);

- CMS' National Impact Assessment of Medicare Quality Measures;
- CDC's National Health and Nutrition Examination Survey (NHANES) and Behavioral Risk Factor Surveillance System (BRFSS); and
- Measure results from the Veterans Health Administration.

There are many channels for facilitating two-way exchange of information among stakeholders. Information can be pushed to a repository through routine submission or pulled into a repository through targeted outreach. Information technology and knowledge management techniques are important to ensure that data collection and storage are systematic and standardized to ease analysis and dissemination of information. One of the essential elements of systematic data collection, regardless of information exchange mechanism, is the need for standardized questions and data elements. Surveys are widely used to collect standardized information; for example, America's Health Insurance Plans (AHIP) and the Quality Alliance Steering Committee (QASC) have recently used surveys to collect information about measure use. Other possible mechanisms for active information exchange include focus groups, listening sessions, online discussion forums, and learning networks.

As NQF prepares to implement feedback loops to better understand measure implementation experience, MAP members were asked to share their perspectives on several questions, including: What are the most important information sources for initial feedback loops? Who can NQF partner with to establish feedback loops? What are the most feasible mechanisms for information exchange? What structured questions should NQF ask—whether through QPS, endorsement maintenance, NPP, MAP, or outreach—about measure implementation experience, use, and impact?

MAP members noted that organizing all of the information related to measure implementation experience, use, and impact is a potentially overwhelming task, so prioritization of the most important information will be essential. Establishment of feedback loops should begin with defining information needs and ultimate uses of the information. MAP members noted the importance of real-time, electronic exchange of information to quickly spot unintended consequences, but they also cautioned that real-time information will not tell the whole story because impact may only be apparent after years of experience with a measure. Analysis of information should focus on identifying trends over time. One MAP member emphasized that in addition to assessing implementation experience, feedback about measure needs should be considered in advance of implementation to be sure that our efforts are addressing what is important to measure, not just what we are already measuring. Another MAP member commented on the importance of social media as an information source.

MAP members provided input on information sources and partners for information exchange. Several members indicated that public- and private-sector program implementers, such as CMS and private health plans, are an obvious starting place for seeking information about the measures used in their programs. MAP members specifically suggested inclusion of other potential partners, including clinician and provider groups, such as Pioneer accountable care organizations (ACO), medical and hospital associations, and medical specialty societies and boards; regional health alliances, such as the collaboratives in Maine, Minnesota, and Wisconsin; Medicare Qualified Entities that receive Medicare data for public reporting purposes; and measure developers, such as the AMA-convened Physician Consortium for Performance Improvement (PCPI) and the National Committee for Quality Assurance (NCQA). Several public commenters expressed support for establishing feedback loops and

indicated an interest in partnering with NQF on the effort. Further, some commenters mentioned specific information sources, such as the National Database of Nursing Quality Indicators (NDNQI) and the National Quality Registry Network (NQRN).

## VI. NEXT STEPS

In its **Strategic Plan**, MAP articulated specific tactics for continually enhancing its input on performance measures and for achieving more consistent and meaningful, and less burdensome, measurement over time. This report demonstrates how MAP's tactics—identifying Families of Measures and high-priority measure gaps, refining the Measure Selection Criteria, making its recommendation categories more meaningful, and establishing feedback loops—will enhance MAP's pre-rulemaking recommendations.

The initial MAP Families of Measures provide guidance for aligned performance measurement (see Progress on Measure Alignment section above). MAP will continue this effort in 2013 by identifying Families of Measures for affordability, population health, patient and family engagement, and mental health. In addition, MAP will continue to identify high-priority measure gaps and contribute to addressing gaps by coordinating with NQF's collaborative gap-filling initiative.

Learning from this pre-rulemaking cycle will further inform implementation of the MAP Strategic Plan. The guiding principles developed

by the Clinician and Hospital Workgroups will serve as important inputs to MAP's 2013 review and revision of the Measure Selection Criteria. MAP will also continue to refine its recommendation categories and rationale. For example, several MAP members suggested adding a new recommendation category, Conditional Support, to be used when MAP recommends implementation of a measure only after specified conditions are met. Several public commenters strongly agreed with revisiting the recommendation categories; commenters reinforced adding a Conditional Support category and suggested that MAP provide timing when using the Phased Removal category.

In 2013, MAP will work to establish feedback loops for two-way exchange of information about measure implementation experience to increase stakeholder engagement and ensure that its recommendations are meeting measurement needs. Also in 2013, MAP intends to develop a formal evaluation plan of its processes and progress on achieving its goals and objectives.

## ENDNOTES

- 1 Song Y, Skinner J, Bynum J, et al. Regional Variations in Diagnostic Practices. *New England Journal of Medicine*. 2010; 363:45-53
- 2 HHS. *2012 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care*. Washington, DC:HHS;2012. Available at <http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf>. Accessed January 2013.
- 3 Centers for Medicare & Medicaid Services (CMS). *National Impact Assessment of Medicare Quality Measures*. Baltimore, MD:CMS;2012. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/NationalImpactAssessmentofQualityMeasuresFINAL.PDF>. Accessed January 2013.
- 4 Institute of Medicine (IOM). *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*. Washington, DC: National Academies Press;2012. Available at <http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx>. Accessed January 2013.

# APPENDIX A: Program Summaries and Measure Tables

## Medicare Shared Savings Program

### Program Type:

Pay for Reporting and Pay for Performance<sup>1</sup>

### Incentive Structure:

Option for one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years).<sup>2</sup>

### Care Settings Included:

Providers, hospitals, and suppliers of services.

### Statutory Mandate:

Sec. 3022 of the Affordable Care Act (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Medicare Shared

Savings Program (MSSP) that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery.<sup>3</sup>

### Statutory Requirements for Measures:

Appropriate measures of clinical processes and outcomes; patient, and, wherever practicable, caregiver experience of care; and utilization (such as rates of hospital admission for ambulatory sensitive conditions).<sup>4</sup>

### MAP Pre-Rulemaking 2013 Input:

The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.

**TABLE A1. MAP INPUT ON MSSP CURRENTLY FINALIZED MEASURES AND RECOMMENDED MEASURES**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0037 Endorsed</b>	Osteoporosis Testing in Older Women		Support: Promotes alignment across programs, settings, and public- and private-sector efforts	MAP recommends aligning with MA 5 Star Quality Reporting Program. Public comments from NHBA, NOF, AMGEN, and ASBMR support MAP's conclusion.
<b>0053 Endorsed</b>	Osteoporosis Management in Women Who Had a Fracture		Support: Promotes alignment across programs, settings, and public- and private-sector efforts	MAP recommends aligning with MA 5 Star Quality Reporting Program. Public comments from NHBA, NOF, SHM, AMGEN, and ASBMR support MAP's conclusion.



**TABLE A1. MAP INPUT ON MSSP CURRENTLY FINALIZED MEASURES AND RECOMMENDED MEASURES**

(continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0553 Endorsed</b>	Care for Older Adults – Medication Review		Support: Promotes alignment across programs, settings, and public- and private-sector efforts	MAP recommends aligning with MA 5 Star Quality Reporting Program.
<b>0576 Endorsed</b>	Follow-Up After Hospitalization for Mental Illness		Support: Promotes alignment across programs, settings, and public- and private-sector efforts	MAP recommends aligning with MA 5 Star Quality Reporting Program.  Public comment from Genentech supports MAP's conclusion, noting that the measure is highly relevant to the improvement of care coordination and outcomes for patients with mental illness.
<b>M1170 Not Endorsed</b>	ACO 8 (CMS): Risk-Standardized, All Condition Readmission	MUC: PQRS FIN: MSSP		Submit for endorsement.
<b>M1204 Not Endorsed</b>	ACO 21 (ACO-Prev-11) (CMS): Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	MUC: FIN: MSSP	Phased Removal: A finalized measure addresses a similar topic and is NQF-endorsed	NQF #0018, an outcome measure in the same topic area, is also included in the finalized set.
<b>M1990 Not Endorsed</b>	ACO 20 (CMS): Preventive Care and Screening: Breast Cancer Screening	MUC: Physician Compare; VBPM FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; MU-EP; Medicare Part C Plan Rating; MSSP; Physician Feedback; PQRS; VBPM	Support Direction: Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure was previously endorsed, but is undergoing updates to reflect current breast cancer screening guidelines. MAP recommends maintaining measure in the program if the measure is updated to reflect guidelines and endorsed prior to 2014 program implementation.
<b>M2117 Not Endorsed</b>	ACO 11 (CMS): Percent of Primary Care Physicians Who Successfully Qualify for an EHR Program Incentive Payment	MUC: FIN: MSSP		Submit for endorsement.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Physician Quality Reporting System

### Program Type:

Pay for Reporting

### Incentive Structure:

In 2012-2014, eligible professionals can receive an incentive payment equal to a percentage (2 percent in 2010, gradually decreasing to 0.5 percent in 2014) of the eligible professional's estimated total allowed charges for covered Medicare Part B services under the Medicare Physician Fee Schedule.<sup>5</sup> Beginning in 2015, eligible professionals and group practices that do not satisfactorily report data on quality measures will receive a reduction (1.5 percent in 2015, and 2 percent in subsequent years) in payment.<sup>6,7</sup>

### Care Settings Included:

Multiple. Eligible professionals include:

- Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical

psychologist, registered dietician, nutrition professional, audiologists

- Therapists—physical therapist, occupational therapist, qualified speech-language therapist<sup>8</sup>

### Statutory Mandate:

The 2006 Tax Relief and Healthcare Act (TRHCA) required the establishment of a physician quality reporting system. The PQRS was initially implemented in 2007 and was extended as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2008 (MMSEA), the Medicare Improvements for Patients and Providers Act of 2009 (MIPPA), and the Affordable Care Act.<sup>9</sup>

### Statutory Requirements for Measures:

No specific types of measures required. Individual clinicians participating in the PQRS may select 3 measures (out of more than 200 measures) to report or may choose to report a specified measure.

### MAP Pre-Rulemaking 2013 Input:

The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0053 Endorsed</b>	Osteoporosis Management in Women Who Had a Fracture	MUC: PQRS FIN: Medicare Part C Plan Rating; Physician Feedback; VBPM	Support: NQF-endorsed measure	Public comments from NHBA, NOF, SHM, ASBMR, and AMGEN support MAP's conclusion.
<b>0057 Endorsed</b>	Comprehensive Diabetes Care: Hemoglobin A1c Testing	MUC: PQRS FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Physician Feedback; VBPM	Support: NQF-endorsed measure	

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0063 Endorsed</b>	Comprehensive Diabetes Care: LDL Screening	MUC: PQRS FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Physician Feedback; VBPM	Support: NQF-endorsed measure	
<b>0076 Endorsed</b>	Optimal Vascular Care	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from AHIP raised concerns about data sources.
<b>0106 Endorsed</b>	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) in Primary Care for School Age Children and Adolescents	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>0107 Endorsed</b>	Management of Attention Deficit Hyperactivity Disorder (ADHD) in Primary Care for School Age Children and Adolescents	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>0112 Endorsed</b>	Bipolar Disorder: Level-of-Function Evaluation	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>0209 Endorsed</b>	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	MUC: PQRS FIN: Hospice Quality Reporting	Support: NQF-endorsed measure	Public comments from CAPC and NCHPC support MAP's conclusion.
<b>0275 Endorsed</b>	Chronic Obstructive Pulmonary Disease (PQI 5)	MUC: PQRS FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; MSSP; Physician Feedback	Support: NQF-endorsed measure	
<b>0277 Endorsed</b>	Congestive Heart Failure Admission Rate (PQI 8)	MUC: PQRS FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; MSSP; Physician Feedback	Support: NQF-endorsed measure	

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0310 Endorsed</b>	Back Pain: Shared Decision Making	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>0312 Endorsed</b>	Back Pain: Repeat Imaging Studies	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from MITA supports MAP's conclusion.
<b>0315 Endorsed</b>	Back Pain: Appropriate Imaging for Acute Back Pain	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from MITA supports MAP's conclusion.
<b>0381 Endorsed</b>	Oncology: Treatment Summary Communication—Radiation Oncology	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>0431 Endorsed</b>	Influenza Vaccination Coverage Among Healthcare Personnel	MUC: OQR; HVBP; IRFQR; PQRS FIN: ASCQR; IQR; LTCHQR	Support: NQF-endorsed measure	
<b>0513 Endorsed</b>	Thorax CT: Use of Contrast Material	MUC: PQRS FIN: OQR	Support: NQF endorsed measure	Public comment from MITA supports MAP's conclusion.
<b>0519 Endorsed</b>	Diabetic Foot Care and Patient Education Implemented	MUC: PQRS FIN: HHQR	Support: NQF-endorsed measure	
<b>0542 Endorsed</b>	Adherence to Chronic Medications	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from SHM supports MAP's conclusion.  Public comment from ACR does not support MAP's conclusion, noting that the measure is intended for facility level use.
<b>0545 Endorsed</b>	Adherence to Chronic Medications for Individuals with Diabetes Mellitus	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>0646 Endorsed</b>	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	MUC: LTCHQR; PQRS FIN:	Support: NQF-endorsed measure	Public comment from AMA does not support MAP's conclusion, noting that the measure is intended for facility level use. Public comment from SHM supports MAP's conclusion.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0647 Endorsed</b>	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	MUC: LTCHQR; PQRS FIN:	Support: NQF-endorsed measure	Public comment from AMA does not support MAP's conclusion, noting that the measure is intended for facility level use. Public comments from SHM, CAPC, and NCHPC support MAP's conclusion.
<b>0648 Endorsed</b>	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	MUC: LTCHQR; PQRS FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults	Support: NQF-endorsed measure	Public comment from AMA does not support MAP's conclusion, noting that the measure is intended for facility level use. Public comment from SHM supports MAP's conclusion.
<b>0649 Endorsed</b>	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from AMA does not support MAP's conclusion, noting that the measure is intended for facility level use. Public comment from SHM supports MAP's conclusion.
<b>0655 Endorsed</b>	Otitis Media with Effusion: Antihistamines or Decongestants—Avoidance of Inappropriate Use	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>0656 Endorsed</b>	Otitis Media with Effusion: Systemic Corticosteroids—Avoidance of Inappropriate Use	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>0657 Endorsed</b>	Otitis Media with Effusion: Systemic Antimicrobials—Avoidance of Inappropriate Use	MUC: PQRS FIN: CHIPRA Quality Reporting	Support: NQF-endorsed measure	
<b>0666 Endorsed</b>	Ultrasound Guidance for Internal Jugular Central Venous Catheter Placement	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comments from MITA and SHM support MAP's conclusion.
<b>0711 Endorsed</b>	Depression Remission at Six Months	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from Takeda Pharmaceuticals supports MAP's conclusion.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1365 Endorsed</b>	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	MUC: PQRS FIN: MU-EP	Support: NQF-endorsed measure	
<b>1523 Endorsed</b>	In-hospital Mortality Following Elective Open Repair of AAAs	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>1524 Endorsed</b>	Assessment of Thromboembolic Risk Factors (CHADS2)	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from SHM supports MAP's conclusion.
<b>1534 Endorsed</b>	In-Hospital Mortality Following Elective EVAR of AAAs	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>1540 Endorsed</b>	Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>1543 Endorsed</b>	Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)	MUC: PQRS FIN:	Support: NQF-endorsed measure	
<b>1617 Endorsed</b>	Patients Treated with an Opioid Who Are Given a Bowel Regimen	MUC: Hospice Quality Reporting; PQRS FIN:	Support: NQF-endorsed measure	Public comments from CAPC and NCHPC support MAP's conclusion.
<b>1625 Endorsed</b>	Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from CAPC supports MAP's conclusion.
<b>1626 Endorsed</b>	Patients Admitted to ICU Who Have Care Preferences Documented	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comments from SHM and CAPC support MAP's conclusion.
<b>1634 Endorsed</b>	Hospice and Palliative Care— Pain Screening	MUC: Hospice Quality Reporting; PQRS FIN:	Support: NQF-endorsed measure	Public comment from CAPC supports MAP's conclusion.
<b>1637 Endorsed</b>	Hospice and Palliative Care— Pain Assessment	MUC: Hospice Quality Reporting; PQRS FIN:	Support: NQF-endorsed measure	Public comment from CAPC supports MAP's conclusion.
<b>1638 Endorsed</b>	Hospice and Palliative Care— Dyspnea Treatment	MUC: Hospice Quality Reporting; PQRS FIN:	Support: NQF-endorsed measure	Public comment from CAPC supports MAP's conclusion.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1639 Endorsed</b>	Hospice and Palliative Care— Dyspnea Screening	MUC: Hospice Quality Reporting; PQRS FIN:	Support: NQF-endorsed measure	
<b>1641 Endorsed</b>	Hospice and Palliative Care— Treatment Preferences	MUC: Hospice Quality Reporting; PQRS FIN:	Support: NQF-endorsed measure	
<b>1741 Endorsed</b>	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from AAO supports MAP’s conclusion.
<b>1789 Endorsed</b>	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	MUC: IQR; PQRS FIN: IQR	Support: NQF-endorsed measure	Public comments from AANS and SHM do not support MAP’s conclusion, noting that the measure should only be applied to facilities. Public comment from APIRE supports MAP’s conclusion.
<b>1799 Endorsed (formerly M2485)</b>	Medication Management for People with Asthma	MUC: PQRS FIN:	Support: NQF endorsed measure	
<b>1822 Endorsed</b>	External Beam Radiotherapy for Bone Metastases	MUC: PQRS FIN:	Support: NQF-endorsed measure	Public comment from MITA supports MAP’s conclusion.
<b>1879 Endorsed</b>	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	MUC: PQRS FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults	Support: NQF -endorsed measure	Public comment from Genentech supports MAP’s conclusion.
<b>2079 Endorsed (formerly M3045)</b>	HIV Medical Visit Frequency	MUC: PQRS FIN: HRSA	Support: NQF endorsed measure	
<b>2080 Endorsed (formerly M3044)</b>	Gap in HIV Medical Visits	MUC: PQRS FIN: HRSA	Support: NQF endorsed measure	

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>2082 Endorsed (formerly M3043)</b>	HIV Viral Load Suppression	MUC: PQRS FIN: HRSA	Support: NQF endorsed measure	
<b>2083 Endorsed (formerly M3046)</b>	Prescription of HIV Antiretroviral Therapy	MUC: PQRS FIN: HRSA	Support: NQF endorsed measure	
<b>M1030 Not Endorsed</b>	Assessment of Asthma Risk— Emergency Department Inpatient Setting	MUC: PQRS FIN:	Do not support: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from SHM does not support MAP's conclusion.
<b>M1031 Not Endorsed</b>	Asthma Discharge Plan— Emergency Department Inpatient Setting	MUC: PQRS FIN:	Do not support: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from SHM does not support MAP's conclusion.
<b>M1170 Not Endorsed</b>	ACO 8 (CMS): Risk-Standardized, All Condition Readmission	MUC: PQRS FIN: MSSP	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Measure should be specified and tested for use at the individual clinician level of analysis. Public comment from SHM supports MAP's conclusion, noting methodology concerns.
<b>M1383 Not Endorsed</b>	Magnetic Resonance Imaging/Computed Tomography Scan (MRI/CT Scan) Results	MUC: PQRS FIN:	Do not support: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from MITA supports MAP's conclusion.
<b>M1384 Not Endorsed</b>	Querying and Counseling about Anti-Epileptic Drug (AED) Side-Effects	MUC: PQRS FIN:	Do not support: Measure previously submitted for endorsement and was not endorsed	



**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1386 Not Endorsed</b>	Counseling About Epilepsy Specific Safety Issues	MUC: PQRS FIN:	Support: NQF endorsed measure	Pending final endorsement decision; measure recommended for endorsement by CDP Steering Committee; currently in public and member commenting period.
<b>M1812 Not Endorsed</b>	Parkinson’s Disease Related Safety Issues Counseling	MUC: PQRS FIN:		Submit for NQF-endorsement
<b>M1879 Not Endorsed</b>	Overall Hypertension Care Satisfaction	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	CAHPS should be used as an overall experience of care measure; care satisfaction should not be limited to one condition.
<b>M 1880 Not Endorsed</b>	Patient Self-care Support	MUC: PQRS FIN:		Submit for NQF-endorsement
<b>M1886 Not Endorsed</b>	Equipment Evaluation for Pediatric CT Imaging Protocols	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Addresses a gap in measures related to pediatric imaging. Public comment from MITA supports MAP’s conclusion.
<b>M1887 Not Endorsed</b>	American Board of Radiology/American Board of Medical Specialties/American College of Radiology/Physician Consortium for Performance Improvement: [DRAFT] Radiation Dose Optimization: Utilization of Pediatric CT Imaging Protocols	MUC: PQRS FIN:		Submit for NQF-endorsement
<b>M2152 Not Endorsed</b>	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t PA) Considered (Paired Measure)	MUC: PQRS FIN:	Do not support: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Previously endorsed measure; endorsement removed during measure maintenance process. Public comment from SHM does not support MAP’s conclusion.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2154 Not Endorsed</b>	Osteoporosis: Current Level of Alcohol Use and Advice on Potentially Hazardous Drinking Prevention	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Alcohol use and advice should not be limited to one chronic condition.
<b>M2211 Not Endorsed</b>	Adverse Drug Event (ADE) Prevention: Outpatient Therapeutic Drug Monitoring	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2283 Not Endorsed</b>	ASPS/AMA-PCPI/NCQA: Chronic Wound Care: Patient Education Regarding Long Term Compression Therapy	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Care planning, discussion of care plans, and shared decision-making measures should not be limited to one condition.
<b>M2285 Not Endorsed</b>	ASPS/AMA-PCPI/NCQA: Chronic Wound Care: Patient Education Regarding Diabetic Foot Care	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Care planning, discussion of care plans, and shared decision-making measures should not be limited to one condition.
<b>M2292 Not Endorsed</b>	Glaucoma Screening in Older Adults	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Measure is not specified for individual clinician use. Public comment from AAO supports MAP's conclusion.
<b>M2414 Not Endorsed</b>	AAO-HNS/AMA-PCPI: Adult Sinusitis: Accurate Diagnosis: Distinguishing Viral vs. Bacterial Sinusitis at Initial Visit	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Appropriate use measures are preferred. Public comment from AMA does not support MAP's conclusion.
<b>M2415 Not Endorsed</b>	AAO-HNS/AMA-PCPI: Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Existing endorsed measure may address a similar concept; measures should be harmonized.
<b>M2416 Not Endorsed</b>	AAO-HNS/AMA-PCPI: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Acute Bacterial Sinusitis (Appropriate Use)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Submit for endorsement; appropriateness measures fill a measure gap.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2417 Not Endorsed</b>	AAO-HNS/AMA-PCPI: Adult Sinusitis: Appropriate Diagnostic Testing for Chronic Sinusitis (Underuse)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Submit for endorsement; appropriateness measures fill a measure gap.  Public comment from MITA supports MAP's conclusion.
<b>M2418 Not Endorsed</b>	AAO-HNS/AMA-PCPI: Adult Sinusitis: Computerized Tomography for Acute Sinusitis (Overuse)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Submit for endorsement; appropriateness measures fill a measure gap.  Public comment from MITA supports MAP's conclusion.
<b>M2419 Not Endorsed</b>	AAO-HNS/AMA-PCPI: Adult Sinusitis: More than 1 Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Submit for endorsement; appropriateness measures fill a measure gap.  Public comment from MITA supports MAP's conclusion.
<b>M2420 Not Endorsed</b>	American Academy of Otolaryngology-Head and Neck Surgery/Physician Consortium for Performance Improvement: Premature Changing of Initial Antibiotic for Acute Bacterial Sinusitis	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Submit for endorsement; appropriateness measures fill a measure gap.
<b>M2421 Not Endorsed</b>	AAO-HNS/AMA-PCPI: Adult Sinusitis: Plain Film Radiography for Acute Sinusitis (overuse)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Submit for endorsement; appropriateness measures fill a measure gap.  Public comment from MITA supports MAP's conclusion.
<b>M2422 Not Endorsed</b>	AAO- HNS/AMA-PCPI: Adult Sinusitis: Watchful Waiting for Acute Bacterial Sinusitis: Initial Observation Without Antibiotics for Patients With Mild Illness (Appropriate Use)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Submit for endorsement; appropriateness measures fill a measure gap.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2431 Not Endorsed</b>	American Association of Nurse Anesthetists/ Certified Registered Nurse Anesthetists/ National Committee for Quality Assurance/ Physician Consortium for Performance Improvement: [DRAFT]: Stroke and Stroke Rehabilitation: Imaging for Transient Ischemic Attack	MUC: PQRS FIN:	Do not support	Measure steward has retired the measure.
<b>M2432 Not Endorsed</b>	American Association of Nurse Anesthetists/ Certified Registered Nurse Anesthetists/ National Committee for Quality Assurance/ Physician Consortium for Performance Improvement: [DRAFT]: Stroke and Stroke Rehabilitation: Lipid Management	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Lipid management measures that are not limited to one condition are preferred; existing measures in the finalized set should be expanded.  Public comment from SHM does not support MAP's conclusion.
<b>M2433 Not Endorsed</b>	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Administered Initiated (Paired Measure)	MUC: PQRS FIN:	Do not support: Measure previously submitted for endorsement and was not endorsed	Public comment from SHM does not support MAP's conclusion.
<b>M2434 Not Endorsed</b>	American Board of Internal Medicine: Diabetes Composite	MUC: PQRS FIN:	Support: Promotes alignment across programs, settings, and public- and private-sector efforts	Submit for NQF-endorsement.
<b>M2435 Not Endorsed</b>	American Board of Internal Medicine: Hypertension Composite	MUC: PQRS FIN:	Support: Promotes alignment across programs, settings, and public-and private-sector efforts	Submit for NQF-endorsement.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2437 Not Endorsed</b>	American Board of Medical Specialties/ American Board of Allergy and Immunology/ American Academy of Dermatology/ American Association of Immunologists/ Physician Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Reevaluation of Treatment	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.
<b>M2438 Not Endorsed</b>	American Board of Medical Specialties/ American Board of Allergy and Immunology/ American Academy of Dermatology/ American Association of Immunologists/ Physician Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Topical Steroid Preparation	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.
<b>M2439 Not Endorsed</b>	American Board of Medical Specialties/ American Board of Allergy and Immunology/ American Academy of Dermatology/ American Association of Immunologists/ Physician Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Disease Assessment	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2440 Not Endorsed</b>	American Board of Medical Specialties/ American Board of Allergy and Immunology/ American Academy of Dermatology/ American Association of Immunologists/ Physician Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Moisture Care	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.
<b>M2441 Not Endorsed</b>	American Board of Medical Specialties/ American Board of Allergy and Immunology/ American Academy of Dermatology/ American Association of Immunologists/ Physician Consortium for Performance Improvement: [DRAFT]: Atopic Dermatitis: Overuse: Role of Antihistamine	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Measure potentially supports alignment and addresses overuse.
<b>M2444 Not Endorsed</b>	American Board of Radiology/American Board of Medical Specialties/American College of Radiology/ Physician Consortium for Performance Improvement: [DRAFT] Radiation Dose Optimization: Appropriateness: Follow-up CT Imaging for Incidental Pulmonary Nodules A	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Measure potentially supports alignment and addresses overuse.  Public comments from ACR and MITA support MAP's conclusion.
<b>M2448 Not Endorsed</b>	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	MUC: PQRS FIN:	Support: NQF endorsed measure	

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2452 Not Endorsed</b>	Biopsy for Barrett’s Esophagus (PCPI and NCQA measure to be updated by AGA)	MUC: PQRS FIN:	Do not support	
<b>M2456 Not Endorsed</b>	Bone Marrow and FNADirect Specimen Acquisition**	MUC: PQRS FIN:	Do not support	
<b>M2461 Not Endorsed</b>	Chronic Medication Therapy—Assessment of GERD Symptoms (PCPI measure to be updated by AGA)	MUC: PQRS FIN:	Do not support	
<b>M2463 Not Endorsed</b>	Concordance Assessment Following Image—Guided Breast Biopsy	MUC: PQRS FIN:	Do not support	
<b>M2467 Not Endorsed</b>	Diabetes/Pre-Diabetes Screening for Patients with DSP	MUC: PQRS FIN:	Do not support	
<b>M2468 Not Endorsed</b>	Distal Symmetric Polyneuropathy (DSP) Diagnosis Criteria: DSP Signs and Symptoms	MUC: PQRS FIN:	Do not support	Public comment from AAN does not support MAP’s conclusion.
<b>M2469 Not Endorsed</b>	Distal Symmetric Polyneuropathy (DSP) Diagnosis Criteria- Electrodiagnostic Study	MUC: PQRS FIN:	Do not support	Public comment from AAN does not support MAP’s conclusion.
<b>M2470 Not Endorsed</b>	Documentation of Offloading Status for Patients with Diabetic Foot Ulcers	MUC: PQRS FIN:	Do not support	
<b>M2471 Not Endorsed</b>	Documentation of Support Surface or Offloading Status for Patients with Serious Pressure Ulcers	MUC: PQRS FIN:	Do not support	
<b>M2472 Not Endorsed</b>	Documentation of Venous Compression at Each Visit for Patients with Venous Stasis Ulcers	MUC: PQRS FIN:	Do not support	
<b>M2473 Not Endorsed</b>	Education of Patient About Symptoms of Choroidal Neovascularization Necessitating Early Return for Examination	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Global patient education measures that are not limited to one condition are needed. Public comment from AAO does not support MAP’s conclusion.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2474 Not Endorsed</b>	Education of Patient About the Role of Good Glucose Control in Slowing Progression of Diabetic Retinopathy	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Global patient education measures that are not limited to one condition are needed.  Public comment from AAO does not support MAP's conclusion.
<b>M2477 Not Endorsed</b>	GERD: Assessment for Alarm Symptoms (PCPI/NCQA measure to be updated by AGA)	MUC: PQRS FIN:	Do not support	
<b>M2478 Not Endorsed</b>	GERD: Barium swallow—Inappropriate Use (PCPI measure to be updated by AGA)	MUC: PQRS FIN:	Do not support	
<b>M2479 Not Endorsed</b>	GERD: Upper Endoscopy for Patients with Alarm Symptoms (PCPI/NCQA measure to be updated by AGA)	MUC: PQRS FIN:	Do not support	
<b>M2481 Not Endorsed</b>	LDL Poor Control	MUC: PQRS FIN:	Do not support: A finalized measure addresses a similar topic and better addresses the needs of the program	Lipid management measures that are not limited to one condition are preferred; existing measures in the finalized set should be expanded.
<b>M2482 Not Endorsed</b>	LDL Superior Control	MUC: PQRS FIN:	Do not support: A finalized measure addresses a similar topic and better addresses the needs of the program	Lipid management measures that are not limited to one condition are preferred; existing measures in the finalized set should be expanded.
<b>M2483 Not Endorsed</b>	Maintenance of Interoperative Normothermia	MUC: PQRS FIN:	Do not support	
<b>M2484 Not Endorsed</b>	Management of Asthma Controller and Reliever Medications—Ambulatory Care Setting	MUC: PQRS FIN:	Do not support: A supported measure under consideration addresses a similar topic and better addresses the needs of the program	An NQF-endorsed measure assesses management of medications for people with asthma.



**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2486 Not Endorsed</b>	National Committee for Quality Assurance/Physician Consortium for Performance Improvement: [DRAFT] Asthma: Assessment of Asthma Risk—Emergency Department Inpatient Setting	MUC: PQRS FIN:	Do not support	Public comment from SHM does not support MAP's conclusion.
<b>M2487 Not Endorsed</b>	National Committee for Quality Assurance/Physician Consortium for Performance Improvement: [DRAFT] Asthma: Asthma Discharge Plan—Emergency Department Inpatient Setting	MUC: PQRS FIN:	Do not support	Public comment from SHM does not support MAP's conclusion.
<b>M2488 Not Endorsed</b>	Nephropathy Assessment for Eligible Patients	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	
<b>M2489 Not Endorsed</b>	New Cancer Patient—Intervention Urgency	MUC: PQRS FIN:	Do not support	
<b>M2490 Not Endorsed</b>	Ophthalmologic Exam	MUC: PQRS FIN:	Do not support	Public comment from AAO supports MAP's conclusion.
<b>M2491 Not Endorsed</b>	Optimal Asthma Care	MUC: PQRS FIN:	Do not support: Measure previously submitted for endorsement and was not endorsed	
<b>M2497 Not Endorsed</b>	Patient Satisfaction with Overall Diabetes Care	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Patient satisfaction should not be limited to one condition.
<b>M2498 Not Endorsed</b>	Patient Satisfaction with Physician Care Provided for Age Related Macular Degeneration	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Patient satisfaction should not be limited to one condition.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2499 Not Endorsed</b>	Patient Satisfaction with Physician Care Provided for Diabetic Retinopathy	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Patient satisfaction should not be limited to one condition.
<b>M2502 Not Endorsed</b>	Peri-Operative Anti-Platelet Therapy for Patients Undergoing Carotid Endarterectomy (CEA)	MUC: PQRS FIN:	Do not support	
<b>M2503 Not Endorsed</b>	Pharmacologic Therapy for Persistent Asthma— Ambulatory Care Setting	MUC: PQRS FIN:	Support direction: Should be submitted for and receive NQF endorsement	Aligns with NQF-endorsed measure #0047.
<b>M2504 Not Endorsed</b>	Physician Consortium for Performance Improvement: [DRAFT]: Adult Major Depressive Disorder: Follow Up Assessment of Depression Care	MUC: PQRS FIN:	Do not support	Public comment from Takeda Pharmaceuticals does not support MAP's conclusion.
<b>M2505 Not Endorsed</b>	Physician Consortium for Performance Improvement: [DRAFT]: Adult Major Depressive Disorder: Continuation of Antidepressant Medications	MUC: PQRS FIN:	Do not support	Public comment from Takeda Pharmaceuticals does not support MAP's conclusion.
<b>M2506 Not Endorsed</b>	Physician Consortium for Performance Improvement: [DRAFT]: Adult Major Depressive Disorder: Patient Education	MUC: PQRS FIN:	Do not support	
<b>M2507 Not Endorsed</b>	Adult Major Depressive Disorder: Screening for Depression	MUC: PQRS FIN:	Do not support	
<b>M2508 Not Endorsed</b>	Physician Consortium for Performance Improvement: [DRAFT]: Adult Major Depressive Disorder: Treatment for Depression	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2510 Not Endorsed</b>	Physician Consortium for Performance Improvement: [DRAFT]: Preventive Care and Screening: Lipid Screening	MUC: PQRS FIN:	Do not support: A finalized measure addresses a similar topic and better addresses the needs of the program	Lipid management measures that are not limited to one condition are preferred; existing measures in the finalized set should be expanded.  Public comment from AMA does not support MAP's conclusion.
<b>M2511 Not Endorsed</b>	Adult Major Depressive Disorder: Coordination of Care of Patients with Comorbid Conditions—Timely Follow Up	MUC: PQRS FIN:	Support Direction: Not ready for implementation, measure concept is promising but requires further development or modifications	Measures of care coordination for individuals with multiple chronic conditions are needed; however, measures could be expanded beyond depression.  Public comment from AMA noted that the measure is currently being implemented in PQRS as a registry reporting option.
<b>M2512 Not Endorsed</b>	Physician Consortium for Performance Improvement: Preventive Care and Screening: Obesity Screening	MUC: PQRS FIN:	Do not support: A finalized measure addresses a similar topic and better addresses the needs of the program	Existing NQF-endorsed measures address obesity screening.
<b>M2513 Not Endorsed</b>	Podiatry Exam	MUC: PQRS FIN:	Do not support	
<b>M2514 Not Endorsed</b>	Post-Anesthetic Transfer of Care Measure: Use of Checklist for Direct Transfer of Care from Procedure Room to Intensive Care Unit	MUC: PQRS FIN:	Do not support	
<b>M2515 Not Endorsed</b>	Preoperative Use of Aspirin for Patients with Drug-Eluting Coronary Artery Stents	MUC: PQRS FIN:	Do not support	
<b>M2517 Not Endorsed</b>	Prevention of Post-Operative Nausea and Vomiting— Multimodal Therapy (Pediatric)	MUC: PQRS FIN:	Do not support	

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2518 Not Endorsed</b>	Prevention of Post-Operative Nausea and Vomiting—Multimodal Therapy (Adults)	MUC: PQRS FIN:	Do not support	
<b>M2519 Not Endorsed</b>	Querying about Falls for Patients with DSP	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Existing measures assess falls beyond patients with DSP.
<b>M2520 Not Endorsed</b>	Querying about Pain and Pain Interference with Function	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2522 Not Endorsed</b>	Renal Physician's Association/ American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement: Adult Kidney Disease: Catheter Use for Greater than or Equal to 90 Days	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from RPA and ASPN do not support MAP's conclusion, noting that the measure addresses NQS priorities.
<b>M2523 Not Endorsed</b>	Renal Physician's Association/ American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	MUC: PQRS FIN:	Do not support: Measure previously submitted for endorsement and was not endorsed	Public comments from RPA and APSN do not support MAP's conclusion, noting that the measure addresses NQS priorities.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2524 Not Endorsed</b>	Renal Physician’s Association/ American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement: Adult Kidney Disease: Arteriovenous Fistula Rate	MUC: PQRS FIN:	Do not support	Public comments from RPA and APSN do not support MAP’s conclusion, noting that the measure addresses NQS priorities.
<b>M2525 Not Endorsed</b>	Renal Physician’s Association/ American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement: Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis Access is a Catheter at the Time Maintenance Hemodialysis is Initiated	MUC: PQRS FIN:	Do not support	Public comments from RPA and APSN do not support MAP’s conclusion, noting that the measure addresses NQS priorities.
<b>M2526 Not Endorsed</b>	Renal Physician’s Association/ American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement: Adult Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level <10g/dL	MUC: PQRS FIN:	Do not support	Public comments from RPA and APSN do not support MAP’s conclusion, noting that the measure addresses NQS priorities.
<b>M2527 Not Endorsed</b>	Renal Physician’s Association/ American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement: Adult Kidney Disease: Referral to Nephrologist	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Measures assessing referrals are not considered to drive improvement; measures should assess if proper care was received.  Public comments from RPA and APSN do not support MAP’s conclusion, noting the measure addresses NQS priorities.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2528 Not Endorsed</b>	Renal Physician's Association/ American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement: Adult Kidney Disease: Transplant Referral	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Measures assessing referrals are not considered to drive improvement; measures should assess if proper care was received.  Public comments from RPA and APSN do not support MAP's conclusion, noting that the measure addresses NQS priorities.
<b>M2530 Not Endorsed</b>	Renal Physician's Association/ American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement: Adult Kidney Disease: Adequacy of Volume Management	MUC: PQRS FIN:	Do not support	Public comments from RPA and APSN do not support MAP's conclusion, noting that the measure addresses NQS priorities.
<b>M2531 Not Endorsed</b>	Screening for Unhealthy Alcohol Use	MUC: PQRS FIN:	Do not support: A finalized measure addresses a similar topic and better addresses the needs of the program	Public comment from AMA does not support MAP's conclusion.
<b>M2532 Not Endorsed</b>	Smoking Status and Cessation Advice and Treatment	MUC: PQRS FIN:	Do not support: A finalized measure addresses a similar topic and better addresses the needs of the program	
<b>M2534 Not Endorsed</b>	Specimen Orientation for Partial Mastectomy or Excisional Breast Biopsy	MUC: PQRS FIN:	Do not support	
<b>M2535 Not Endorsed</b>	Static Ultrasound in Elective Internal Jugular Vein Cannulation	MUC: PQRS FIN:	Do not support	Public comment from MITA supports MAP's conclusion.
<b>M2536 Not Endorsed</b>	Surgeon Assessment for Hereditary Cause of Breast Cancer	MUC: PQRS FIN:	Do not support	

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2538 Not Endorsed</b>	The Endocrine Society DRAFT Baseline Gonadotropin (LH or FSH) Measurement	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	
<b>M2539 Not Endorsed</b>	The Endocrine Society DRAFT Follow-up Hematocrit or Hemoglobin Test	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	
<b>M2540 Not Endorsed</b>	The Endocrine Society DRAFT Follow-up Testosterone Measurement	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	
<b>M2541 Not Endorsed</b>	The Endocrine Society DRAFT Testosterone Measurement	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	
<b>M2544 Not Endorsed</b>	Vascular Testing of Patients with Leg Ulcers	MUC: PQRS FIN:	Do not support	
<b>M2579 Not Endorsed</b>	30 Day Post-Discharge Visit	MUC: PQRS FIN:	Do not support	Public comment from SHM does not support MAP's conclusion.
<b>M2580 Not Endorsed</b>	All Cause Readmissions	MUC: PQRS FIN: VBPM	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Measures should be specified and tested for use at the individual clinician level of analysis.  Public comment from SHM supports MAP's conclusion, noting measure methodology concerns.
<b>M2700 Not Endorsed</b>	Osteoporosis Composite	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AMGEN, NOF, NBHA, and ASBMR support MAP's conclusion.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2789 Not Endorsed</b>	Ventral Hernia 5: Surgical Site Infection (SSI) (1 of 5: Measures Group Ventral Hernia)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	MAP has previously recommended NQF #0753 be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred.  Public comment from ACS does not support MAP's recommendation to expand NQF #0753, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2790 Not Endorsed</b>	Ventral Hernia 4: Unplanned Hospital Readmission within 30 days of Principal Procedure (4 of 5: Measures Group Ventral Hernia)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred.  Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2791 Not Endorsed</b>	Appendectomy 4: Surgical Site Infection (SSI) (4 of 4: Measures Group Appendectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	MAP has previously recommended NQF #0753 be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred.  Public comment from ACS does not support MAP's recommendation to expand NQF #0753, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.



**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2792 Not Endorsed</b>	AV Fistula 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 5 Measures Group: AV Fistula)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2793 Not Endorsed</b>	AAO- HNS/AMA-PCPI: Adult Sinusitis: Premature Changing of Initial Antibiotic for Acute Bacterial Sinusitis (Overuse)	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.
<b>M2794 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: Behavioral Health Risk Assessment	MUC: PQRS FIN: CHIPRA Quality Reporting	Do not support	Public comment from AMA do not support MAP's conclusion.
<b>M2795 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: BMI Assessment and Recommended Weight Gain	MUC: PQRS FIN:	Do not support:	Public comment from AMA does not support MAP's conclusion.
<b>M2796 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: Care Coordination: Prenatal Record Present at Time of Delivery	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.
<b>M2797 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: Cesarean Delivery for Nulliparous (NTSV) Women (Appropriate Use)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2798 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: Elective Delivery or Early Induction Without Medical Indication at $\geq 37$ and $< 39$ weeks (Overuse)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Measure should be aligned with facility-level measures addressing the same topic.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2799 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: Episiotomy (Overuse)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2800 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: Establishment of Gestational Age	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Process measure that does not drive improvement; outcome measure regarding early induction is preferred. Public comment from AMA does not support MAP's conclusion.
<b>M2801 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: Post-Partum Follow-Up and Care Coordination	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.
<b>M2802 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: Prenatal Care Screening	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.
<b>M2803 Not Endorsed</b>	ACOG/NCQA/AMA-PCPI: Maternity Care: Spontaneous Labor and Birth	MUC: PQRS FIN:	Do not support	Public comment from AMA does not support MAP's conclusion.
<b>M2806 Not Endorsed</b>	ALS Cognitive Impairment and Behavioral Impairment Screening	MUC: PQRS FIN:	Do not support	Public comment from AAN does not support MAP's conclusion.
<b>M2807 Not Endorsed</b>	ALS Communication Support Referral	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Measures assessing referrals are not considered to drive improvement; measures should assess if proper care was received. Public comment from AAN does not support MAP's conclusion.
<b>M2809 Not Endorsed</b>	ALS Multidisciplinary Care Plan Developed or Updated	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comment from AAN does not support MAP's conclusion.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2810 Not Endorsed</b>	ALS Noninvasive Ventilation Treatment for Respiratory Insufficiency Discussed	MUC: PQRS FIN:	Do not support	Public comment from AAN does not support MAP's conclusion.
<b>M2811 Not Endorsed</b>	ALS Nutritional Support Offered	MUC: PQRS FIN:	Do not support	Public comment from AAN does not support MAP's conclusion.
<b>M2812 Not Endorsed</b>	ALS Respiratory Insufficiency Querying and Referral for Pulmonary Function Testing	MUC: PQRS FIN:	Do not support	Public comment from AAN does not support MAP's conclusion.
<b>M2813 Not Endorsed</b>	ALS Screening for Dysphagia, Weight Loss or Impaired Nutrition	MUC: PQRS FIN:	Do not support:	Public comment from AAN does not support MAP's conclusion.
<b>M2814 Not Endorsed</b>	ALS Symptomatic Therapy Treatment Offered	MUC: PQRS FIN:	Do not support	Public comment from AAN does not support MAP's conclusion.
<b>M2817 Not Endorsed</b>	Appendectomy 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 4: Measures Group Appendectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2818 Not Endorsed</b>	Appendectomy 2: Unplanned Reoperation Within the 30 Day Postoperative Period (2 of 4: Measures Group Appendectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2819 Not Endorsed</b>	Appendectomy 3: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (3 of 4: Measures Group Appendectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2820 Not Endorsed</b>	Assessment of Patient History, Physical Examination and Radiographic Evidence of Arthritis	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Measure assesses a standard of practice and may not meet importance criteria.
<b>M2821 Not Endorsed</b>	Asthma: Spirometry Evaluation	MUC: PQRS FIN:	Do not support: A finalized measure addresses a similar topic and better addresses the needs of the program	Asthma management measures are preferred.
<b>M2822 Not Endorsed</b>	AV Fistula 2: Post-Operative Death Within 30 Days of Procedure (2 of 5 Measures Group: AV Fistula)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader mortality measures are preferred.
<b>M2823 Not Endorsed</b>	AV Fistula 3: Unplanned Reoperation Within the 30 Day Postoperative Period (3 of 5 Measures Group: AV Fistula)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2824 Not Endorsed</b>	AV Fistula 4: Unplanned Hospital Readmission Within 30 days of Principal Procedure (4 of 5 Measures Group: AV Fistula)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2825 Not Endorsed</b>	AV Fistula 5: Surgical Site Infection (SSI) (5 of 5 Measures Group: AV Fistula)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	MAP has previously recommended NQF #0753 be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred.  Public comment from ACS does not support MAP's recommendation to expand NQF #0753, noting that a broader measure would not be as meaningful for surgeons And the measure is part of a measure group.
<b>M2826 Not Endorsed</b>	Bariatric Lap Band Procedure 2: Unplanned Reoperation Within the 30 Day Postoperative Period (2 of 3 Measures Group: Bariatric Lap Band Procedure)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2827 Not Endorsed</b>	Bariatric Lap Band Procedure 3: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (3 of 3 Measures Group: Bariatric Lap Band Procedure)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2828 Not Endorsed</b>	Bariatric Lap Band Procedure 1: Iatrogenic Injury to Adjacent Organ/ Structure (1 of 3 Measures Group: Bariatric Lap Band Procedure)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2829 Not Endorsed</b>	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 1: Anastomotic Leak Intervention (1 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2830 Not Endorsed</b>	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 2: Iatrogenic Injury to Adjacent Organ/Structure (2 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2831 Not Endorsed</b>	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 3: Unplanned Reoperation Within the 30 Day Postoperative Period (3 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2832 Not Endorsed</b>	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 4: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (4 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2833 Not Endorsed</b>	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 5: Surgical Site Infection (SSI) (5 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2834 Not Endorsed</b>	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 6: Bleeding Requiring Transfusion (3 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2835 Not Endorsed</b>	Bariatric Sleeve Gastrectomy 1: Leak Intervention (1 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2836 Not Endorsed</b>	Bariatric Sleeve Gastrectomy 2: Iatrogenic Injury to Adjacent Organ/Structure (2 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2837 Not Endorsed</b>	Bariatric Sleeve Gastrectomy 3: Unplanned Reoperation Within the 30 Day Postoperative Period (3 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2838 Not Endorsed</b>	Bariatric Sleeve Gastrectomy 4: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (4 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2839 Not Endorsed</b>	Bariatric Sleeve Gastrectomy 5: Surgical Site Infection (SSI) (5 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2840 Not Endorsed</b>	Bariatric Sleeve Gastrectomy 6: Bleeding Requiring Transfusion (6 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Bariatric surgery is of low importance for this program. Public comment from ACS does not support MAP's conclusion, noting that bariatric procedures are common and the measure would support alignment with MOC programs.
<b>M2845 Not Endorsed</b>	Cardiovascular Disease Risk Factor Assessment for Psoriasis Patients	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Cardiovascular risk should be more broadly assessed and not limited to one condition. Public comment from AAD does not support MAP's conclusion, noting that this measure would allow dermatologists to participate in PQRS.
<b>M2846 Not Endorsed</b>	Cholecystectomy 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 4: Measures Group Cholecystectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	



**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2847 Not Endorsed</b>	Cholecystectomy 2: Unplanned Reoperation Within the 30 Day Postoperative Period (2 of 4: Measures Group Cholecystectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2848 Not Endorsed</b>	Cholecystectomy 3: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (3 of 4: Measures Group Cholecystectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2849 Not Endorsed</b>	Cholecystectomy 4: Surgical Site Infection (SSI) (4 of 4: Measures Group Cholecystectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	MAP has previously recommended NQF #0753 be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred. Public comment from ACS does not support MAP's recommendation to expand NQF #0753, noting that a broader measure would not be as meaningful for surgeons And the measure is part of a measure group.
<b>M2850 Not Endorsed</b>	Colectomy 1: Anastomotic Leak Intervention (1 of 6: Measures Group Colectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2851 Not Endorsed</b>	Colectomy 2: Iatrogenic Injury to Adjacent Organ/Structure (2 of 6: Measures Group Colectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2852 Not Endorsed</b>	Colectomy 3: Post-Operative Death Within 30 Days of Procedure (3 of 6: Measures Group Colectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader mortality measures are preferred.
<b>M2853 Not Endorsed</b>	Colectomy 4: Unplanned Reoperation Within the 30 Day Postoperative Period (4 of 6: Measures Group Colectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2854 Not Endorsed</b>	Colectomy 5: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (5 of 6: Measures Group Colectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2855 Not Endorsed</b>	Colectomy 6: Surgical Site Infection (SSI) (6 of 6: Measures Group Colectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	MAP has previously recommended NQF #0753 be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred. Public comment from ACS does not support MAP's recommendation to expand NQF #0753, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2856 Not Endorsed</b>	Colonoscopy 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 4: Measures Group Colonoscopy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2857 Not Endorsed</b>	Colonoscopy 2: Cecal Intubation Rate (2 of 4: Measures Group Colonoscopy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2858 Not Endorsed</b>	Colonoscopy 3: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (3 of 4: Measures Group Colonoscopy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2859 Not Endorsed</b>	Colonoscopy 4: Examination Time During Endoscope Withdrawal, When No Biopsies or Polypectomies are Performed (4 of 4: Measures Group Colonoscopy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2860 Not Endorsed</b>	Colonoscopy Quality Composite eMeasure	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	This composite measure is preferred over the individual measures. Public comment from Tri-Society supports MAP's conclusion.
<b>M2862 Not Endorsed</b>	Disease Modifying Pharmacotherapy for ALS Discussed	MUC: PQRS FIN:	Do not support	
<b>M2863 Not Endorsed</b>	Electroencephalogram (EEG) Results Reviewed, Requested, or Test Ordered	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2864 Not Endorsed</b>	Esophagogastro-duodenoscopy (EGD) 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 2: Measures Group Esophagogastro-duodenoscopy [EGD])	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2865 Not Endorsed</b>	Esophagogastro-duodenoscopy (EGD) 2: Unplanned Intubation (2 of 2: Measures Group Esophagogastro-duodenoscopy [EGD])	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2867 Not Endorsed</b>	Hemorrhoidectomy 1: Bleeding Requiring Transfusion (1 of 4: Measures Group Hemorrhoidectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2868 Not Endorsed</b>	Hemorrhoidectomy 2: Iatrogenic Injury to Adjacent Organ/Structure (2 of 4: Measures Group Hemorrhoidectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2869 Not Endorsed</b>	Hemorrhoidectomy 3: Unplanned Reoperation Within the 30 Day Postoperative Period (3 of 4: Measures Group Hemorrhoidectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2870 Not Endorsed</b>	Hemorrhoidectomy 4: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (4 of 4: Measures Group Hemorrhoidectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2886</b> <b>Not Endorsed</b>	HRS-1 Complications of Catheter Ablation Treatment for Atrial Fibrillation (AF)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Public comment from HRS does not support MAP's conclusion.
<b>M2888</b> <b>Not Endorsed</b>	HRS-12: Cardiac Tamponade Following Atrial Fibrillation Ablation	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Public comment from HRS does not support MAP's conclusion.
<b>M2889</b> <b>Not Endorsed</b>	HRS-2 Failure to Achieve Adequate Heart Rate Control for Patients with Atrial Fibrillation (AF)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	Public comment from HRS does not support MAP's conclusion.
<b>M2890</b> <b>Not Endorsed</b>	HRS-3 Implantable Cardioverter-Defibrillator (ICD) Complications Rate	MUC: PQRS FIN:	Support direction: Not ready for implementation; should be submitted for and receive NQF endorsement	This clinician-level measure aligns with NQF# 0694, which assess the same concept at the hospital level of analysis.
<b>M2892</b> <b>Not Endorsed</b>	HRS-4 In-person Evaluation Following Implantation of a Cardiovascular Implantable Electronic Device (CIED)	MUC: PQRS FIN:	Do not support	Public comment from HRS does not support MAP's conclusion.
<b>M2893</b> <b>Not Endorsed</b>	HRS-9: Infection Within 180 Days of CIED Implantation, Replacement, or Revision	MUC: PQRS FIN:	Do not support	Public comment from HRS does not support MAP's conclusion.
<b>M2895</b> <b>Not Endorsed</b>	Inguinal Hernia 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 3) Measures Group Inguinal Hernia	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2896</b> <b>Not Endorsed</b>	Inguinal Hernia 2: Unplanned Reoperation Within the 30 Day Postoperative Period (2 of 3) Measures Group Inguinal Hernia	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2897 Not Endorsed</b>	Inguinal Hernia 3: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (3 of 3) Measures Group Inguinal Hernia	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2899 Not Endorsed</b>	Lung Cancer Reporting (Biopsy/Cytology Specimens)	MUC: PQRS FIN:	Do not support	Public comments from AMA, ASC, ASCP, AMP, APC, and CAP do not support MAP's conclusion. Commenters noted that the measure was developed to address a gap identified by the NQF Cancer Care CDP Steering Committee; however, there has not been an opportunity to submit the measure for NQF endorsement.
<b>M2900 Not Endorsed</b>	Lung Cancer Reporting (Resection Specimens)	MUC: PQRS FIN:	Do not support	Public comments from AMA, ASC, ASCP, AMP, APC, and CAP do not support MAP's conclusion. Commenters indicated that the measure was developed to address a gap identified by the NQF Cancer Care CDP Steering Committee; however, there has not been an opportunity to submit the measure for NQF endorsement.
<b>M2901 Not Endorsed</b>	Mastectomy +/- Lymphadenectomy or SLNB 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2902</b> <b>Not Endorsed</b>	Mastectomy +/- Lymphadenectomy or SLNB 2: Unplanned Reoperation Within the 30 Day Postoperative Pperiod (2 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2903</b> <b>Not Endorsed</b>	Mastectomy +/- Lymphadenectomy or SLNB 3: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (3 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2904</b> <b>Not Endorsed</b>	Mastectomy +/- Lymphadenectomy or SLNB 4: Surgical Site Infection (SSI) (4 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	MAP has previously recommended NQF #0753 be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred. Public comment from ACS does not support MAP's recommendation to expand NQF #0753, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2905 Not Endorsed</b>	Melanoma Reporting	MUC: PQRS FIN:	Do not support	Public comment from AAD does not support MAP's conclusion, noting that the measure would allow dermatologists to participate in PQRS. Public comments from AMA, ASC, APC, ASCP, AMP, and CAP do not support MAP's conclusion. Commenters noted that the measure was developed to address a gap identified by the NQF Cancer Care CDP Steering Committee; however, there has not been an opportunity to submit the measure for NQF endorsement.
<b>M2907 Not Endorsed</b>	Neurosurgery: Initial Visit (Similar to PQRS Measure 148)	MUC: PQRS FIN:	Do not support	
<b>M2908 Not Endorsed</b>	Neurosurgery: Shared Decision Making	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Shared decision making is a significant measure gap; this measure should be specified more broadly to address multiple conditions.
<b>M2909 Not Endorsed</b>	Objective Characterization of Pelvic Organ Prolapse Prior to Surgery	MUC: PQRS FIN:	Support Direction: Not ready for implementation, measure concept is promising	The measure concept has passed the endorsement Importance Criterion; part of GI/GU two-stage CDP.
<b>M2910 Not Endorsed</b>	Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 4: Measures Group Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	



**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2911 Not Endorsed</b>	Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB 2: Unplanned Reoperation Within the 30 Day Postoperative Period (2 of 4: Measures Group Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2912 Not Endorsed</b>	Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB 3: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (3 of 4: Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2913 Not Endorsed</b>	Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB 4: Surgical Site Infection (SSI) (4 of 4: Measures Group Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	MAP has previously recommended NQF #0753 be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred. Public comment from ACS does not support MAP's recommendation to expand NQF #0753, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2916 Not Endorsed</b>	Patient-centered Surgical Risk Assessment and Communication: The Percent of Patients Who Underwent Non-emergency Major Surgery Who Received Preoperative Risk Assessment for Procedure-specific Postoperative Complications Using a Data-based, Patient-specific Risk Calculator, and Who Also Received a Personal Discussion of Risks with the Surgeon	MUC: PQRS FIN:	Do not support	Public comment from ACS does not support MAP's conclusion, noting that the measure addresses NQS priorities.
<b>M2919 Not Endorsed</b>	Percutaneous Central Line Placement 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 3: Measures Group Percutaneous Central Line Placement)	MUC: PQRS FIN:	Do not support	Public comment from ACS does not support MAP's conclusion, noting that the measure aligns with MOC programs and registries. Public comment from SHM does not support MAP's conclusion.
<b>M2920 Not Endorsed</b>	Percutaneous Central Line Placement 2: Central line-Associated Bloodstream Infection (CLABSI) (2 of 3: Measures Group Percutaneous Central Line Placement)	MUC: PQRS FIN:	Do not support: Measure does not adequately address any current needs of the program	NQF-endorsed CLABSI should be explored for use at the individual clinician level of analysis. Public comment from ACCP supports MAP's conclusion. Public comments from SHM and ACS do not support MAP's conclusion. ACS noted that the measure aligns with MOC programs and registries.
<b>M2921 Not Endorsed</b>	Percutaneous Central Line Placement 3: Failure to Complete Procedure (unable to obtain access) (3 of 3: Measures Group Percutaneous Central Line Placement)	MUC: PQRS FIN:	Do not support	Public comment from ACS does not support MAP's conclusion, noting that the measure aligns with MOC programs and registries.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2922 Not Endorsed</b>	Performing Vaginal Apical Suspension (Uterosacral, Iliococcygeus, Sacrospinous or Sacral Colpopexy) at the Time Of Hysterectomy To Address Uterovaginal Prolapse	MUC: PQRS FIN:	Support Direction: Not ready for implementation, measure concept is promising	The measure concept has passed the endorsement Importance Criterion; part of GI/GU two-stage CDP.
<b>M2927 Not Endorsed</b>	Querying About Parkinson’s Disease Medication-Related Motor Complications	MUC: PQRS FIN:	Do not support	
<b>M2928 Not Endorsed</b>	Querying about Symptoms of Autonomic Dysfunction	MUC: PQRS FIN:	Do not support	
<b>M2930 Not Endorsed</b>	Rate of Major Complications (Discharged to Home by Post- Operative Day 2) Carotid Artery Stenting (CAS) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day 2)	MUC: PQRS FIN:	Do not support	
<b>M2934 Not Endorsed</b>	Rate of Stratification by Aneurysm Size of Patients Undergoing Abdominal Aortic Aneurysm Repair	MUC: PQRS FIN:	Do not support	
<b>M2935 Not Endorsed</b>	Rate of Stratification by Symptom Status of Patients Undergoing Carotid Intervention	MUC: PQRS FIN:	Do not support	
<b>M2938 Not Endorsed</b>	Screening Colonoscopy Adenoma Detection Rate Measure	MUC: PQRS FIN:	Do not support	Public comment from Tri-Society does not support MAP’s conclusion.
<b>M2939 Not Endorsed</b>	Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	MUC: PQRS FIN:	Do not support	
<b>M2940 Not Endorsed</b>	Skin/Soft Tissue Lesion Excision 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 4: Measures Group Skin/Soft Tissue Lesion Excision)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2941 Not Endorsed</b>	Skin/Soft Tissue Lesion Excision 2: Unplanned Reoperation Within the 30 Day Postoperative Period (2 of 4: Measures Group Skin/Soft Tissue Lesion Excision)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2942 Not Endorsed</b>	Skin/Soft Tissue Lesion Excision 3: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (3 of 4: Measures Group Skin/Soft Tissue Lesion Excision)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2943 Not Endorsed</b>	Skin/Soft Tissue Lesion Excision 4: Surgical site infection (SSI)/wound dehiscence (4 of 4: Measures Group Skin/Soft Tissue Lesion Excision)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	MAP has previously recommended NQF #0753 be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred. Public comment from ACS does not support MAP's recommendation to expand NQF #0753, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2944 Not Endorsed</b>	Surgical Therapy Referral Consideration for Intractable Epilepsy	MUC: PQRS FIN:	Do not support	Public comment from Eisai supports MAP's conclusion.
<b>M2945 Not Endorsed</b>	Thyroidectomy 1: Recurrent Laryngeal Nerve Injury (1 of 5: Measures Group Thyroidectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2946 Not Endorsed</b>	Thyroidectomy 2: Neck Hematoma/Bleeding (2 of 5: Measures Group Thyroidectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2947 Not Endorsed</b>	Thyroidectomy 3: Iatrogenic Injury to Adjacent Organ/Structure (3 of 5: Measures Group Thyroidectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2948 Not Endorsed</b>	Thyroidectomy 4: Unplanned Reoperation Within the 30 Day Postoperative Period (4 of 5: Measures Group Thyroidectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2949 Not Endorsed</b>	Thyroidectomy 5: Unplanned Hospital Readmission Within 30 Days of Principal Procedure (5 of 5: Measures Group Thyroidectomy)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2951 Not Endorsed</b>	Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	This measure should be expanded to address tuberculosis prevention for anyone on a biological immune response modifier; it should not be limited to individuals with psoriasis and psoriatic arthritis. Public comment from AAD does not support MAP's conclusion, noting that the measure would allow dermatologists to participate in PQRS.

TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2953 Not Endorsed</b>	Use of Cystoscopy Concurrent with Prolapse Repair Surgery	MUC: PQRS FIN:	Support Direction: Not ready for implementation, measure concept is promising	The measure concept has passed the endorsement Importance Criterion; part of GI/GU two-stage CDP.
<b>M2954 Not Endorsed</b>	Varicose Veins 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 3: Measures Group Varicose Veins)	MUC: PQRS FIN:	Do Not Support: Measure does not adequately address any current needs of the program	
<b>M2955 Not Endorsed</b>	Varicose Veins 2: Venous Thromboembolism (VTE) (2 of 3: Measures Group Varicose Veins)	MUC: PQRS FIN:	Do Not Support: Measure does not adequately address any current needs of the program	Measures broadly assessing VTE are preferred.
<b>M2956 Not Endorsed</b>	Varicose Veins 3: Surgical Site Infection (SSI) (3 of 3: Measures Group Varicose Veins)	MUC: PQRS FIN:	Do Not Support: Measure does not adequately address any current needs of the program	MAP has previously recommended NQF #0753 be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred.  Public comment from ACS does not support MAP's recommendation to expand NQF #0753, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2957 Not Endorsed</b>	Ventral Hernia 1: Iatrogenic Injury to Adjacent Organ/Structure (1 of 5: Measures Group Ventral Hernia)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	
<b>M2958 Not Endorsed</b>	Ventral Hernia 2: Post-Operative Death Within 30 Days of Procedure (2 of 5: Measures Group Ventral Hernia)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader mortality measures are preferred.

**TABLE A2. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2959 Not Endorsed</b>	Ventral Hernia 3: Unplanned Reoperation Within the 30 Day Postoperative Period (3 of 5: Measures Group Ventral Hernia)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Broader readmission measures are preferred. Public comment from ACS does not support MAP's recommendation, noting that a broader measure would not be as meaningful for surgeons and the measure is part of a measure group.
<b>M2987 Not Endorsed</b>	Acute Composite: Acute Composite (1 of 3): Bacterial Pneumonia Acute Composite (2 of 3): UTI Acute Composite (3 of 3): Dehydration	MUC: PQRS FIN:	Support Direction: Not ready for implementation, measure concept is promising but requires further development or modifications	This measure is typically assessed at the community level; testing for use at the individual clinician level is needed. Public comment from SHM supports MAP's conclusion, noting measure methodology concerns.
<b>M2991 Not Endorsed</b>	Chronic Composite (See 2 individual measures AND 1 composite measure consisting of 4 additional individual measures below [Total of 7 measures] to define Chronic Composite)	MUC: PQRS FIN:	Support Direction: Not ready for implementation, measure concept is promising but requires further development or modifications	This measure is typically assessed at the community level; testing for use at the individual clinician level is needed. Public comment from SHM supports MAP's conclusion, noting measure methodology concerns.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0396 Endorsed</b>	Paired Measure: HCV Genotype Testing Prior to Treatment (paired with 0395)	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M109 Not Endorsed</b>	Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from MITA supports MAP's conclusion.
<b>M142 Not Endorsed (formerly NQF #0232)</b>	Vital Signs for Community-Acquired Bacterial Pneumonia	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M143 Not Endorsed</b>	Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M144 Not Endorsed</b>	Assessment Mental Status for Community-Acquired Bacterial Pneumonia	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M162 Not Endorsed (formerly NQF #0397)</b>	Hepatitis C: Prescribed Antiviral Therapy	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	



**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M164 Not Endorsed (formerly NQF #0401)</b>	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M165 Not Endorsed (formerly NQF #0394)</b>	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Treatment	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M167 Not Endorsed</b>	092 Acute Otitis Externa (AOE): Pain Assessment	MUC: FIN: Physician Feedback; PQRS	Phased removal: Measure previously submitted for endorsement and was not endorsed	
<b>M174 Not Endorsed</b>	Prostate Cancer: Three-Dimensional Radiotherapy	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M189 Not Endorsed</b>	121 Adult Kidney Disease: Laboratory Testing (Lipid Profile)	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.
<b>M190 Not Endorsed</b>	122 Adult Kidney Disease (CKD): Blood Pressure Management	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.
<b>M227 Not Endorsed</b>	123 Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.
<b>M228 Not Endorsed</b>	Adoption of Health Information Technology	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.
<b>M233 Not Endorsed</b>	Pain Assessment Prior to Initiation of Patient Therapy	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.

TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M238 Not Endorsed</b>	Melanoma Coordination of Care	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comments from AAD and AAO do not support MAP's conclusion, noting that the measure fills a gap in the program.
<b>M247 Not Endorsed</b>	Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M253 Not Endorsed</b>	154 Falls: Risk Assessment	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.
<b>M254 Not Endorsed</b>	155 Falls: Plan of Care	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.
<b>M257 Not Endorsed</b>	158 Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M260 Not Endorsed (Formerly NQF #0406)</b>	HIV/AIDS: Adolescent and adult patients with HIV/AIDS who are prescribed potent Antiretroviral Therapy	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M271 Not Endorsed</b>	Hemodialysis Vascular Access Decision-making by Surgeon to Maximize Placement of Autogenous Arterial Venous Fistula	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M272 Not Endorsed</b>	173 Preventive Care and Screening: Unhealthy Alcohol Use Screening	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.

**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M275 Not Endorsed</b>	176 Rheumatoid Arthritis (RA): Tuberculosis Screening	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement; measure assesses a standard of practice and may not meet importance criterion.
<b>M276 Not Endorsed</b>	177 Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement; measure assesses a standard of practice and may not meet importance criterion.  Public comment from ACR supports inclusion of the measure in PQRS.
<b>M277 Not Endorsed</b>	178 Rheumatoid Arthritis (RA): Functional Status Assessment	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement; measure assesses a standard of practice and may not meet importance criteria.  Public comment from ACR supports inclusion of the measure in PQRS.
<b>M278 Not Endorsed</b>	179 Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement; measure assesses a standard of practice and may not meet importance criterion.  Public comment from ACR supports inclusion of the measure in PQRS.
<b>M279 Not Endorsed</b>	180 Rheumatoid Arthritis (RA): Glucocorticoid Management	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.  Public comment from ACR supports inclusion of the measure in PQRS.
<b>M280 Not Endorsed</b>	181 Elder Maltreatment Screen and Follow-Up Plan	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.
<b>M281 Not Endorsed</b>	182 Functional Outcome Assessment in Chiropractic Care	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.

TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M283 Not Endorsed (formerly NQF #0400)</b>	Paired Measure: Hepatitis C: Hepatitis B Vaccination (paired with 0399)	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M285 Not Endorsed</b>	186 Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers	MUC: FIN: Physician Feedback; PQRS		Submit for NQF endorsement.
<b>M287 Not Endorsed</b>	188 Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear	MUC: FIN: Physician Feedback; PQRS	Phased removal: Measure does not adequately address any current needs of the program	Measures assessing referrals are not considered to drive improvement; measures should assess if proper care was received.  Public comment from ASLHA supports MAP's conclusion.
<b>M288 Not Endorsed</b>	189 Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days	MUC: FIN: Physician Feedback; PQRS	Phased removal: Measure previously submitted for endorsement and was not endorsed	Measures assessing referrals are not considered to drive improvement; measures should assess if proper care was received.  Public comment from ASLHA supports MAP's conclusion.
<b>M289 Not Endorsed</b>	190 Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss	MUC: FIN: Physician Feedback; PQRS	Phased removal: Measure previously submitted for endorsement and was not endorsed	Measures assessing referrals are not considered to drive improvement; measures should assess if proper care was received.  Public comment from ASLHA supports MAP's conclusion.
<b>M295 Not Endorsed</b>	Chronic Stable Coronary Artery Disease: Symptom and Activity Assessment	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	

**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M298 Not Endorsed</b>	Heart Failure (HF) : Patient Education	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M299 Not Endorsed</b>	Heart Failure (HF) : Warfarin Therapy Patients with Atrial Fibrillation	MUC: FIN: MU-EP; Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M305 Not Endorsed (formerly NQF #0413)</b>	HIV/AIDS: Screening for High Risk Sexual Behaviors	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M306 Not Endorsed (formerly NQF #0415)</b>	HIV/AIDS: Screening for Injection Drug Use	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M307 Not Endorsed (formerly NQF #0410)</b>	HIV/AIDS: Sexually Transmitted Diseases - Syphilis Screening	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M308 Not Endorsed</b>	Functional Communication Measure: Spoken Language Comprehension	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ASLHA does not support MAP's conclusion, noting that these measures allow speech-language pathologists to participate in PQRS.

**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M309 Not Endorsed</b>	Functional Communication Measure: Attention	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ASLHA does not support MAP's conclusion, noting that these measures allow speech-language pathologists to participate in PQRS.
<b>M310 Not Endorsed</b>	Functional Communication Measure: Memory	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ASLHA does not support MAP's conclusion, noting that these measures allow speech-language pathologists to participate in PQRS.
<b>M311 Not Endorsed</b>	Functional Communication Measure: Motor Speech	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ASLHA does not support MAP's conclusion, noting that these measures allow speech-language pathologists to participate in PQRS.
<b>M312 Not Endorsed</b>	Functional Communication Measure: Reading	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ASLHA does not support MAP's conclusion, noting that these measures allow speech-language pathologists to participate in PQRS.
<b>M313 Not Endorsed</b>	Functional Communication Measure: Spoken Language Expression	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ASLHA does not support MAP's conclusion, noting that these measures allow speech-language pathologists to participate in PQRS.
<b>M314 Not Endorsed</b>	Functional Communication Measure: Writing	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ASLHA does not support MAP's conclusion and indicated, noting that these measures allow speech-language pathologists to participate in PQRS.

**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M315 Not Endorsed</b>	Functional Communication Measure: Swallowing	MUC: FIN: Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ASLHA does not support MAP's conclusion, noting that these measures allow speech-language pathologists to participate in PQRS.
<b>M1006 Not Endorsed</b>	304 Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1020 Not Endorsed</b>	245 Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (overuse measure)	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1021 Not Endorsed</b>	246 Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (overuse measure)	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1029 Not Endorsed</b>	248 Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1033 Not Endorsed</b>	242 Coronary Artery Disease (CAD): Symptom Management	MUC: FIN: PQRS		Submit for NQF endorsement. Public comment from ACC supports inclusion of the measure in PQRS.
<b>M1040 Not Endorsed</b>	280 Dementia: Staging of Dementia	MUC: FIN: PQRS	Phased removal: Measure previously submitted for endorsement and was not endorsed	Public comment from AAN does not support MAP's conclusion.
<b>M1041 Not Endorsed</b>	281 Dementia: Cognitive Assessment	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from AAN does not support MAP's conclusion.

**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1042 Not Endorsed</b>	282 Dementia: Functional Status Assessment	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from AAN does not support MAP's conclusion.
<b>M1043 Not Endorsed</b>	283 Dementia: Neuropsychiatric Symptom Assessment	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from AAN does not support MAP's conclusion.
<b>M1044 Not Endorsed</b>	284 Dementia: Management of Neuropsychiatric Symptoms	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from AAN does not support MAP's conclusion.
<b>M1045 Not Endorsed</b>	285 Dementia: Screening for Depressive Symptoms	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from AAN does not support MAP's conclusion.
<b>M1046 Not Endorsed</b>	286 Dementia: Counseling Regarding Safety Concerns	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from AAN does not support MAP's conclusion.
<b>M1047 Not Endorsed</b>	287 Dementia: Counseling Regarding Risks of Driving	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from AAN does not support MAP's conclusion.



**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1049 Not Endorsed</b>	288 Dementia: Caregiver Education and Support	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from AAN does not support MAP's conclusion.
<b>M1057 Not Endorsed</b>	251 Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1059 Not Endorsed (formerly NQF #0503)</b>	Anticoagulation for acute pulmonary embolus patients	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M1060 Not Endorsed</b>	Pregnancy Test for Female Abdominal Pain Patients.	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M1071 Not Endorsed</b>	256 Surveillance After Endovascular Abdominal Aortic Aneurysm Repair (EVAR)	MUC: FIN: PQRS	Phased removal: Measure previously submitted for endorsement and was not endorsed	
<b>M1072 Not Endorsed</b>	257 Statin Therapy at Discharge after Lower Extremity Bypass (LEB)	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1073 Not Endorsed</b>	258 Rate of Open Elective Repair of Small or Moderate Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day 7)	MUC: FIN: PQRS		Submit for NQF endorsement.

TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1074 Not Endorsed</b>	259 Rate of Elective Endovascular Aortic Repair (EVAR) of Small or Moderate Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day 2)	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1075 Not Endorsed</b>	260 Rate of Carotid Endarterectomy for Asymptomatic Patients, without Major Complications (Discharged to Home No Later than Post-Operative Day 2)	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1076 Not Endorsed</b>	276 Sleep Apnea: Assessment of Sleep Symptoms	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1077 Not Endorsed</b>	277 Sleep Apnea: Severity Assessment at Initial Diagnosis	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1078 Not Endorsed</b>	278 Sleep Apnea: Positive Airway Pressure Therapy Prescribed	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1079 Not Endorsed</b>	279 Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1080 Not Endorsed</b>	261 Referral for Otolgic Evaluation for Patients with Acute or Chronic Dizziness	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1084 Not Endorsed</b>	269 Inflammatory Bowel Disease (IBD): Type, Anatomic Location and Activity All Documented	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1085 Not Endorsed</b>	270 Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Sparing Therapy	MUC: FIN: PQRS		Submit for NQF endorsement.

**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1086 Not Endorsed</b>	271 Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury - Bone Loss Assessment	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1087 Not Endorsed</b>	272 Inflammatory Bowel Disease (IBD): Preventive Care: Influenza Immunization	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1088 Not Endorsed</b>	273 Inflammatory Bowel Disease (IBD): Preventive Care: Pneumococcal Immunization	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1089 Not Endorsed</b>	274 Inflammatory Bowel Disease (IBD): Screening for Latent TB Before Initiating Anti-TNF Therapy	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1090 Not Endorsed</b>	275 Inflammatory Bowel Disease (IBD): Hepatitis B Assessment Before Initiating Anti-TNF Therapy	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1099 Not Endorsed</b>	262 Image Confirmation of Successful Excision of Image-Localized Breast Lesion	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1100 Not Endorsed</b>	263 Preoperative Diagnosis of Breast Cancer	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1101 Not Endorsed</b>	264 Sentinel Lymph Node Biopsy for Invasive Breast Cancer	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1103 Not Endorsed</b>	Biopsy Follow-up	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comments from AAD and AAO do not support MAP's conclusion, noting that the measure fills a gap within the program.
<b>M1248 Not Endorsed</b>	228 GPRO HF-2 Heart Failure (HF): Left Ventricular Function (LVF) Testing	MUC: FIN: PQRS		Submit for NQF endorsement.

TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1249 Not Endorsed</b>	231 Asthma: Tobacco Use Screening - Ambulatory Care Setting	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1250 Not Endorsed</b>	232 Asthma: Tobacco Use Intervention - Ambulatory Care Setting	MUC: FIN: PQRS		Submit for NQF-endorsement.
<b>M1253 Not Endorsed</b>	Hypertension Plan of Care	MUC: FIN: PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M1380 Not Endorsed</b>	266 Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)	MUC: FIN: PQRS		Submit for NQF endorsement.  Public comment from AAN supports inclusion of the measure in PQRS.
<b>M1381 Not Endorsed</b>	267 Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome	MUC: FIN: PQRS	Phased removal: Measure previously submitted for endorsement and was not endorsed	Pending final endorsement decision; not recommended for endorsement by the CDP Steering Committee; currently in public and member commenting period.  Public comment from AAN does not support MAP's conclusion.
<b>M1387 Not Endorsed</b>	268: Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy	MUC: FIN: PQRS	Support: NQF- endorsed measure	Pending final endorsement decision; measure recommended for endorsement by CDP Steering Committee; currently in public and member commenting period.  Public comment from AAN encouraged maintaining the measure in the program.
<b>M1426 Not Endorsed</b>	Asthma: Assessment of Asthma Control	MUC: FIN: MU-EP; Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	

**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1429 Not Endorsed</b>	Prenatal Screening for Human Immunodeficiency Virus (HIV)	MUC: FIN: MU-EP; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M1430 Not Endorsed</b>	Hypertension: Blood Pressure Control	MUC: FIN: MU-EP; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ACC does not support MAP's conclusion, noting that the measure is appropriate for a clinician/group level of accountability and will be resubmitted for NQF endorsement.
<b>M1431 Not Endorsed</b>	Prenatal Anti-D Immune Globulin	MUC: FIN: MU-EP; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M1795 Not Endorsed</b>	316 Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed AND Risk-Stratified Fasting LDL	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1807 Not Endorsed</b>	289 Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review	MUC: FIN: PQRS		Submit for NQF endorsement. Public comment from AAN supports inclusion of the measure in PQRS.
<b>M1808 Not Endorsed</b>	290 Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment	MUC: FIN: PQRS		Submit for NQF endorsement. Public comment from AAN supports inclusion of the measure in PQRS.
<b>M1809 Not Endorsed</b>	291 Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment	MUC: FIN: PQRS		Submit for NQF endorsement. Public comment from AAN supports inclusion of the measure in PQRS.

TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1810 Not Endorsed</b>	292 Parkinson's Disease: Querying about Sleep Disturbances	MUC: FIN: PQRS		Submit for NQF endorsement.  Public comment from AAN supports inclusion of the measure in PQRS.
<b>M1811 Not Endorsed</b>	293 Parkinson's Disease: Rehabilitative Therapy Options	MUC: FIN: PQRS	Phased removal: Measure does not adequately address any current needs of the program	Measures of care planning and discussion of care plan that are not limited to one condition are needed.  Public comment from AAN does not support MAP's conclusion.
<b>M1813 Not endorsed</b>	294 Parkinson's Disease: Medical and Surgical Treatment Options Reviewed	MUC: FIN: PQRS		Submit for NQF endorsement.  Public comment from AAN supports inclusion of the measure in PQRS.
<b>M1871 Not Endorsed</b>	295 Hypertension: Appropriate Use of Aspirin or Other Anti-Platelet or Anti-Coagulant Therapy	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1872 Not Endorsed</b>	296 Hypertension: Complete Lipid Profile	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1873 Not Endorsed</b>	297 Hypertension: Urine Protein Test	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1874 Not Endorsed</b>	298 Hypertension: Annual Serum Creatinine Test	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1875 Not Endorsed</b>	Preventive Cardiology Composite: Diabetes Documentation or Screen test	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1876 Not Endorsed</b>	302 Hypertension: Dietary and Physical Activity Modifications Appropriately Prescribed	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M1877 Not Endorsed</b>	300 Hypertension: Blood Pressure Control	MUC: FIN: PQRS		Submit for NQF endorsement.

**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1878 Not Endorsed</b>	301 Hypertension: Low Density Lipoprotein (LDL-C) Control	MUC: FIN: PQRS	Phased removal: A finalized measure addresses a similar topic and better addresses the needs of the program	
<b>M1882 Not Endorsed</b>	Radiation Dose Optimization: Cumulative Count of Potential High Dose Radiation Imaging Studies: CT Scans and Cardiac Nuclear Medicine Scans	MUC: FIN: PQRS		Submit for NQF endorsement.  Public comments from ABR and ACR support inclusion of the measure in PQRS.
<b>M1883 Not Endorsed</b>	Radiation Dose Optimization: Utilization of a Standardized Nomenclature for CT Imaging Description	MUC: FIN: PQRS	Phased removal: Measure does not adequately address any current needs of the program	Measure assesses a practice standard and does not drive improvement.  Public comments from ABR and ACR do not support MAP's conclusion, noting that the measure promotes alignment between the ABR MOC and CMS programs.  Public comment from MITA supports MAP's conclusion.
<b>M1888 Not Endorsed</b>	Radiation Dose Optimization: Search for Prior Imaging Studies through a Secure, Authorized, Media-free, Shared Archive	MUC: FIN: PQRS		Submit for NQF endorsement.  Public comments from ABR and ACR support inclusion of the measure in PQRS.
<b>M1892 Not Endorsed</b>	317 GPRO Prev-11 Preventive Care and Screening: Blood Pressure Measurement	MUC: FIN: PQRS		Submit for NQF endorsement.

TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1990 Not Endorsed</b>	Breast Cancer Screening	MUC: Physician Compare; VBPM FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; MU-EP; Medicare Part C Plan Rating; MSSP; Physician Feedback; PQRS; VBPM	Support Direction: Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure was previously endorsed, but is undergoing updates to reflect current breast cancer screening guidelines. MAP recommends maintaining measure in the program if the measure is updated to reflect guidelines and endorsed prior to 2014 program implementation.
<b>M2143 Not Endorsed</b>	247 Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2153 Not Endorsed</b>	Osteoporosis: Status of Participation in Weight-bearing Exercise and Weight-Bearing Exercise Advice	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2155 Not Endorsed</b>	Osteoporosis: Screen for Falls Risk Evaluation and Complete Falls Risk Assessment and Plan of Care	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2249 Not Endorsed (formerly NQF #0403)</b>	HIV/AIDS: Medical Visit	MUC: FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; MU-EP; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M2262 Not Endorsed</b>	Pregnant Women that had HBsAg Testing.	MUC: FIN: MU-EP; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M2271 Not Endorsed</b>	Functional Status Assessment for Knee Replacement	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.



TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2272 Not Endorsed</b>	Functional Status Assessment for Hip Replacement	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.
<b>M2274 Not Endorsed</b>	Hypertension: Improvement in Blood Pressure	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.
<b>M2276 Not Endorsed</b>	Functional Status Assessment for Complex Chronic Conditions	MUC: FIN: MU-EP; PQRS		Submit for endorsement; functional status assessment should assess change in function (i.e., maintenance versus improvement).
<b>M2277 Not Endorsed</b>	Closing the Referral Loop: Receipt of Specialist Report	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.
<b>M2411 Not Endorsed</b>	244 Hypertension: Blood Pressure Management	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2412 Not Endorsed</b>	299 Hypertension: Diabetes Mellitus Screening Test	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2424 Not Endorsed</b>	Total Knee Replacement: Coordination of Post Discharge Care	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2425 Not Endorsed</b>	Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2427 Not Endorsed</b>	Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2429 Not Endorsed</b>	Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	MUC: FIN: PQRS	Phased removal: Measure does not adequately address any current needs of the program	Risk assessment prior to surgery is a standard practice of care; measure does not drive improvement.
<b>M2436 Not Endorsed</b>	Preventive Cardiology Composite	MUC: FIN: PQRS		Submit for NQF endorsement.

TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2442 Not Endorsed</b>	Radiation Dose Optimization: Images Available for Patient Follow-up and Comparison Purposes	MUC: FIN: PQRS		Submit for NQF endorsement.  Public comments from ABR and ACR support inclusion of the measure in PQRS.
<b>M2443 Not Endorsed</b>	Radiation Dose Optimization: Reporting to a Radiation Dose Index Registry	MUC: FIN: PQRS		Submit for NQF endorsement  Public comments from ABR and ACR support inclusion of the measure in PQRS.
<b>M2448 Not Endorsed</b>	Radiation Dose Optimization: Reporting to a Radiation Dose Index Registry	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2449 Not Endorsed</b>	Preventive Cardiology Composite: Appropriate use of aspirin or other antiplatelet anticoagulant therapy	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2453 Not Endorsed</b>	Preventive Cardiology Composite: Blood Pressure at Goal	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2464 Not Endorsed</b>	Preventive Cardiology Composite: Correct Determination of Ten-Year Risk for Coronary Death or MI	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2465 Not Endorsed</b>	Preventive Cardiology Composite: Counseling for Diet and Physical Activity	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2480 Not Endorsed</b>	Preventive Cardiology Composite: LDL Cholesterol at Goal	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2493 Not Endorsed</b>	Osteoporosis: Calcium Intake Assessment and Counseling	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2494 Not Endorsed</b>	Osteoporosis: DXA Scan	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2495 Not Endorsed</b>	Osteoporosis: Pharmacologic Therapy	MUC: FIN: PQRS		Submit for NQF endorsement.

**TABLE A3. MAP INPUT ON PQRS CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2496 Not Endorsed</b>	Osteoporosis: Vitamin D Intake Assessment and Counseling	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2509 Not Endorsed</b>	Adult Major Depressive Disorder: Coordination of Care of Patients with Comorbid Conditions	MUC: FIN: PQRS		Submit for NQF endorsement; care coordination for individuals with depression addresses an important measure gap. Public comment from Takeda Pharmaceuticals supports inclusion of the measure in PQRS.
<b>M2529 Not Endorsed</b>	Pediatric Kidney Disease: Adequacy of Volume Management	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2533 Not Endorsed</b>	Smoking Status and Cessation Support	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2542 Not Endorsed</b>	Timing of Lipid Testing Complies with Guidelines	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M2986 Not Endorsed</b>	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	MUC: FIN: PQRS		Submit for NQF endorsement.
<b>M3007 Not Endorsed</b>	CG-CAHPS for ACOs	MUC: FIN: PQRS		Submit for NQF endorsement.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Physician Compare

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### Program Type:

Public Reporting<sup>10</sup>

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### Incentive Structure:

None

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### Care Settings Included:

Multiple. Eligible professionals include:<sup>11</sup>

- Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist

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### Statutory Mandate:

Section 10331 of the Patient Protection and Affordable Care Act of 2010. The website was launched on December 30, 2010. Performance information will be reported on the website beginning on January 1, 2013.

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### Statutory Requirements for Measures:

Data reported under the existing Physician Quality Reporting System will be used as an initial step for making physician measure performance information public on Physician Compare. The following types of measures are required to be included for public reporting on Physician Compare:<sup>12</sup>

- Patient health outcomes and functional status of patients
- Continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use
- Efficiency
- Patient experience and patient, caregiver, and family engagement
- Safety, effectiveness, and timeliness of care

## Physician Feedback Program/Value-Based Payment Modifier

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### Program Type:

Pay for Performance

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### Incentive Structure:

#### Physician Feedback Program

CMS is statutorily required to provide confidential feedback reports to physicians that measure the quality and resources involved in furnishing care to Medicare Fee-for-Service (FFS) beneficiaries. Physician feedback reports also serve currently as the preview vehicle to inform physicians of the types of measures that will comprise the value modifier. Starting in the fall of 2013, all groups of physicians with 25 or more eligible professionals will begin receiving Physician Feedback reports.<sup>13</sup>

#### Value-Based Payment Modifier

The modifier begins in 2015 for groups of 100 or more eligible professionals, and it is applicable to all physicians and groups of physicians on or after January 1, 2017. The modifier payment adjustment varies over time and must be implemented in a budget neutral manner. Payment adjustment amount is built on satisfactory reporting through PQRS.<sup>14</sup>

- The VM as proposed for implementation in 2015 provides groups of physicians with 100 or more eligible professionals an option that their Value Modifier be “O” or be calculated using a tiering approach if they are successful PQRS group reporters or have a -1% payment reduction if not successful PQRS reporter or did not register for a PQRS group option or report any measures.

- For those electing a tiering approach, CMS will focus the Value Modifier payment adjustment (both upward and downward) on those groups of physicians that are outliers; that is, those that are significantly different from the national mean.

In 2015 and 2016, the value-based payment modifier will not be applied to groups of physicians that are participating in the Medicare Shared Savings Program, testing of the Pioneer ACO model, or the Comprehensive Primary Care Initiative.<sup>15</sup> Additionally, future rulemaking cycles will determine a value-based payment modifier for individuals, smaller groups, and hospital-based physicians.<sup>16</sup>

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### Statutory Mandate:

Section 1848(p) of the Social Security Act (the Act) as established by Section 3003 and 3007 of the Affordable Care Act of 2010 (ACA).<sup>17</sup>

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### Statutory Requirements for Measures:

The program must include a composite of appropriate, quality measures and a composite of appropriate cost measures.<sup>18</sup> The Secretary is also required to use NQF-endorsed measures, whenever possible. Final rule indicated, for 2013 and beyond, the use of all measures included in the PQRS.

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### MAP Pre-Rulemaking 2013 Input

The following are MAP’s recommendations on measures under consideration and currently finalized measures, as applicable.

TABLE A4. MAP INPUT ON VBPM MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0005 Endorsed</b>	CAHPS Clinician/Group Surveys—(Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	MUC: Physician Compare; VBPM FIN: MSSP	Support: NQF-endorsed measure	CAHPS should be incorporated into the Value-Based Payment Modifier. Public comment from AANS does not support MAPs conclusion, noting burden as a barrier to reporting. Public comment from ACS and AAO suggested that MAP consider CAHPS-Surgical Care for VBPM and Physician Compare.
<b>M2762 Not Endorsed</b>	Clinician/Group CAHPS: Care Coordination	MUC: Physician Compare; VBPM FIN:	Support: NQF-endorsed measure	CAHPS should be incorporated into the Value-Based Payment Modifier.
<b>M2763 Not Endorsed</b>	Clinician/Group CAHPS: Between Visit Communication	MUC: Physician Compare; VBPM FIN:	Support: NQF-endorsed measure	CAHPS should be incorporated into the Value-Based Payment Modifier.
<b>M2764 Not Endorsed</b>	Clinician/Group CAHPS: Educating Patients about Medication Adherences	MUC: Physician Compare; VBPM FIN:	Support: NQF-endorsed measure	CAHPS should be incorporated into the Value-Based Payment Modifier.
<b>M2765 Not Endorsed</b>	Clinician/Group CAHPS: Stewardship of Patient Resources	MUC: Physician Compare; VBPM FIN:	Support: NQF-endorsed measure	CAHPS should be incorporated into the Value-Based Payment Modifier.
<b>M2876 Not Endorsed</b>	Episode Grouper: Acute Myocardial Infarction (AMI)	MUC: Physician Compare; Physician Feedback; VBPM FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AAOS, ACC, and SHM support MAP's conclusion. AAOS and SHM noted concerns with the measure methodology.
<b>M2878 Not Endorsed</b>	Episode Grouper: Pneumonia	MUC: Physician Compare; Physician Feedback; VBPM FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AAOS, ACC, and SHM support MAP's conclusion. AAOS and SHM noted concerns with the measure methodology.

**TABLE A4. MAP INPUT ON VBPM MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2879 Not Endorsed</b>	Episode Grouper: Coronary Artery Bypass Graft (CABG)	MUC: Physician Compare; Physician Feedback; VBPM FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AAOS, ACC, and SHM support MAP's conclusion. AAOS and SHM noted concerns with the measure methodology.
<b>M2880 Not Endorsed</b>	Episode Grouper: Percutaneous Coronary Intervention (PCI)	MUC: Physician Compare; Physician Feedback; VBPM FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AAOS, ACC, and SHM support MAP's conclusion. AAOS and SHM noted concerns with the measure methodology.
<b>M2882 Not Endorsed</b>	Episode Grouper: Coronary Artery Disease	MUC: Physician Compare; Physician Feedback; VBPM FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AAOS, ACC, and SHM support MAP's conclusion. AAOS and SHM noted concerns with the measure methodology.
<b>M2884 Not Endorsed</b>	Episode Grouper: Congestive Heart Failure (CHF)	MUC: Physician Compare; Physician Feedback; VBPM FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AAOS, ACC, and SHM support MAP's conclusion. AAOS and SHM noted concerns with the measure methodology.
<b>M2885 Not Endorsed</b>	Episode Grouper: Chronic Obstructive Pulmonary disease (COPD)	MUC: Physician Compare; Physician Feedback; VBPM FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AAOS, ACC, and SHM support MAP's conclusion. AAOS and SHM noted concerns with the measure methodology.
<b>M2887 Not Endorsed</b>	Episode Grouper: Asthma	MUC: Physician Compare; Physician Feedback; VBPM FIN:	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AAOS, ACC, and SHM support MAP's conclusion. AAOS and SHM noted concerns with the measure methodology.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

TABLE A5. MAP INPUT ON VBPM CURRENTLY FINALIZED MEASURES

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2147 Not Endorsed</b>	Total Per Capita Cost Measure	MUC: FIN: Physician Feedback; VBPM	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comments from AAO and AANS do not support MAP's conclusion, noting concerns with the implementation and methodology of the measure. Public comment from ACC supports MAP's conclusion.
<b>M2148 Not Endorsed</b>	Condition-specific Per Capita Cost Measures for COPD, Diabetes, HF, and CAD	MUC: FIN: Physician Feedback; VBPM	Support Direction: Not ready for implementation, should be submitted for and receive NQF endorsement	Public comment from ACC supports MAP's conclusion.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.



## Medicare and Medicaid EHR Incentive Program for Eligible Professionals

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### Program Type:

Payment incentive program for using EHRs

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### Incentive Structure:

Eligible professionals who demonstrate meaningful use of certified EHR technology, which includes reporting clinical quality measures, can receive incentive payments. The incentives vary by program.<sup>19</sup>

- Medicare: Up to \$44,000 over five continuous years. The program started in 2011 and will continue through 2014. The last year to begin participation is 2014. Penalties will take effect in 2015 and in each subsequent year for providers who are eligible but do not participate. The penalty is a payment adjustment to Medicare reimbursements that starts at 1 percent per year, up to a maximum 5 percent annual adjustment.
- Medicaid: Up to \$63,750 over six years. The program started in 2011 and will continue through 2021. The last year to begin participation is 2016. Penalty payment adjustments do not apply to Medicaid.<sup>20</sup>

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### Care Settings Included:

Multiple. Under the Medicare EHR incentive program, eligible professionals include doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry as well as chiropractors. Under the Medicaid EHR incentive program, eligible professionals include doctors of medicine and osteopathy, nurse practitioners, certified nurse-midwives, dentists, and physicians assistances furnishing services in a federally qualified health center or rural health clinic.<sup>21</sup>

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### Statutory Mandate:

The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

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### Statutory Requirements for Measures:

Measures are of processes, experience, and outcomes of patient care that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.<sup>22</sup> Preference should be given to quality measures endorsed by NQF.<sup>23</sup>

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### Anticipated Future Rules:

It is anticipated that the Meaningful Use Stage 3 proposed rule will be published in early 2014.

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### Additional Program Considerations:

The goal of the Medicare and Medicaid EHR Incentive Program is to provide measures for eligible professionals under three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing;
- The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and
- The use of certified EHR technology to submit clinical quality and other measures.

For Stage 1:<sup>24</sup>

- Eligible Professionals must report on six total clinical quality measures: three required core

measures (substituting alternate core measures where necessary), and three additional measures (selected from a set of 38 clinical quality measures).

National Quality Strategy priorities (selected from a set of 64 clinical quality measures).

For Stage 2 (2014 and beyond):<sup>25</sup>

- Eligible Professionals must report on 9 total clinical quality measures that cover 3 of the

**MAP Pre-Rulemaking 2013 Input:**

The following are MAP’s recommendations on measures under consideration and currently finalized measures, as applicable.

**TABLE A6. MAP INPUT ON CLINICIAN MEANINGFUL USE MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M3041 Not Endorsed</b>	Annual Wellness Assessment: Assessment of Health Risks (Draft)	MUC: MU-EP FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Preventive care composites would enhance the measure set; however, several finalized measures in the set address the same screenings and are not limited to the context of an annual visit.
<b>M3042 Not Endorsed</b>	Annual Wellness Assessment: Management of Health Risks (Draft)	MUC: MU-EP FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Preventive care composites would enhance the measure set; however, several finalized measures in the set address the same management of risks and are not limited to the context of an annual visit.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

**TABLE A7. MAP INPUT ON CLINICIAN MEANINGFUL USE CURRENTLY FINALIZED MEASURES**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M299 Not Endorsed</b>	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation	MUC: FIN: MU-EP; PQRS	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	

**TABLE A7. MAP INPUT ON CLINICIAN MEANINGFUL USE CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1426 Not Endorsed</b>	Asthma: Assessment of Asthma Control	MUC: FIN: MU-EP	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M1429 Not Endorsed</b>	Prenatal Screening for Human Immunodeficiency Virus (HIV)	MUC: FIN: MU-EP	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M1430 Not Endorsed</b>	Hypertension: Blood Pressure Control	MUC: FIN: MU-EP; Physician Feedback; PQRS	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ACC does not support MAP's conclusion.
<b>M1431 Not Endorsed</b>	Prenatal Anti-D Immune Globulin	MUC: FIN: MU-EP; PQRS	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M1990 Not Endorsed</b>	Breast Cancer Screening	MUC: FIN: MU-EP; PQRS	Support Direction: Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure was previously endorsed, but is undergoing updates to reflect current breast cancer screening guidelines; MAP recommends maintaining measure in the program if the measure is updated to reflect guidelines and endorsed.
<b>M2249 Not Endorsed (formerly NQF #0403)</b>	HIV/AIDS: Medical Visit	MUC: FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; MU-EP; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	

TABLE A7. MAP INPUT ON CLINICIAN MEANINGFUL USE CURRENTLY FINALIZED MEASURES (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2262 Not Endorsed</b>	Pregnant Women that Had HBsAg Testing	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.
<b>M2271 Not Endorsed</b>	Functional Status Assessment for Knee Replacement	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.
<b>M2272 Not Endorsed</b>	Functional Status Assessment for Hip Replacement	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.
<b>M2273 Not Endorsed</b>	Preventive Care and Screening: Risk- Stratified Cholesterol - Fasting Low Density Lipoprotein (LDL-C)	MUC: FIN: MU-EP		Submit for NQF endorsement.
<b>M2274 Not Endorsed</b>	Hypertension: Improvement in Blood Pressure	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.
<b>M2275 Not Endorsed</b>	Preventive Care and Screening: Screening for High Blood Pressure and Follow up Documented	MUC: FIN: MU-EP		Submit for NQF endorsement.
<b>M2276 Not Endorsed</b>	Functional Status Assessment for Complex Chronic Conditions	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.
<b>M2277 Not Endorsed</b>	Closing the Referral Loop: Receipt of Specialist Report	MUC: FIN: MU-EP; PQRS		Submit for NQF endorsement.
<b>M2287 Not Endorsed</b>	Dementia: Cognitive Assessment	MUC: FIN: MU-EP		Submit for NQF endorsement.
<b>M2294 Not Endorsed (formerly NQF #0407)</b>	HIV/AIDS: HIV RNA Control after Six Months of Potent Antiretroviral Therapy	MUC: FIN: MU-EP; Physician Feedback; PQRS	Phased removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M3008 Not Endorsed</b>	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	MUC: FIN: MU-EP		Submit for NQF endorsement.
<b>M3009 Not Endorsed</b>	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	MUC: FIN: MU-EP		Submit for NQF endorsement.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Hospital Inpatient Quality Reporting

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### Program Type:

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Pay for Reporting—Information is reported on the Hospital Compare website.<sup>26</sup>

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### Incentive Structure:

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Hospitals receive a reduction of 2.0 percentage points of their annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) payment update for non-participation.<sup>27</sup>

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### Care Settings Included:

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Hospitals paid under the Inpatient Prospective Payment System (IPPS).

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### Statutory Mandate:

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The Hospital Inpatient Quality Reporting Program (IQR) was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and subsequently updated in the Deficit Reduction Act of 2005.

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### Statutory Requirements for Measures:

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The program was required to begin with the baseline set of performance measures set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription

Drug, Improvement, and Modernization Act of 2003.

The program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

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### Additional Program Considerations:

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- Measures should align with the National Quality Strategy<sup>28</sup> and promote the health and well-being of Medicare beneficiaries.<sup>29,30</sup>
- Measures should align with the Meaningful Use program when possible.<sup>31,32</sup>

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### MAP Pre-Rulemaking 2013 Input:

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The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.

TABLE A8. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0330 Endorsed</b>	Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate Following Heart Failure Hospitalization for Patients 18 and Older	MUC: IQR; Readmission Reduction  FIN: IQR; Readmission Reduction	Support: New specifications are improvement over the existing finalized measure	Recommendation is contingent on NQF endorsement.  Public comments from AAMC, AHIP, California Hospital Association, FAH, GNYHA, and SHM support MAP's conclusion as the updated methodology excludes planned readmissions.
<b>0471 Endorsed</b>	PC-02 Cesarean Section	MUC: Not Under Consideration for a Program  FIN:	Support: Addresses a high-impact condition not adequately addressed in the program measure set	C-sections have become the most common surgery with very high rates.  Public comments from Consumers Union, the Children's Hospital Association, and TJC support MAP's conclusion. Comment from the Armstrong Institute for Patient Safety and Quality questions the feasibility of implementing this measure.
<b>0480 Endorsed</b>	PC-05 Exclusive Breast Milk Feeding	MUC: IQR  FIN: MU-Hospitals, CAHs	Support: Addresses a NQS priority not adequately addressed in the program measure set	Both rates of the measure should be reported.  Public comments from the Children's Hospital Association and TJC support MAP's conclusion. Public comments from AHIP cautioned that implementation of this measure may reveal cultural challenges that need to be addressed.

**TABLE A8. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0500 Endorsed</b>	Severe Sepsis and Septic Shock: Management Bundle	MUC: IQR; OQR; LTCHQR FIN:	Support: Addresses a NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; early detection and treatment of sepsis in the emergency department and inpatient settings is important.  Public comments from ACCP, AHIP, GNYHA, and SHM do not support MAP's conclusion, noting measure collection burden, the need for more evidence for the individual composite elements, and issues regarding case selection and transfer.
<b>0505 Endorsed</b>	Hospital 30-day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	MUC: IQR; Readmission Reduction FIN: IQR; Readmission Reduction	Support: New specifications are improvement over the existing finalized measure	Recommendation is contingent on NQF endorsement.  Public comments from AAMC, AHIP, California Hospital Association, FAH, GNYHA, and SHM support MAP's conclusion as the updated methodology excludes planned readmissions.
<b>0506 Endorsed</b>	Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization	MUC: IQR; Readmission Reduction FIN: IQR; Readmission Reduction	Support: New specifications are improvement over the existing finalized measure	Recommendation is contingent on NQF endorsement.  Public comments from AAMC, AHIP, California Hospital Association, FAH, GNYHA, and SHM support MAP's conclusion as the updated methodology excludes planned readmissions.
<b>0716 Endorsed</b>	Healthy Term Newborn	MUC: IQR FIN: MU-Hospitals, CAHs	Support Direction: Not ready for implementation; more experience with the measure is needed	MAP strongly supports the direction of this measure for inclusion in the program as soon as technical issues are resolved.

**TABLE A8. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1354</b> <b>Endorsed</b>	Hearing Screening Prior to Hospital Discharge (EHDI-1a)	MUC: IQR FIN: MU-Hospitals, CAHs; HRSA	Support: Addresses a high-impact condition not adequately addressed in the program measure set	Addresses a high-impact pediatric condition. Public comment from the Children’s Hospital Association supports MAP’s conclusion.
<b>1551</b> <b>Endorsed</b>	Hospital-level 30-day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	MUC: IQR; Readmission Reduction FIN: IQR	Support: Addresses a high volume diagnosis or procedure	Recommendation is contingent on NQF endorsement; addresses a high volume, elective procedure. Public comments from AAMC, AHIP, California Hospital Association, FAH, GNYHA, and SHM support MAP’s conclusion as the updated methodology excludes planned readmissions.
<b>1789</b> <b>Endorsed</b>	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	MUC: IQR; PQRS FIN: IQR	Support: New specifications are improvement over the existing finalized measure	Recommendation is contingent on NQF endorsement. Public comments from AAMC, AHIP, California Hospital Association, FAH, GNYHA, and SHM support MAP’s conclusion as the updated methodology excludes planned readmissions. Comments from AANS and ACS do not support MAP’s conclusion because the measure lacks “state of the art” modeling for risk factors and does not take into consideration readmissions related to trauma or staged procedures.



**TABLE A8. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1893 Endorsed</b>	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	MUC: IQR FIN:	Support: Addresses a high-impact condition not adequately addressed in the program measure set	Concern noted that this measure does not exclude palliative care patients and functional status is not included in the risk-adjustment.  Public comments from SHM support MAP’s conclusion, noting that the measure has appropriate exclusions for patients transferred to the facility and should also expand exclusions for patients receiving end-of-life care.
<b>M524 Not Endorsed</b>	Stroke: 30-day All-Cause Risk-Standardized Mortality Measure	MUC: IQR FIN:	Do Not Support: Measure previously submitted for endorsement and was not endorsed	Stroke mortality remains an important gap area that should be addressed in IQR.  Public comment from AANS supports MAP’s conclusion, but notes concerns about the risk modeling and data source of this measure.  Comment from SHM supports the direction of this measure, noting exclusions should be made for patients discharged to hospice care.  Comment from AmeriHealth Mercy Family of Companies does not support MAP’s conclusion, citing a rigorous process was used to develop this measure.
<b>M1637 Not Endorsed</b>	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	MUC: IQR; Readmission Reduction FIN:	Support: Addresses a high-impact condition not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement.  Public comments from SHM support MAP’s conclusion because this measure relates to a high volume diagnosis.

**TABLE A8. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1643 Not Endorsed</b>	Medicare Spending Per Beneficiary	MUC: IQR; HVBP; LTCHQR; PCHQR FIN:	Support: Addresses specific program attributes. Addresses an NQS priority not adequately addressed in the program measure set	Statutorily required to report this measure; should be submitted for NQF endorsement.  Public comments from PhRMA and SHM do not support MAP's conclusion, noting that this measure is not NQF-endorsed, does not contain any adjustment for acuity, and excludes many population groups.
<b>M2307 Not Endorsed</b>	CAC-3: Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver	MUC: IQR FIN: MU-Hospitals, CAHs	Do Not Support: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>M2698 Not Endorsed</b>	AMI Episode of Care (Inpatient Hospitalization + 30 Days Post-Discharge)	MUC: IQR FIN:	Support Direction: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement.
<b>M2758 Not Endorsed</b>	Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following an Acute Ischemic Stroke Hospitalization	MUC: IQR; Readmission Reduction FIN:	Do Not Support: Measure previously submitted for endorsement and was not endorsed	Stroke readmissions remain an important gap area that should be addressed in IQR.  Public comment from AANS supports MAP's conclusion, noting concerns about the risk modeling and data source of this measure. Comment from SHM supports the direction of this measure, noting that exclusions should be made for patients discharged to inpatient rehabilitation. Comment from AmeriHealth Mercy Family of Companies does not support MAP's conclusion, citing a rigorous process was used to develop this measure.

**TABLE A8. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M3035</b> <b>Not Endorsed</b>	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; most recent NQF version should be applied.  Public comments from SHM, NY-Presbyterian Hospital, ACCP, and GNYHA support MAP's conclusion, noting that the methodology is improved; however, SHM would recommend an exclusion for emergently placed lines. Comment from ACCP notes that this measure should be harmonized with measure M2920.
<b>M3036</b> <b>Not Endorsed</b>	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; most recent NQF version should be applied.  Public comments from SHM, NY-Presbyterian Hospital, ACCP, and GNYHA support MAP's conclusion.
<b>M3038</b> <b>Not Endorsed</b>	Reliability Adjusted Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia	MUC: HAC Reduction; IQR; HVBP FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; most recent NQF version should be applied.  Public comment from SHM supports the concept of this measure, noting that it should not include community-acquired MRSA.  Public comment from GNYHA does not support MAP's conclusion, noting that public reporting would be ineffective since MRSA infection rates are low.

**TABLE A8. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M3039 Not Endorsed</b>	Reliability Adjusted <i>Clostridium difficile</i> SIR Measure	MUC: HAC Reduction; IQR; HVBP; IRFQR FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; most recent NQF version should be applied.  Public comment from SHM supports this measure, noting that it should be adjusted for background prevalence rates of <i>C. difficile</i> .

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

**TABLE A9. MAP INPUT ON IQR CURRENTLY FINALIZED MEASURES**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0135 Endorsed Reserve</b>	Evaluation of Left Ventricular Systolic Function (LVS)	MUC: FIN: IQR; HRSA	Phased Removal: NQF endorsement placed in reserve status (performance on this measure is topped out)	Measure should be suspended from the program.
<b>0142 Endorsed Reserve</b>	Aspirin Prescribed at Discharge for AMI	MUC: FIN: IQR; MU-Hospitals, CAHs	Phased Removal: NQF endorsement placed in reserve status (performance on this measure is topped out)	Measure should be suspended from the program.
<b>M499 Not Endorsed (Formerly 0376)</b>	Incidence of Potentially Preventable Venous Thromboembolism	MUC: HAC Reduction FIN: IQR; MU-Hospitals, CAHs	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Measure may not reflect truly preventable events and is burdensome to collect.
<b>0639 Endorsed</b>	Statin Prescribed at Discharge	MUC: FIN: IQR; MU-Hospitals, CAHs	Phased Removal: Performance on this measure is likely topped out	Timely and accurate data is needed for decision-making. Measure may not produce useful information.

**TABLE A9. MAP INPUT ON IQR CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M8 Not Endorsed</b>	Heart Failure (HF): Detailed Discharge Instructions	MUC: Long-term Care Hospital Quality Reporting FIN: IQR; HVBP	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	A MAP member noted that research shows a weak correlation between performance on this measure and patient outcomes.
<b>M13 Not Endorsed</b>	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	MUC: FIN: IQR; HVBP; HRSA	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Measure may be topped out, and there may be feasibility issues with administration.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Hospital Value-Based Purchasing

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### Program Type:

Pay for Performance—Information is reported on the Hospital Compare website.<sup>33</sup>

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### Incentive Structure:

Starting on October 1, 2012, Medicare began basing a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing Program (HVBP). Medicare began withholding 1 percent of its regular hospital reimbursements from all hospitals paid under its Inpatient Prospective Payment System (IPPS) to fund a pool of HVBP incentive payments. The amount withheld from reimbursements increases over time:

- FY 2014: 1.25 percent
- FY 2015: 1.5 percent
- FY 2016: 1.75 percent
- FY 2017 and succeeding fiscal years: 2 percent.

Hospitals are scored based on their performance on each measure within the program relative to other hospitals as well as on how their performance on each measure has improved over time. The higher of these scores on each measure is used in determining incentive payments.

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### Care Settings Included:

Hospitals paid under the IPPS.

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### Statutory Mandate:

Hospital VBP was mandated by section 3001 of the Patient Protection and Affordable Care Act.

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### Statutory Requirements for Measures:

Measures selected for the HVBP program must be included in the IQR program and reported on the Hospital Compare website for at least one year prior to use in the HVBP program.

The program was required to begin with a baseline set of performance measures for FY 2013 that included measures addressing acute myocardial infarction (AMI), heart failure, pneumonia, surgeries as measured by the Surgical Care Improvement Project, healthcare-associated infections as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan), and HCAHPS. For FY 2014 or a subsequent fiscal year, the program set should include efficiency measures including measures of “Medicare Spending per Beneficiary.”

The Secretary of HHS can replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice). Measures of readmissions are statutorily excluded and cannot be included in the HVBP program.<sup>34</sup>

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### MAP Pre-Rulemaking 2013 Input:

The following are MAP’s recommendations on measures under consideration and currently finalized measures, as applicable.

**TABLE A10. MAP INPUT ON HVBP MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0138 Endorsed</b>	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	MUC: HAC Reduction; HVBP FIN: IQR; IRFQR; LTCHQR; PCHQR	Support: Addresses an NQS priority not adequately addressed in the program measure set	Most recent NQF endorsed version should be applied. Public comment from ACCP supports MAP's conclusion.
<b>0228 Endorsed</b>	3-Item Care Transition Measure (CTM-3)	MUC: HVBP; LTCHQR FIN: IQR	Support: Addresses an NQS priority not adequately addressed in the program measure set. Addresses a high-leverage opportunity for dual eligible beneficiaries. Enables measurement across the person-centered episode of care	Public comment from SHM supports MAP's conclusion. Comments from the Connecticut Hospital Association and AHA do not support MAP's conclusion, noting that new measures should be publicly reported for one year in the IQR program prior to implementation in the HVBP program.
<b>0431 Endorsed</b>	Influenza Vaccination Coverage Among Healthcare Personnel	MUC: OQR; HVBP; IRFQR; PQRS FIN: ASCQR; IQR; LTCHQR	Do Not Support: More experience with the measure is needed	Measure not ready for use in a pay-for-performance program. Public comment from SHM does not support MAP's conclusion.
<b>0469 Endorsed</b>	PC-01 Elective Delivery	MUC: HVBP FIN: IQR; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; MU-Hospitals, CAHs	Support: Addresses an NQS priority not adequately addressed in the program measure set	Concerns were noted about the measure's applicability to a Medicare population. Public comments from TJC and the Children's Hospital Association support MAP's conclusion, noting that pre-term births are a rapidly escalating public health problem.

TABLE A10. MAP INPUT ON HVBP MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0495</b> <b>Endorsed</b> <b>Time-Limited</b>	Median Time from ED Arrival to ED Departure for Admitted ED Patients	MUC: HVBP FIN: IQR; MU-Hospitals, CAHs	Support Direction: Not ready for implementation; measure concept is promising but requires modification or further development	Concerns were noted about the validity of this measure; ED overcrowding and improving wait times are critical patient safety issues. Public comment from SHM does not support MAP's conclusion, noting the need to clarify observation time.
<b>0497</b> <b>Endorsed</b> <b>Time-Limited</b>	Admit Decision Time to ED Departure Time for Admitted Patients	MUC: HVBP FIN: IQR; MU-Hospitals, CAHs	Support Direction: Not ready for implementation; measure concept is promising but requires modification or further development	Concerns were noted about the validity of this measure; ED overcrowding and improving wait times are critical patient safety issues. Public comment from SHM does not support MAP's conclusion, noting concerns about bias.
<b>0753</b> <b>Endorsed</b>	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	MUC: HAC Reduction; HVBP; PCHQR FIN: IQR	Support: Addresses an NQS priority not adequately addressed in the program measure set	Public comments from SHM cautioned that the numerator for this measure would be variable and highly inaccurate.
<b>1550</b> <b>Endorsed</b>	Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	MUC: HVBP FIN: IQR	Support: Addresses a high- volume diagnosis or procedure	Addresses a high- volume, elective procedure with variation in performance.
<b>1653</b> <b>Endorsed</b>	Pneumococcal Immunization (PPV 23)	MUC: End-Stage Renal Disease Quality Reporting; HVBP FIN: IQR	Support: Addresses a high-impact condition not adequately addressed in the program measure set	Early data show variation in performance. Public comment from Pfizer recommended measure titles and specifications reflect the latest evidence-based guidelines.



**TABLE A10. MAP INPUT ON HVBP MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1659 Endorsed</b>	Influenza Immunization	MUC: HVBP FIN: IQR	Support: Addresses a high-impact condition not adequately addressed in the program measure set	Early data show variation in performance.
<b>1716 Endorsed</b>	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia Outcome Measure	MUC: HAC Reduction; VBP; LTCHQR FIN: IQR	Support Direction: Addresses an NQS priority not adequately addressed in the program measure set	Measure should be applied to this program following public reporting on Hospital Compare, per HVBP statutory requirement; most recent NQF-endorsed version should be applied.  Public comment from Consumers Union supports the inclusion of this measure (recommending support, rather than support direction). Public comment from SHM does not support MAP's conclusion.
<b>1717 Endorsed</b>	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure	MUC: HAC Reduction; HVBP; LTCHQR FIN: IQR	Support Direction: Addresses an NQS priority not adequately addressed in the program measure set	Measure should be applied to this program following public reporting on Hospital Compare, per HVBP statutory requirement; most recent NQF-endorsed version should be applied.  Public comment from Consumers Union supports the inclusion of this measure (recommending support, rather than support direction). Public comment from SHM does not support MAP's conclusion.

TABLE A10. MAP INPUT ON HVBP MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1643</b> <b>Not Endorsed</b>	Medicare Spending Per Beneficiary	MUC: IQR; HVBP; LTCHQR; PCHQR FIN:	Support: Addresses specific program attributes. Addresses an NQS priority not adequately addressed in the program measure set	Statutorily required to report this measure; should be submitted for NQF endorsement.  Public comments from PhRMA and SHM do not support MAP's conclusion, noting that this measure is not NQF-endorsed, does not contain any adjustment for acuity, and excludes many population groups.
<b>M3035</b> <b>Not Endorsed</b>	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; most recent NQF-endorsed version should be applied.  Public comments from SHM and NY-Presbyterian Hospital support MAP's conclusion, noting that this methodology will improve variability. ACCP suggests harmonization with measure M2920. Public comment from GNYHA does not support MAP's conclusion, indicating additional testing is needed before including this measure in a payment program.

**TABLE A10. MAP INPUT ON HVBP MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M3036</b> <b>Not Endorsed</b>	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; most recent NQF-endorsed version should be applied.  Public comments from SHM, NY-Presbyterian Hospital, and ACCP support MAP's conclusion, noting that this methodology will improve variability. Comment from GNYHA does not support MAP's conclusion, indicating additional testing is needed before including this measure in a payment program.
<b>M3038</b> <b>Not Endorsed</b>	Reliability Adjusted Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia	MUC: HAC Reduction; IQR; HVBP FIN:	Support Direction: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; most recent NQF-endorsed version should be applied.  Public comment from SHM supports MAP's conclusion. Comment from GNYHA does not support MAP's conclusion, noting that public reporting would be ineffective since MRSA infection rates are low.
<b>M3039</b> <b>Not Endorsed</b>	Reliability Adjusted <i>Clostridium difficile</i> SIR Measure	MUC: HAC Reduction; IQR; HVBP; IRFQR FIN:	Support Direction: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; most recent NQF-endorsed version should be applied.  Public comment from SHM supports MAP's conclusion.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

TABLE A11. MAP INPUT ON HVBP CURRENTLY FINALIZED MEASURES

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M8 Not Endorsed</b>	Heart Failure (HF): Detailed Discharge Instructions	MUC: LTCHQR FIN: IQR; HVBP	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	A MAP member noted that research shows a weak correlation between performance on this measure and patient outcomes.
<b>M13 Not Endorsed</b>	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	MUC: FIN: IQR; HVBP; HRSA	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Measure may be topped out, and there may be feasibility issues with administration.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs

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### Program Type:

Pay for Reporting—Information not publicly reported at this time.

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### Incentive Structure:

The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. For the Medicare Incentive program (hospitals), incentive payments began in 2011 and are comprised of an Initial Amount, Medicare Share, and Transition Factor.<sup>35</sup> The CAH EHR Incentive payment is based on a formula for Allowable Costs and the Medicare Share.<sup>36</sup> The Medicaid Incentive program includes an Overall EHR Amount and Medicaid Share.<sup>37</sup> Medicare payment penalties will take effect in 2015 for providers who are eligible but do not participate. Payment penalties do not apply to Medicaid.<sup>38</sup>

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### Care Settings Included:

Hospitals paid under IPPS, Medicare Advantage, and critical access hospitals.<sup>39</sup>

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### Statutory Mandate:

The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

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### Statutory Requirements for Measures:

Measures of processes, experience, and/or outcomes of patient care, observations, or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care should be included. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.<sup>40</sup> Preference should be given to quality measures endorsed by NQF.<sup>41</sup>

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### Additional Program Considerations:

- For Stage 1:<sup>42</sup>
  - Eligible Hospitals and CAHs must report on all 15 total clinical quality measures.
- For Stage 2 (2014 and beyond):<sup>43</sup>
  - Eligible Hospitals and CAHs must report on 16 clinical quality measures that cover 3 of the National Quality Strategy Domains. Measures are selected from a set of 29 clinical quality measures that includes the 15 measures from Stage 1.

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### MAP Pre-Rulemaking 2013 Input:

The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.

TABLE A12. MAP INPUT ON HOSPITAL MEANINGFUL USE MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M3040</b> <b>Not Endorsed</b>	Appropriate Monitoring of Patients Receiving PCA	MUC: MU-Hospitals, CAHs FIN:	Support direction: Measure requires modification or further development	Measure is still in development; concerns were noted regarding institutionalizing current workflows.  Fifteen public commenters supported MAP's conclusion; however, commenters wanted the specifications modified for continuous respiratory monitoring through various methods. Three commenters did not support MAP's conclusion, noting alarm fatigue, inaccuracy of technology, and unnecessary care at end of life.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

TABLE A13. MAP INPUT ON HOSPITAL MEANINGFUL USE CURRENTLY FINALIZED MEASURES

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>O142</b> <b>Endorsed Reserve</b>	Aspirin Prescribed at Discharge for AMI	MUC: FIN: IQR; MU-Hospitals, CAHs	Phased Removal: NQF endorsement placed in reserve status (performance on this measure is topped out)	Measure should be suspended from the program.
<b>M499 Not Endorsed (Formerly O376)</b>	Incidence of Potentially Preventable Venous Thromboembolism	MUC: HAC Reduction FIN: IQR; MU-Hospitals, CAHs	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Measure may not reflect truly preventable events and is burdensome to collect.
<b>O639</b> <b>Endorsed</b>	Statin Prescribed at Discharge	MUC: IQR FIN: MU-Hospitals, CAHs	Phased Removal: Performance on this measure is likely topped out	Timely and accurate data is needed for decision-making. Measure may not produce useful information.

**TABLE A13. MAP INPUT ON HOSPITAL MEANINGFUL USE CURRENTLY FINALIZED MEASURES** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0716</b> <b>Endorsed</b>	Healthy Term Newborn	MUC: IQR FIN: MU-Hospitals, CAHs	Phased Removal: Measure requires modification or further development	MAP strongly supports this measure concept for inclusion in the program once technical issues are resolved.
<b>M2307</b> <b>Not Endorsed</b>	CAC-3: Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver	MUC: IQR FIN: MU-Hospitals, CAHs	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Hospital Readmission Reduction Program

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### Program Type:

Pay for Performance—Hospitals' readmissions information, including their risk-adjusted readmission rates, will be made available on the Hospital Compare website.

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### Incentive Structure:

CMS has defined a “readmission” as an admission to an acute care hospital within 30 days of a discharge from the same or another acute care hospital. CMS will calculate an excess readmission ratio for each of the applicable conditions selected for the program. These ratios will be measured by the hospital's readmission performance in the previous three years as compared to the national average and adjusted for factors that CMS deems clinically relevant, including patient demographic characteristics, comorbidities, and patient frailty. These ratios will be re-calculated each year using the most recent three years of discharge data and no less than 25 cases. Diagnosis Related Group (DRG) payment rates will be reduced based on a hospital's ratio of actual to expected admissions. In FY 2013, the maximum payment reduction is 1 percent, 2 percent in FY 2014, and capped at 3 percent for FY 2015 and beyond.

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### Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS).

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### Statutory Mandate:

The Hospital Readmission Reduction Program was mandated by section 3025 of the Affordable Care Act.

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### Statutory Requirements for Measures:

The Affordable Care Act requires that each condition selected by the Secretary of HHS for the Hospital Readmission Reduction Program have measures of readmissions that have been NQF-endorsed and that the endorsed measures have exclusions for readmissions unrelated to the prior discharge.<sup>44</sup> Measures should address conditions and procedures for which readmissions are high volume or high expenditure.<sup>45</sup>

On August 18, 2011, CMS issued the FY 2012 IPPS final rule, which established the use of the NQF-endorsed readmission measures for acute myocardial infarction (#0505), heart failure (#0330), and pneumonia (#0506) as required by the ACA. Beginning in FY 2015, the Secretary of HHS can expand the program to include other applicable conditions.<sup>46</sup>

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### MAP Pre-Rulemaking 2013 Input:

The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.



**TABLE A14. MAP INPUT ON HRRP READMISSION MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0330 Endorsed</b>	Hospital 30-day, All-cause, Risk-Standardized Readmission Rate Following Heart Failure Hospitalization for Patients 18 and Older	MUC: IQR; Readmission Reduction FIN: IQR; Readmission Reduction	Support: New specifications are improvement over the existing finalized measure	Recommendation is contingent on NQF endorsement.  Public comments from FAH, AAMC, SHM, California Hospital Association, AHIP, and GNYHA support MAP’s conclusion, noting that the updated methodology excludes planned readmissions.
<b>0505 Endorsed</b>	Hospital 30-day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	MUC: IQR; Readmission Reduction FIN: IQR; Readmission Reduction	Support: New specifications are improvement over the existing finalized measure	Recommendation is contingent on NQF endorsement.  Public comments from FAH, AAMC, SHM, California Hospital Association, AHIP, and GNYHA support MAP’s conclusion, noting that the updated methodology excludes planned readmissions.
<b>0506 Endorsed</b>	Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization	MUC: IQR; Readmission Reduction FIN: IQR; Readmission Reduction	Support: New specifications are improvement over the existing finalized measure	Recommendation is contingent on NQF endorsement.  Public comments from FAH, AAMC, SHM, California Hospital Association, AHIP, and GNYHA support MAP’s conclusion, noting that the updated methodology excludes planned readmissions.
<b>1551 Endorsed</b>	Hospital-level 30-day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	MUC: IQR; Readmission Reduction FIN: IQR	Support: Addresses a high-volume diagnosis or procedure	Recommendation is contingent on NQF endorsement; addresses a high- volume, elective procedure.  Public comments from FAH, AAMC, SHM, California Hospital Association, AHIP, and GNYHA support MAP’s conclusion, noting that the updated methodology excludes planned readmissions.

**TABLE A14. MAP INPUT ON HRRP READMISSION MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1637 Not Endorsed</b>	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	MUC: IQR; Readmission Reduction FIN:	Support Direction: Addresses a high-impact condition not adequately addressed in the program measure set. Not ready for implementation; more experience with the measure is needed	Recommendation is contingent on NQF endorsement; more experience with the measure is needed before applying it to a pay-for-performance program.  Public comment from SHM supports MAP's conclusion, noting that this measure relates to a high volume diagnosis.
<b>M2758 Not Endorsed</b>	Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following an Acute Ischemic Stroke Hospitalization	MUC: IQR; Readmission Reduction FIN:	Do Not Support: Measure previously submitted for endorsement and was not endorsed	Stroke readmissions remain an important gap.  Public comment from AANS supports MAP's conclusion, noting concerns about the risk modeling and data source of this measure. Comment from SHM supports the direction of this measure, noting exclusions should be made for patients discharged to inpatient rehabilitation. Comment from AmeriHealth Mercy Family of Companies does not support MAP's conclusion, citing a rigorous process was used to develop this measure.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Hospital-Acquired Condition Payment Reduction Program (ACA 3008)

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### Program Type:

Pay for Performance—Information will be reported on the Hospital Compare website beginning FY 2015.<sup>47</sup>

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### Incentive Structure:

Hospitals scoring in the top quartile for rates of hospital acquired conditions (HACs) as compared to the national average will have their Medicare payments reduced by 1 percent for all DRGs.<sup>48</sup> Calculated rates will include an appropriate risk-adjustment methodology. The applicable period for determination of the rates will be the fiscal year. Prior to FY 2015 and each subsequent fiscal year, hospitals will receive confidential reports on their HAC rates to give them the opportunity to review and submit corrections before their information is made public.

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### Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS).

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### Statutory Mandate:

Section 3008 of the Affordable Care Act established this new payment adjustment for HACs.

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### Statutory Requirements for Measures:

The conditions addressed by this program are the same as those already selected for the current HAC payment policy and any other conditions acquired during a hospital stay that the Secretary deems appropriate. The conditions included at this time are:<sup>49</sup>

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers

- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burn
  - Other Injuries
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
- Surgical Site Infection Following Bariatric Surgery for Obesity
  - Laparoscopic Gastric Bypass
  - Gastroenterostomy
  - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures:
  - Spine
  - Neck
  - Shoulder
  - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:

- Total Knee Replacement
- Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

**Additional Program Considerations:**

The Hospital-Acquired Conditions (HAC) Program should include measures that address conditions that are high cost, high volume, or both; are

assigned to a higher-paying MS-DRG when present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence-based guidelines.<sup>50</sup>

**MAP Pre-Rulemaking 2013 Input:**

The following are MAP’s recommendations on measures under consideration and currently finalized measures, as applicable.

**TABLE A15. MAP INPUT ON HAC PAYMENT REDUCTION PROGRAM MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0138 Endorsed</b>	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	MUC: HAC Reduction; HVBP FIN: IQR; IRFQR; LTCHQR; PCHQR	Support: Addresses an NQS priority not adequately addressed in the program measure set	Most recent NQF-endorsed version should be applied; concerns were noted regarding unintended consequences, such as antibiotic overuse; attainable measure score may not be zero.  Public comments from ACCP and SHM support MAP’s conclusion. SHM highlighted that this measure is benchmarked against a standardized expected rate of UTI.
<b>0139 Endorsed</b>	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	MUC: HAC Reduction FIN: CHIPRA Quality Reporting; IQR; HVBP; LTCHQR; PCHQR	Support: Addresses an NQS priority not adequately addressed in the program measure set	Most recent NQF-endorsed version should be applied.  Public comments from ACCP and SHM support MAP’s conclusion.

**TABLE A15. MAP INPUT ON HAC MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0345 Endorsed</b>	Accidental Puncture or Laceration Rate (PSI 15)	MUC: HAC Reduction FIN:	Support: NQF-endorsed measure. Addresses an NQS priority not adequately addressed in the program measure set	If composite (NQF #0531) is selected, then remove the components from the program (NQF #0450 and 0345).  Public comments from NY-Presbyterian Hospital, Connecticut Hospital Association, and AHA do not support MAP's conclusion, noting that this measure is a poor quality indicator, inappropriate for a program where a rare occurrence has potential to reduce payments, and uses administrative claims data. Comment from SHM supports MAP's conclusion, noting that this information should be publicly reported.
<b>0351 Endorsed</b>	Death Among Surgical Inpatients with Serious, Treatable Complications (PSI 4)	MUC: HAC Reduction FIN: IQR	Support Direction: Not ready for implementation; more experience with the measure is needed	Concerns were noted regarding the reliability and validity of this measure when applied to only a Medicare population.  Public comment from SHM supports inclusion of this measure in the program, noting this information should be publicly reported.
<b>0363 Endorsed</b>	Foreign Body Left During Procedure (PSI 5)	MUC: HAC Reduction FIN:	Support: NQF-endorsed measure. Addresses an NQS priority not adequately addressed in the program measure set	Public comments from NY-Presbyterian Hospital, Connecticut Hospital Association, and AHA do not support MAP's conclusion, noting that this measure uses administrative claims data and fails to exclude foreign bodies intentionally left in when a surgeon feels it is clinically too dangerous to remove them. Comment from SHM supports MAP's conclusion.

TABLE A15. MAP INPUT ON HAC MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M499 Not Endorsed (Formerly 0376)</b>	Incidence of Potentially Preventable Venous Thromboembolism	MUC: HAC Reduction FIN: IQR; MU-Hospitals, CAHs	Do Not Support: A supported measure under consideration addresses a similar topic and better addresses the needs of the program	Prefer NQF #0450 Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12).  Public comment from SHM does not support MAP's conclusion.
<b>0450 Endorsed</b>	Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12)	MUC: HAC Reduction FIN:	Support: NQF-endorsed measure. Addresses an NQS priority not adequately addressed in the program measure set	If composite (NQF #0531) is selected, then remove the components from the program (NQF #0450 and 0345).  Public comments from NY-Presbyterian Hospital and ACCP do not support MAP's conclusion, expressing concern with the weight placed on a zero DVT rate and with use of administrative claims data.
<b>0531 Endorsed</b>	Patient Safety for Selected Indicators	MUC: HAC Reduction FIN: IQR; HVBP	Support Direction: NQF-endorsed measure. Addresses an NQS priority not adequately addressed in the program measure set	If composite (NQF #0531) is selected, then remove the components from the program (NQF #0450 and 0345).  Public comments from NY-Presbyterian Hospital, ACCP, Connecticut Hospital Association, and AHA do not support MAP's conclusion, noting concerns about the construct of the composite and use of administrative claims data. Comment from SHM supports inclusion of this measure in the program.
<b>0753 Endorsed</b>	American College of Surgeons - Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	MUC: HAC Reduction; HVBP; PCHQR FIN: IQR	Support: Addresses an NQS priority not adequately addressed in the program measure set	Public comment from SHM cautioned that the numerator for this measure would be variable and highly inaccurate.

**TABLE A15. MAP INPUT ON HAC MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1716 Endorsed</b>	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia Outcome Measure	MUC: HAC Reduction; HVBP; LTCHQR FIN: IQR	Support Direction: Not ready for implementation; more experience with the measure is needed	While MAP did not recommend this measure for immediate use, the measure addresses an area of high importance and should be considered for this program soon after it is publicly reported.  Public comment from SHM does not support MAP's conclusion, stating that further research and validation of the feasibility of prevention of MRSA bacteremia in the hospital setting is needed.
<b>1717 Endorsed</b>	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure	MUC: HAC Reduction; HVBP; LTCHQR FIN: IQR	Support Direction: Not ready for implementation; more experience with the measure is needed	While MAP did not recommend this measure for immediate use, the measure addresses an area of high importance and should be considered for this program soon after it is publicly reported.  Public comment from SHM does not support MAP's conclusion, stating concerns about potential unintended consequences of increased costs related to universal screening for <i>C. difficile</i> at admission.
<b>M479 Not Endorsed</b>	Falls and Trauma (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)	MUC: LTCHQR; HAC Reduction FIN:	Support Direction: Not ready for implementation; should be submitted for and receive NQF endorsement	NQF #0141 and 0202 could be considered as alternatives.  Public comment from NY-Presbyterian Hospital expressed concern for MAP's support of NQF #0141 and 0202, noting that these measures rely on participation in the NDNQI nursing registry and create additional cost burden for hospitals.

TABLE A15. MAP INPUT ON HAC MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M504 Not Endorsed</b>	Blood Incompatibility	MUC: HAC Reduction FIN:	Do Not Support: Measure has not been submitted for NQF endorsement	
<b>M506 Not Endorsed</b>	Air Embolism	MUC: HAC Reduction FIN:	Do Not Support: Measure has not been submitted for NQF endorsement	
<b>M507 Not Endorsed</b>	Foreign Object Retained After Surgery	MUC: HAC Reduction FIN:	Do Not Support: Measure has not been submitted for NQF endorsement	Prefer NQF #0363 Foreign Body Left During Procedure (PSI 5).
<b>M508 Not Endorsed</b>	Pressure Ulcer Stages III & IV	MUC: HAC Reduction FIN:	Support Direction: Not ready for implementation; should be submitted for and receive NQF endorsement	One public commenter suggested NQF #0201 could be considered as an alternative.
<b>M1369 Not Endorsed</b>	Vascular Catheter-Associated Infections	MUC: HAC Reduction FIN:	Do Not Support: Measure has not been submitted for NQF endorsement	
<b>M1371 Not Endorsed</b>	Manifestations of Poor Glycemic Control	MUC: HAC Reduction, LTCHQR FIN:	Do Not Support: Measure has not been submitted for NQF endorsement	Public comment from ACCP supports MAP's conclusion, stating that measures referring to poor glycemic control are not appropriate because it is unclear what is "good" glycemic control, and there is the potential for negative unintended consequences (hypoglycemia).
<b>M1642 Not Endorsed</b>	Catheter-Associated Urinary Tract Infections (UTI)	MUC: HAC Reduction FIN:	Do Not Support: Measure has not been submitted for NQF endorsement	



**TABLE A15. MAP INPUT ON HAC MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2755 Not Endorsed</b>	HAC-8—Composite Measure of Seven Hospital-Acquired Conditions	MUC: HAC Reduction FIN:	Do Not Support: Measure has not been submitted for NQF endorsement	Composite and component measures are not NQF endorsed. Public comment from ACCP supports MAP’s conclusion, noting harmonization issues with HAC 8 and HAC 10. Public comment from SHM does not support MAP’s conclusion and would support inclusion of this measure contingent on receipt of NQF-endorsement.
<b>M2756 Not Endorsed</b>	HAC-10—Composite Measure of Nine Hospital-Acquired Conditions	MUC: HAC Reduction FIN:	Do Not Support: Measure has not been submitted for NQF endorsement	Composite and component measures are not NQF endorsed. Public comment from ACCP supports MAP’s conclusion, noting harmonization issues with HAC 8 and HAC 10. Public comment from SHM does not support MAP’s conclusion and would support inclusion of this measure contingent on receipt of NQF-endorsement.

TABLE A15. MAP INPUT ON HAC MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M3035</b> <b>Not Endorsed</b>	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; Most recent NQF- version should be applied.  Public comments from NY-Presbyterian Hospital and ACCP expressed support for MAP's conclusion, noting that reliability-adjusted SIR will help account for and improve variability in reporting. Public comment from GNYHA does not support MAP's conclusion, indicating additional testing is needed before including this measure in a payment program.
<b>M3036</b> <b>Not Endorsed</b>	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; most recent NQF-endorsed version should be applied following public reporting of this measure.  Public comments from NY-Presbyterian Hospital and ACCP expressed support for MAP's conclusion, noting that reliability-adjusted SIR will help account for and improve variability in reporting and suggesting that similar measures should be harmonized (such as NQF #0138). Public comment from GNYHA does not support MAP's conclusion, indicating additional testing is needed before including this measure in a payment program.

**TABLE A15. MAP INPUT ON HAC MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M3038</b> <b>Not Endorsed</b>	Reliability Adjusted Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia	MUC: HAC Reduction; IQR; HVBP FIN:	Support Direction: Not ready for implementation; more experience with the measure is needed	Recommendation is contingent on NQF endorsement; most recent NQF-endorsed version should be applied following public reporting of this measure.  Public comment from GNYHA does not support MAP's conclusion, indicating additional testing is needed before including this measure in a payment program.
<b>M3039</b> <b>Not Endorsed</b>	Reliability Adjusted <i>Clostridium difficile</i> SIR Measure	MUC: HAC Reduction; IQR; HVBP; IRFQR FIN:	Support Direction: Not ready for implementation; more experience with the measure is needed	Recommendation is contingent on NQF endorsement; most recent NQF-endorsed version should be applied following public reporting of this measure.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## PPS-Exempt Cancer Hospital Quality Reporting Program

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### Program Type:

Required Public Reporting—Information will be reported on the CMS website.<sup>51</sup>

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### Incentive Structure:

The Prospective Payment System-Exempt Cancer Hospital (PCH) Quality Reporting Program does not currently include an incentive or a penalty for failing to report quality measures as specified. CMS plans to address incentives for the PCH Quality Reporting Program in future rulemaking.<sup>52</sup>

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### Care Settings Included:

PPS-exempt hospitals that primarily provide care for persons with cancer (as described in Section 1866(k)(1) of the Social Security Act).

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### Statutory Mandate:

Sec. 3005 of the Affordable Care Act (ACA) requires CMS to establish a quality reporting program for PCHs beginning FY 2014.

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### Statutory Requirements for Measures:

The program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures. The measure set should also include measures

that reflect the level of care and most important aspects of care furnished by PCHs, in addition to the gaps in the quality of cancer care.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

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### Additional Program Considerations:

Future rulemaking will consider measures of clinical quality of care, care coordination, patient safety and experience, population health, and efficiency. PPS-Exempt Cancer hospitals will also be measured in the future on informed decision-making and quality improvement programs.<sup>53</sup>

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### MAP Pre-Rulemaking 2013 Input

The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.

**TABLE A16. MAP INPUT ON PCHQR MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0166</b> <b>Endorsed</b>	HCAHPS	MUC: LTCHQR; PCHQR FIN: IQR; HVBP	Support Direction: Not ready for implementation; more experience with the measure is needed	Cancer module of CAHPS survey currently being piloted by many PPS-exempt Cancer Hospitals; patient experience in PPS-exempt cancer hospitals is a high priority, and the cancer module of CAHPS should be submitted for NQF endorsement as soon as possible.  Public comments from AAHPM, ADCC, CAPC, CUSPP, MSKCC, NCHPC, and UT-MD Anderson agree with MAP’s conclusion; however, commenters noted that this measure needs additional development and testing to address the cancer population, palliative/end-of-life care, and to include outpatient services.
<b>0218</b> <b>Endorsed</b>	Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time	MUC: PCHQR FIN: IQR; HVBP	Support: Addresses an NQS priority not adequately addressed in the program measure set	Measure addresses important component of surgical care quality that has not been reported for these hospitals in the past.  Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP’s conclusion.
<b>0284</b> <b>Endorsed</b>	Surgery Patients on Beta Blocker Therapy Prior to Admission Who Received a Beta Blocker During the Perioperative Period	MUC: PCHQR FIN: IQR; HVBP	Support: Addresses an NQS priority not adequately addressed in the program measure set	Measure addresses important component of surgical care quality that has not been reported for these hospitals in the past.  Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP’s conclusion.

TABLE A16. MAP INPUT ON PCHQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0300 Endorsed</b>	Cardiac Surgery Patients with Controlled Postoperative Blood Glucose	MUC: PCHQR FIN: IQR; HVBP	Support: Addresses an NQS priority not adequately addressed in the program measure set	Measure addresses important component of surgical care quality that has not been reported for these hospitals in the past.  Public comments from ADCC, MSKCC, and UT-MD Anderson do not support MAP's conclusion, noting that the measure has not been tested and validated for the cancer population.
<b>0380 Endorsed</b>	Multiple Myeloma—Treatment with Bisphosphonates	MUC: PCHQR FIN: Physician Feedback; PQRS	Support: Addresses a high- volume diagnosis or procedure	Measure addresses a high-volume cancer diagnosis.  Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP's conclusion; however, commenters request delaying implementation until the measure can be developed and tested to reflect the most current evidence.
<b>0382 Endorsed</b>	Oncology: Radiation Dose Limits to Normal Tissues	MUC: PCHQR FIN: Physician Feedback; PQRS	Support: Addresses an NQS priority not adequately addressed in the program measure set	Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP's conclusion.
<b>0383 Endorsed</b>	Oncology: Plan of Care for Pain—Medical Oncology and Radiation Oncology (Paired with 0384)	MUC: PCHQR FIN: Physician Feedback; PQRS	Support: Addresses an NQS priority not adequately addressed in the program measure set	Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP's conclusion.
<b>0384 Endorsed</b>	Oncology: Pain Intensity Quantified—Medical Oncology and Radiation Oncology (Paired with 0383)	MUC: PCHQR FIN: MU-Eligible Professionals; Physician Feedback; PQRS	Support: Addresses a measure type not adequately represented in the program measure set	Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP's conclusion.

**TABLE A16. MAP INPUT ON PCHQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0389 Endorsed</b>	Prostate Cancer: Avoidance of Overuse Measure—Bone Scan for Staging Low-Risk Patients	MUC: PCHQR FIN: MU-Eligible Professionals; Physician Feedback; PQRS	Support: Addresses a high-impact condition not adequately addressed in the program measure set	Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP’s conclusion.
<b>0390 Endorsed</b>	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients	MUC: PCHQR FIN: Physician Feedback; PQRS	Support: Addresses a high-impact condition not adequately addressed in the program measure set	Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP’s conclusion.
<b>0452 Endorsed</b>	Surgery Patients with Perioperative Temperature Management	MUC: PCHQR FIN: IQR	Support: Addresses an NQS priority not adequately addressed in the program measure set	Measure addresses important component of surgical care quality that has not been reported for these hospitals in the past. Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP’s conclusion.
<b>0453 Endorsed</b>	Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero	MUC: PCHQR FIN: IQR; HVBP; MU-Hospitals, CAHs	Support: Addresses an NQS priority not adequately addressed in the program measure set	Measure addresses important component of surgical care quality that has not been reported for these hospitals in the past. Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP’s conclusion.
<b>0527 Endorsed</b>	Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision	MUC: PCHQR FIN: IQR; HVBP; MU-Hospitals, CAHs	Support: Addresses an NQS priority not adequately addressed in the program measure set	Measure addresses important component of surgical care quality that has not been reported for these hospitals in the past. Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP’s conclusion.

TABLE A16. MAP INPUT ON PCHQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0528 Endorsed</b>	Prophylactic Antibiotic Selection for Surgical Patients	MUC: PCHQR FIN: IQR; HVBP; MU- Hospitals, CAHs; HRSA	Support: Addresses an NQS priority not adequately addressed in the program measure set	Measure addresses important component of surgical care quality that has not been reported for these hospitals in the past.  Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP's conclusion.
<b>0529 Endorsed</b>	Prophylactic Antibiotics Discontinued within 24 Hours After Surgery End Time	MUC: PCHQR FIN: IQR; HVBP	Support: Addresses an NQS priority not adequately addressed in the program measure set	Measure addresses important component of surgical care quality that has not been reported for these hospitals in the past.  Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP's conclusion.
<b>0753 Endorsed</b>	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	MUC: HAC Reduction; HVBP; PCHQR FIN: IQR	Support: Addresses an NQS priority not adequately addressed in the program measure set	Public comments from ADCC, MSKCC, and UT-MD Anderson support MAP's conclusion.
<b>M1643 Not Endorsed</b>	Medicare Spending Per Beneficiary	MUC: IQR; HVBP; LTCHQR; PCHQR FIN:	Support Direction: Not ready for implementation; more experience with the measure is needed	Concerns were noted regarding application of this measure to PPS-exempt cancer hospitals.  Public comments from ADCC, MSKCC, NSQIP, PhRMA, and UT-MD Anderson do not support MAP's conclusion, noting that substantial testing and adjustments are needed before this measure could be applied to PCHQR.



**TABLE A16. MAP INPUT ON PCHQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<p><b>M3035</b> <b>Not Endorsed</b></p>	<p>Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)</p>	<p>MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:</p>	<p>Support: Addresses an NQS priority not adequately addressed in the program measure set</p>	<p>Most recent NQF-endorsed version should be applied. Public comments from ADCC and UT-MD Anderson requested complete measure specifications to provide input. Comment from MSKCC raised concerns about inclusion of patients with profound neutropenia or gut graft versus host disease in this measure.</p>
<p><b>M3036</b> <b>Not Endorsed</b></p>	<p>Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)</p>	<p>MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:</p>	<p>Support: Addresses an NQS priority not adequately addressed in the program measure set</p>	<p>Most recent NQF-endorsed version should be applied. Public comments from ADCC and UT-MD Anderson requested complete measure specifications to provide input. Comment from MSKCC raised concerns about inclusion of patients with indwelling genitourinary hardware in this measure.</p>

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Inpatient Psychiatric Facilities Quality Reporting Program

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### Program Type:

Pay for Reporting—Information will be reported on the CMS website.<sup>54</sup>

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### Incentive Structure:

Inpatient psychiatric hospitals or psychiatric units will receive a reduction of 2.0 percentage points of their annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) Prospective Payment System (PPS) update for non-participation.<sup>55</sup>

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### Care Settings Included:

Inpatient Psychiatric Facilities (IPFs) required to report in the program include inpatient psychiatric hospitals or psychiatric units paid under the IPF PPS. The IPF Quality Reporting Program applies to freestanding psychiatric hospitals, government-operated psychiatric hospitals, and distinct psychiatric units of acute care hospitals and critical access hospitals. The IPF Quality Reporting Program does not apply to children's hospitals, which are paid under a different system.

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### Statutory Mandate:

Section 1886(s)(4) of the Social Security Act as amended by sections 3401(f) and 10322(a) of the Affordable Care Act (ACA) requires CMS to establish quality measures required for the IPF Quality Reporting Program.

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### Statutory Requirements for Measures:

The IPF Quality Reporting Program was required to begin with performance measures established by CMS by October 1, 2012, for FY 2014.

The program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

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### MAP Pre-Rulemaking 2013 Input

The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.

**TABLE A17. MAP INPUT ON IPHQR MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0576 Endorsed</b>	Follow-Up After Hospitalization for Mental Illness	MUC: IPHQR; Physician Compare; VBM FIN: CHIPRA Quality Reporting; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Physician Feedback; PQRS	Support: Addresses an NQS priority not adequately addressed in the program measure set. Addresses a high-leverage opportunity for dual eligible beneficiaries. Enables measurement across the person-centered episode of care	Preferred over NQF #1937 for inclusiveness of all hospitalizations for mental illness; encourages hospitals to develop stronger links to the community. Public comment from Genentech supports MAP's conclusion. Comment from NAPHS does not support MAP's conclusion, noting concerns about measurement burden and patient confidentiality.
<b>0726 Endorsed</b>	Inpatient Consumer Survey (ICS) Consumer Evaluation of Inpatient Behavioral Healthcare Services	MUC: IPHQR FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set. Addresses a measure type not adequately represented in the program measure set	There is no psychiatric- or behavioral health-specific CAHPS module available at this time. Public comment from NAPHS does not support MAP's conclusion, noting concerns that the survey is too long and has not been tested in non-state hospital settings.
<b>1937 Endorsed</b>	Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	MUC: IPHQR FIN:	Do Not Support: A supported measure under consideration addresses a similar topic and better addresses the needs of the program	Preferred NQF #0576, understanding that the measure developer is updating that measure's specifications to include stratification by this population.
<b>M2753 Not Endorsed</b>	SUB-1 Alcohol Use Screening	MUC: IPHQR FIN:	Support Direction: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement. Public comment from NAPHS agrees with MAP's conclusion.

**TABLE A17. MAP INPUT ON IPHQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2754 Not Endorsed</b>	SUB-4 Alcohol & Drug Use: Assessing Status After Discharge	MUC: IPHQR FIN:	Support Direction: Enables measurement across the person-centered episode of care	Recommendation is contingent on NQF endorsement. Public comment from NAPHS agrees with MAP's conclusion.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Hospital Outpatient Quality Reporting

### Program Type:

Pay for Reporting—Information is reported on the Hospital Compare website.<sup>56</sup>

### Incentive Structure:

Hospitals receive a reduction of 2.0 percentage points of their annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) payment update for non-participation.<sup>57</sup> Hospitals providing outpatient services such as clinic visits, emergency department visits, critical care services (including trauma team activation) that do not meet the minimum Outpatient Quality Reporting Program (OQR) requirements will not receive the Outpatient Prospective Payment System (OPPS) payment updates for CY 2012, which may result in a reduction in the OPPS payments.

### Care Settings Included:

Hospitals providing outpatient services such as clinic visits, emergency department visits, and critical care services (including trauma team activation) paid under the OPPS.

### Statutory Mandate:

The OQR program was first established in the Balanced Budget Act of 2007. The program was

mandated by Congress to replace Title XVIII of the Social Security Act reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 2007 established PPS for outpatient services rendered on or after August 2010.<sup>58</sup> The Affordable Care Act of 2010 established the role of the OQR program as a pay-for-reporting program for hospitals.

### Statutory Requirements for Measures:

The OQR program measure set should include process, structure, outcome, patients’ perspectives on care, efficiency, and costs of care measures.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

### Additional Program Considerations:

- Future rule-making will consider measures of clinical quality of care, care coordination, patient safety and experience, population health, and efficiency.<sup>59</sup>

**TABLE A18. MAP INPUT ON OQR MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0431 Endorsed</b>	Influenza Vaccination Coverage Among Healthcare Personnel	MUC: OQR; HVBP; IRFQR; PQRS FIN: ASCQR; IQR; LTCHQR	Support: Addresses a measure type not adequately represented in the program measure set	

TABLE A18. MAP INPUT ON OQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0500</b> <b>Endorsed</b>	Severe Sepsis and Septic Shock: Management Bundle	MUC: IQR; OQR; LTCHQR FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; early detection and treatment of sepsis in the emergency department and inpatient settings is important.  Public comments from AHIP, ACCP, GNYHA, and SHM do not support MAP's conclusion, noting measure collection burden, the need for more evidence for the individual composite elements, and issues regarding case selection and transfer.
<b>0564</b> <b>Endorsed</b> <b>Time-Limited</b>	Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	MUC: ASCQR; OQR FIN: MU-Eligible Professionals; Physician Feedback; PQRS	Support: Addresses a high-impact condition not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; measure should be tested and NQF endorsed for the facility level of analysis.  Public comment from AAO does not support MAP's conclusion, noting that the measure is not tested and specified for a facility level of analysis.
<b>0658</b> <b>Endorsed</b> <b>Time-Limited</b>	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	MUC: ASCQR; OQR FIN: PQRS	Support Direction: Not ready for implementation; concerns regarding feasibility of data collection	Recommendation is contingent on full NQF endorsement; measure should be tested and NQF endorsed for the facility level of analysis.  Public comments from AHA, CHA, and Tri-Society (Gastroenterology) do not support MAP's conclusion, noting implementation challenges and concerns regarding the specified level of measurement.

**TABLE A18. MAP INPUT ON OQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0659 Endorsed Time-Limited</b>	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use	MUC: ASCQR; OQR FIN: Physician Feedback; PQRS	Support Direction: Not ready for implementation; concerns regarding feasibility of data collection	Recommendation is contingent on full NQF endorsement; measure should be tested and NQF endorsed for the facility level of analysis.  Public comments from AHA, CHA, and Tri-Society (Gastroenterology) do not support MAP’s conclusion, noting implementation challenges and concerns regarding the specified level of measurement.
<b>1536 Endorsed</b>	Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery	MUC: ASCQR; OQR FIN: PQRS	Support: Addresses a high-impact condition not adequately addressed in the program measure set. Addresses a measure type not adequately represented in the program measure set	Measure should be tested and NQF endorsed for the facility level of analysis.  Public comments from AAO and AAEECE do not support MAP’s conclusions because the measure was not designed or tested for the facility level of analysis.
<b>M2785 Not Endorsed</b>	Intra-Procedure Colonoscopy Complication Rate: Percentage of Patients Who Developed One or More Intra-Procedure Complications.	MUC: ASCQR; OQR FIN:	Insufficient Information: MAP has insufficient information (e.g., specifications, measure testing, measure use) to evaluate the measure	Detailed measure specifications were not available.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

**TABLE A19. MAP INPUT ON QQR CURRENTLY FINALIZED MEASURES**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M601 Not Endorsed</b>	Left Without Being Seen	MUC: FIN: OQR	Phased Removal: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.



## Ambulatory Surgical Centers Quality Reporting Program

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### Program Type:

Pay for Reporting—Information is reported to the Centers for Medicare and Medicaid Services (CMS).<sup>60</sup>

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### Incentive Structure:

Medicare ambulatory surgical centers (ASCs) will receive a reduction of 2.0 percentage points of their annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) ASC payment system update for non-participation beginning CY 2014.<sup>61</sup> The ASC Quality Reporting program data collection begins CY 2012 with most measures to be used for payment determination beginning CY 2014.

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### Care Settings Included:

An ASC operating exclusively to provide surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission to the ASC facility.<sup>62</sup>

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### Statutory Mandate:

CMS is authorized but not required to implement a reduction in annual payment updates for failing to report on quality measures (ASC Quality Reporting) under the Medicare Improvements and Extension Act of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006.

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### Statutory Requirements for Measures:

The ASC Quality Reporting Program may include the same or similar measures reported in the Hospital Outpatient Quality Reporting or Inpatient Quality Reporting Programs.

The program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures. To the extent feasible, outcome and patient experience measures should be risk-adjusted. In order to reduce burden of measurement on smaller ASCs, CMS finalized only claims-based measures for the first year of the program and only structural measures in the second year of the program.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

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### MAP Pre-Rulemaking 2013 Input:

The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.

TABLE A20. MAP INPUT ON ASCQR MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	MAP Findings or Comments
<b>0564 Endorsed Time-Limited</b>	Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	MUC: ASCQR; OQR FIN: MU-Eligible Professionals; Physician Feedback; PQRS	Support: Addresses a high-impact condition not adequately addressed in the program measure set	Recommendation is contingent on NQF endorsement; measure should be tested and NQF endorsed for the facility level of analysis.  Public comments from AAO, ASCQC, ASCRS, and OOSS do not support MAP's conclusion, noting that the measure is specified for registry-based reporting only and not tested or specified for a facility level of analysis.
<b>0658 Endorsed Time-Limited</b>	Endoscopy/Poly Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	MUC: ASCQR; OQR FIN: PQRS	Support Direction: Not ready for implementation; concerns regarding feasibility of data collection	Recommendation is contingent on NQF endorsement; measure should be tested and NQF endorsed for the facility level of analysis.  Public comments from ASCQC and Tri-Society (Gastroenterology) do not support MAP's conclusion, noting that the measure is not tested and specified for a facility level of analysis.
<b>0659 Endorsed Time-Limited</b>	Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	MUC: ASCQR; OQR FIN: Physician Feedback; PQRS	Support Direction: Not ready for implementation; concerns regarding feasibility of data collection	Recommendation is contingent on NQF endorsement; measure should be tested and NQF endorsed for the facility level of analysis.  Public comments from ASCQC and Tri-Society (Gastroenterology) do not support MAP's conclusion, noting that the measure is not tested and specified for a facility level of analysis.

**TABLE A20. MAP INPUT ON ASCQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	MAP Findings or Comments
<b>1536 Endorsed</b>	Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery	MUC: ASCQR; OQR FIN: PQRS	Support: Addresses a high-impact condition not adequately addressed in the program measure set. Addresses a measure type not adequately represented in the program measure set	Measure should be tested and NQF endorsed for the facility level of analysis. Public comments from AAEECE, AAO, ASCQC, ASCRS, and OOSS do not support MAP’s conclusion, noting that the measure is specified for registry-based reporting only and not tested or specified for a facility level of analysis.
<b>M2785 Not Endorsed</b>	Intra-Procedure Colonoscopy Complication Rate: Percentage of Patients Who Developed One or More Intra-Procedure Complications	MUC: ASCQR; OQR FIN:	Insufficient Information: MAP has insufficient information (e.g., specifications, measure testing, measure use) to evaluate the measure	Detailed measure specifications were not available.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Long-Term Care Hospital Quality Reporting

### Program Type:

Pay for Reporting, Public Reporting

### Incentive Structure:

For fiscal year 2014, and each year thereafter, Long-Term Care Hospital providers (LTCHs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive full annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual payment update.<sup>63</sup> The data must be made publicly available, with LTCH providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.<sup>64</sup>

### Care Settings Included:

Long-Term Care Hospitals

### Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for LTCHs.

### Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), promote enhanced quality with regard to the priorities most relevant to LTCHs (such as patient safety, better coordination of care, and person- and family-centered care), and address the primary role of LTCHs—furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).<sup>65</sup>

### MAP Pre-Rulemaking 2013 Input:

The following are MAP’s recommendations on measures under consideration and currently finalized measures, as applicable.

TABLE A21. MAP INPUT ON LTCHQR MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0097 Endorsed</b>	Medication Reconciliation	MUC: LTCHQR; Physician Compare; VBM FIN: MSPP; Physician Feedback; PQRS	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.

**TABLE A21. MAP INPUT ON LTCHQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0141 Endorsed</b>	Patient Fall Rate	MUC: LTCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>0166 Endorsed</b>	HCAHPS	MUC: LTCHQR; PCHQR FIN: IQR; HVBP	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>0228 Endorsed</b>	3-Item Care Transition Measure (CTM-3)	MUC: HVBP; LTCHQR FIN: IQR	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>M1695 Not Endorsed (formerly NQF #0302)</b>	Ventilator Bundle	MUC: LTCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure has lost endorsement but is currently being updated and will be submitted for NQF endorsement.
<b>0326 Endorsed</b>	Advance Care Plan	MUC: LTCHQR FIN: Physician Feedback; PQRS	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.

**TABLE A21. MAP INPUT ON LTCHQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0371 Endorsed</b>	Venous Thromboembolism Prophylaxis	MUC: LTCHQR FIN: IQR; MU-Hospitals, CAHs	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>0500 Endorsed</b>	Severe Sepsis and Septic Shock: Management Bundle	MUC: IQR; OQR Reporting; LTCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>0554 Endorsed</b>	Medication Reconciliation Post-Discharge	MUC: LTCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>0640 Endorsed</b>	HBIPS-2 Hours of Physical Restraint Use	MUC: LTCHQR FIN: IPHQR	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>0646 Endorsed</b>	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	MUC: LTCHQR; PQRS FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.

**TABLE A21. MAP INPUT ON LTCHQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0647 Endorsed</b>	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	MUC: LTCHQR; PQRS FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>0648 Endorsed</b>	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	MUC: LTCHQR; PQRS FIN: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>0674 Endorsed</b>	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	MUC: LTCHQR FIN: Nursing Home Quality Initiative and Nursing Home Compare	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>0682 Endorsed</b>	Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)	MUC: IRFQR; LTCHQR FIN: Nursing Home Quality Initiative and Nursing Home Compare	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>M8 Not Endorsed</b>	Heart Failure (HF): Detailed Discharge Instructions	MUC: LTCHQR FIN: IQR; HVBP	Do not support: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	

TABLE A21. MAP INPUT ON LTCHQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1717 Endorsed (formerly M474)</b>	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure	MUC: HAC Reduction; HVBP; LTCHQR FIN: IQR	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>M479 Not Endorsed</b>	Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)	MUC: LTCHQR FIN: HAC Reduction	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure addresses a core measure concept; however, MAP would prefer exploring the applicability of falls measures included in the Nursing Home Quality Initiative for LTCHs.
<b>M498 Not Endorsed</b>	Venous Thromboembolism Warfarin Therapy Discharge Instructions	MUC: LTCHQR FIN: IQR; MU-Hospitals, CAHs	Do not support: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	
<b>1716 Endorsed (formerly M582)</b>	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia Outcome Measure	MUC: HAC Reduction; HVBP; LTCHQR FIN: IQR	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure should be specified and tested for the LTCH setting.
<b>M1371 Not Endorsed</b>	Manifestations of Poor Glycemic Control	MUC: LTCHQR FIN: HAC Reduction	Do not support: Measure does not adequately address any current needs of the program	MAP has previously not supported this healthcare-acquired condition rate and would prefer the use of endorsed measures that address healthcare acquired conditions.



**TABLE A21. MAP INPUT ON LTCHQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1643 Not Endorsed</b>	Medicare Spending Per Beneficiary	MUC: IQR; HVBP; LTCHQR; PCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	A cost measure would enhance the measure set; however, this measure excludes facilities with an average length of stay exceeding 25 days. LTCHs are defined as a hospital which has an average inpatient length of stay greater than 25 days. A cost measure that addresses the LTCH population is needed.
<b>M1671 Not Endorsed</b>	Functional Change: Change in Motor Score	MUC: IRFQR; LTCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure addresses a core measure concept but is still under development and needs to be tested.
<b>M2561 Not Endorsed</b>	Functional Outcome Measure (Change in Mobility)	MUC: LTCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure addresses a core measure concept but is still under development and needs to be tested.
<b>M2562 Not Endorsed</b>	Functional Outcome Measure (Change in Self-care)	MUC: LTCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure addresses a core measure concept but is still under development and needs to be tested.
<b>M2684 Not Endorsed</b>	Restraint Rate per 1000 Patient Days	MUC: LTCHQR FIN:	Do not support: A finalized measure addresses a similar topic and better addresses the needs of the program	Restraint use is an important concept, but MAP would prefer the use of an NQF-endorsed measure. MAP suggests exploring the applicability of restraint measures included in the Nursing Home Quality Initiative for LTCHs.

**TABLE A21. MAP INPUT ON LTCHQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2707 Not Endorsed</b>	30-Day All Cause Post Long-Term Care Hospital (LTCH) Discharge Hospital Readmission Measure	MUC: LTCHQR FIN:	Support Direction: Not ready for implementation; measure concept is promising but requires modification or further development	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population.
<b>M3035 Not Endorsed</b>	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	This measure updates an existing measure finalized for use in LTCHs, NQF #0139. The updated measure would risk adjust for volume of exposure within a facility. MAP supports the update pending review for NQF endorsement.
<b>M3036 Not Endorsed</b>	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	This measure updates an existing measure finalized for use in LTCHs, NQF #0138. The updated measure would risk-adjust for volume of exposure within a facility. MAP supports the update pending review for NQF endorsement.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Inpatient Rehabilitation Facility Quality Reporting

### Program Type:

Pay for Reporting, Public Reporting

### Incentive Structure:

For fiscal year 2014, and each year thereafter, Inpatient Rehabilitation Facility providers (IRFs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive annual payment updates. Failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year.<sup>66</sup> The data must be made publicly available, with IRF providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.<sup>67</sup>

### Care Settings Included:

Inpatient Rehabilitation Facilities

### Statutory Mandate:

Section 3004(b) of the Affordable Care Act (ACA) directs the Secretary to establish quality reporting requirements for IRFs.

### Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), be relevant to the priorities of IRFs (such as patient safety, reducing adverse events, better coordination of care, and person- and family-centered care), and address the primary role of IRFs—rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community post-discharge.<sup>68</sup>

### MAP Pre-Rulemaking 2013 Input

The following are MAP’s recommendations on measures under consideration and currently finalized measures, as applicable.

**TABLE A22. MAP INPUT ON IRFQR MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0431 Endorsed</b>	Influenza Vaccination Coverage Among Healthcare Personnel	MUC: OQR; HVBP; IRFQR; PQRS FIN: ASCQR; IQR; LTCHQR	Support: Promotes alignment across programs, settings, and public- and private-sector efforts	Measure addresses a core measure concept and can be applied across all PAC/LTC settings.

TABLE A22. MAP INPUT ON IRFQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0680</b> <b>Endorsed</b>	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)	MUC: IRFQR FIN: LTCHQR; Nursing Home Quality Initiative and Nursing Home Compare	Support: Promotes alignment across programs, settings, and public- and private-sector efforts	<p>Measure addresses a core measure concept and can be applied across all PAC/ LTC settings. MAP expressed concern that the measure may not address a high-leverage opportunity for this setting; MAP recommends looking at the impact of vaccination rates across settings.</p> <p>Public comments from HealthSouth Corporation, FAH, CHA, ARN, and AHA do not support MAP's conclusion, noting that this is not an appropriate setting for immunization measures. Public comment from AAMPR supports immunization measures across settings.</p>
<b>0682</b> <b>Endorsed</b>	Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)	MUC: IRFQR; LTCHQR FIN: Nursing Home Quality Initiative and Nursing Home Compare	Support: Promotes alignment across programs, settings, and public- and private-sector efforts	<p>Measure addresses a core measure concept and can be applied across all PAC/ LTC settings. MAP expressed concern that the measure may not address a high-leverage opportunity for this setting; MAP recommends looking at the impact of vaccination rates across settings.</p> <p>Public comments from HealthSouth Corporation, FAH, CHA, ARN, and AHA do not support MAP's conclusion, noting that this is not an appropriate setting for immunization measures. Public comment from AAMPR supports immunization measures across settings.</p>

**TABLE A22. MAP INPUT ON IRFQR MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M1425 Not Endorsed</b>	30-day All-Cause Post Inpatient Rehabilitation Facility (IRF) Discharge Hospital Readmission Measure	MUC: IRFQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings.
<b>M1671 Not Endorsed</b>	Functional Change: Change in Motor Score	MUC: IRFQR; LTCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure addresses a core measure concept but is still under development and needs to be tested.
<b>M2558 Not Endorsed</b>	Functional Outcome Measure (Change in Mobility)	MUC: IRFQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure addresses a core measure concept but is still under development and needs to be tested.
<b>M2559 Not Endorsed</b>	Functional Outcome Measure (Change in Self-care)	MUC: IRFQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure addresses a core measure concept but is still under development and needs to be tested.

TABLE A22. MAP INPUT ON IRFQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M3035</b> <b>Not Endorsed</b>	Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Do not support: Measure does not adequately address any current needs of the program	MAP recognizes CLABSI is an important safety issue; however, this does not reflect a high-leverage opportunity for measurement in IRFs, because few patients have a central line.  Public comments from HealthSouth Corporation and ARN support MAP's conclusion.
<b>M3036</b> <b>Not Endorsed</b>	Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)	MUC: HAC Reduction; IQR; HVBP; IRFQR; LTCHQR; PCHQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	This measure updates an existing measure finalized for use in IRFs, NQF #0138. The updated measure would risk adjust for volume of exposure within a facility. MAP supports the update pending review for NQF endorsement.  Public comment from AHA does not support MAP's conclusion, noting that this condition is low incidence in this setting.
<b>M3039</b> <b>Not Endorsed</b>	Reliability Adjusted <i>Clostridium difficile</i> SIR Measure	MUC: HAC Reduction; IQR; HVBP; IRFQR FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	This measure updates an existing NQF-endorsed measure, NQF #1717. The updated measure would risk adjust for volume of exposure within a facility. MAP supports the update pending review for NQF endorsement. Additionally, MAP would support the use of NQF#1717 until the updated measure is endorsed.  Public comments from HealthSouth Corporation, AHA, and FAH do not support MAP's conclusion, noting that this condition is low incidence in this setting.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## End Stage Renal Disease Quality Improvement

### Program Type:

Pay for Performance, Public Reporting

### Incentive Structure:

Starting in 2012, payments to dialysis facilities will be reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions will be on a sliding scale, which could amount to a maximum of 2 percent per year.<sup>69</sup> Performance is reported on the Dialysis Facility Compare website.

### Care Settings Included:

Dialysis Providers/Facilities

### Statutory Mandate:

The End Stage Renal Disease Quality Incentive

Program (ESRD-QIP), required by section 1881 (h) of the Social Security Act and added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c), was developed by CMS to be the first pay-for-performance (also known as “value-based purchasing”) model quality incentive program.<sup>70</sup>

### Statutory Requirements for Measures:

Measures of anemia management that reflect labeling approved by the Food and Drug Administration (FDA), dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access.<sup>71</sup>

### MAP Pre-Rulemaking 2013 Input:

The following are MAP’s recommendations on measures under consideration and currently finalized measures, as applicable.

TABLE A23. MAP INPUT ON ESRD MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0226 Endorsed</b>	Influenza Immunization in the ESRD Population (Facility Level)	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure may not address a high-leverage opportunity. MAP recommends looking at the impact of vaccination rates across settings. Public comment from KCP does not support MAP’s conclusion (KCP recommends support, rather than support direction), stating that the evidence supports vaccination of ESRD patients and this is a high-leverage opportunity for quality improvement. Public comment from ASN supports MAP’s conclusion, noting that this measure should include dialysis facility staff as well as patients.

TABLE A23. MAP INPUT ON ESRD MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0251 Endorsed</b>	Vascular Access— Functional Arteriovenous Fistula (AVF) or AV Graft or Evaluation for Placement	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses specific program attributes	Addresses an important patient safety issue in the dialysis facility setting.  Public comment from ASN notes that it supports the concept but suggests modifications that should be addressed prior to implementation.
<b>0255 Endorsed</b>	Measurement of Serum Phosphorus Concentration	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses specific program attributes	Addresses the program requirement to measure dialysis adequacy.  Public comment from ASN does not support MAP's conclusion, noting that this measure is not impactful and can create undue burden.
<b>0258 Endorsed</b>	CAHPS In-Center Hemodialysis Survey	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	There is a need for greater patient and family engagement in the dialysis facility setting.  Public comment from ASN supports MAP's conclusion.
<b>0369 Endorsed</b>	Dialysis Facility Risk- adjusted Standardized Mortality Ratio	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses an NQS priority not adequately addressed in the program measure set	Mortality is an important outcome for patients; however, the measure should be linked to structural and process measures.  Public comment from ASN supports the concept of this measure but notes concern about data for risk adjustment.
<b>1418 Endorsed</b>	Frequency of Adequacy Measurement for Pediatric Hemodialysis Patients	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Allows measurement in the pediatric population.  Public comment from ASN supports MAP's conclusion.



**TABLE A23. MAP INPUT ON ESRD MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1424</b> <b>Endorsed</b>	Monthly Hemoglobin Measurement for Pediatric Patients	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Allows measurement in the pediatric population. Public comment from ASN supports MAP's conclusion.
<b>1425</b> <b>Endorsed</b> <b>Time-Limited</b>	Measurement of nPCR for Pediatric Hemodialysis Patients	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Allows measurement in the pediatric population. Public comment from ASN supports MAP's conclusion.
<b>1433</b> <b>Endorsed</b> <b>Time-Limited</b>	Use of Iron Therapy for Pediatric Patients	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Allows measurement in the pediatric population. Public comment from ASN supports MAP's conclusion.
<b>1438</b> <b>Endorsed</b> <b>Time-Limited</b>	Periodic Assessment of Post-Dialysis Weight by Nephrologists	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses specific program attributes	Addresses an important patient safety issue in the dialysis facility setting. Public comment from ASN does not support MAP's conclusion, noting that there is no evidence that this measure leads to improved outcomes for patients.
<b>1454</b> <b>Endorsed</b>	Proportion Of Patients With Hypercalcemia	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses specific program attributes	Addresses the program requirement to measure dialysis adequacy. Public comment from ASN does not support MAP's conclusion, noting that there is no robust evidence to support this measure and there is a potential for unintended consequences.
<b>1460</b> <b>Endorsed</b>	Bloodstream Infection in Hemodialysis Outpatients	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support: Addresses specific program attributes	Addresses an important patient safety issue in the dialysis facility setting. Public comment from ASN supports MAP's conclusion, while noting caveats.

TABLE A23. MAP INPUT ON ESRD MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1463</b> <b>Endorsed</b>	Standardized Hospitalization Ratio for Admissions	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population.  Public comment from ASN supports MAP's conclusion, noting concerns about the limitations of risk adjustment for this measure.
<b>1653</b> <b>Endorsed</b>	Pneumococcal Immunization (PPV 23)	MUC: End-Stage Renal Disease Quality Reporting; HVBP FIN: IQR	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	Measure may not address a high-leverage opportunity. MAP recommends looking at the impact of vaccination rates across settings.  Public comment from ASN supports MAP's conclusion, noting that clinicians have no control over vaccination provided during a hospitalization.
<b>M2059</b> <b>Not Endorsed</b>	Measurement of Serum Calcium Concentration	MUC: End-Stage Renal Disease Quality Reporting FIN:	Do not support: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)	Public comment from ASN supports MAP's conclusion, noting that there is a lack of evidence to support this measure.

**TABLE A23. MAP INPUT ON ESRD MEASURES UNDER CONSIDERATION** (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2132 Not Endorsed</b>	30 Day Readmission Measure	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population.  Public comment from ASN supports MAP’s conclusion; however, ASN raises several concerns regarding the measure.
<b>M2769 Not Endorsed</b>	Risk-Adjusted Facility Level Transfusion Rate “STrR”	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	The measure addresses an important concept, but establishment of guidelines for hemoglobin range is needed.  Public comments from AMGEN and ASN support MAP’s conclusion, noting that there is no solid evidence to fully support this measure.
<b>M2771 Not Endorsed</b>	Achieved Hgb Level To Avoid Adverse Outcomes	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	The measure addresses an important concept, but establishment of guidelines for hemoglobin range is needed.  Public comments from AMGEN and ASN support MAP’s conclusion, noting that there is no solid evidence to fully support this measure.

TABLE A23. MAP INPUT ON ESRD MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2772 Not Endorsed</b>	Anemia Management Process Measure	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	The measure addresses an important concept, but establishment of guidelines for hemoglobin range is needed.  Public comments from AMGEN and ASN support MAP's conclusion, noting that there is no solid evidence to fully support this measure.
<b>M2774 Not Endorsed</b>	Blood Transfusion Appropriateness	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	The measure addresses an important concept, but establishment of guidelines for hemoglobin range is needed.  Public comments from AMGEN and ASN support MAP's conclusion, noting that there is no solid evidence to fully support this measure.
<b>M2775 Not Endorsed</b>	Phosphorus Concentrations	MUC: End-Stage Renal Disease Quality Reporting FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	The measure may offer more granular information than the NQF-endorsed measure under consideration, Measurement of Serum Phosphorus Concentration, but it should be submitted for NQF endorsement.  Public comment from ASN supports MAP's conclusion, noting that the measure lacks strong scientific evidence.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Hospice Quality Reporting Program

### Program Type:

Pay for Reporting, Public Reporting

### Incentive Structure:

Failure to submit required quality data, beginning in FY 2014 and for each year thereafter, shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.<sup>72</sup> The data must be made publicly available, with Hospice Programs having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of hospice quality data.<sup>73</sup>

### Care Settings Included:

Multiple; hospice care can be provided in inpatient and outpatient settings.

### Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Programs.<sup>74</sup>

### Statutory Requirements for Measures:

None.

### MAP Pre-Rulemaking 2013 Input:

The following are MAP’s recommendations on measures under consideration and currently finalized measures, as applicable.

TABLE A24. MAP INPUT ON HOSPICE MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>0208 Endorsed</b>	Family Evaluation of Hospice Care	MUC: Hospice Quality Reporting FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Measure has previously been supported in the MAP Hospice Family of Measures. Public comments from AAHPM, CAPC, and NCHPC support MAP’s conclusion.
<b>1617 Endorsed</b>	Patients Treated with an Opioid Who are Given a Bowel Regimen	MUC: Hospice Quality Reporting; PQRS FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Measure has previously been supported in the MAP Hospice Family of Measures. Public comments from AAHPM, CAPC, and NCHPC support MAP’s conclusion.
<b>1634 Endorsed</b>	Hospice and Palliative Care—Pain Screening	MUC: Hospice Quality Reporting; PQRS FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Measure has previously been supported in the MAP Hospice Family of Measures. Public comments from AAHPM, CAPC, and NCHPC support MAP’s conclusion.

TABLE A24. MAP INPUT ON HOSPICE MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>1637 Endorsed</b>	Hospice and Palliative Care—Pain Assessment	MUC: Hospice Quality Reporting; PQRS FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Measure has previously been supported in the MAP Hospice Family of Measures. Public comments from AAHPM, CAPC, and NCHPC support MAP's conclusion.
<b>1638 Endorsed</b>	Hospice and Palliative Care—Dyspnea Treatment	MUC: Hospice Quality Reporting; PQRS FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Measure has previously been supported in the MAP Hospice Family of Measures. Public comments from AAHPM, CAPC, and NCHPC support MAP's conclusion.
<b>1639 Endorsed</b>	Hospice and Palliative Care—Dyspnea Screening	MUC: Hospice Quality Reporting; PQRS FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Measure has previously been supported in the MAP Hospice Family of Measures. Public comments from AAHPM, CAPC, and NCHPC support MAP's conclusion.
<b>1641 Endorsed</b>	Hospice and Palliative Care—Treatment Preferences	MUC: Hospice Quality Reporting; PQRS FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Measure has previously been supported in the MAP Hospice Family of Measures. Public comments from AAHPM, CAPC, and NCHPC support MAP's conclusion.
<b>1647 Endorsed</b>	Percentage Of Hospice Patients With Documentation In The Clinical Record Of A Discussion Of Spiritual/ Religious Concerns Or Documentation That The Patient/Caregiver Did Not Want To Discuss	MUC: FIN:	Support: Addresses a PAC/LTC core concept not adequately addressed in the program measure set	Measure has previously been supported in the MAP Hospice Family of Measures.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## Nursing Home Quality Initiative and Nursing Home Compare

### Program Type:

Pay for Reporting, Public Reporting

### Incentive Structure:

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. Part of this requirement includes completing the Minimum Data Set (MDS), a clinical assessment of all residents in Medicare- or Medicaid-certified nursing facilities. Quality measures are reported on the Nursing Home Compare website using a Five-Star Quality Rating System, which assigns each nursing home a rating of 1 to 5 stars, with 5 representing highest standard of quality, and 1 representing the lowest.<sup>75</sup>

### Care Settings Included:

Medicare- or Medicaid-certified nursing facilities

### Statutory Mandate:

The 1987 Omnibus Budget Reconciliation Act (OBRA) mandated the development of a nursing home resident assessment instrument.

### Statutory Requirements for Measures:

OBRA mandated the inclusion of the domains of resident health and quality of life in the resident assessment instrument.

### MAP Pre-Rulemaking 2013 Input:

The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.

**TABLE A25. MAP INPUT ON NURSING HOME MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2634 Not Endorsed</b>	Percentage of Long Stay Residents Who Are Receiving Antipsychotic Medication	MUC: Nursing Home Quality Initiative and Nursing Home Compare FIN:	Support direction: Not ready for implementation; should be submitted for and receive NQF endorsement	Measure should be submitted for NQF endorsement with as few exclusions as possible.  Public comment from AHCA does not support MAP's conclusion, stating that the measure should exclude diagnoses for which the medication is FDA-approved.
<b>M2636 Not Endorsed</b>	Percentage of Short Stay Patients Who Have Antipsychotics Started—Incidence	MUC: Nursing Home Quality Initiative and Nursing Home Compare FIN:	Support direction: Not ready for implementation; should be submitted for and receive NQF endorsement	Measure should be submitted for NQF endorsement with as few exclusions as possible.  Public comment from AHCA does not support MAP's conclusion, stating that the measure should exclude diagnoses for which the medication is FDA-approved.

TABLE A25. MAP INPUT ON NURSING HOME MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2638 Not Endorsed</b>	SNF Hospital Readmission Reduction Measure— Short Stay	MUC: Nursing Home Quality Initiative and Nursing Home Compare FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population  Public comment from AHCA notes that a SNF-specific measure could have a more appropriate timeframe and risk adjustment, and could be collected through the MDS.
<b>M2654 Not Endorsed</b>	Percent Of Long-Stay Residents Who Are Hospitalized During The Reporting Period	MUC: Nursing Home Quality Initiative and Nursing Home Compare FIN:	Support direction: Not ready for implementation; measure concept is promising but requires modification or further development	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population  Public comment from AHCA notes that a SNF-specific measure could have a more appropriate timeframe and risk-adjustment, and could be collected through the MDS.
<b>M2656 Not Endorsed</b>	Percentage Of Residents Discharged To The Community	MUC: Nursing Home Quality Initiative and Nursing Home Compare FIN:	Support: Addresses specific program attributes.	Addresses an important goal for nursing home patients and their caregivers; however, the measure should be submitted for NQF endorsement.  Public comment from AHCA does not support MAP's conclusion, stating that the measure should be risk-adjusted.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.



## Home Health Quality Reporting

### Program Type:

Pay for Reporting, Public Reporting

### Incentive Structure:

Medicare-certified<sup>76</sup> home health agencies (HHAs) are required to collect and submit the Outcome Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.<sup>77</sup> Home health agencies meet their quality data reporting requirements through the submission of OASIS assessments and Home Health CAHPS. HHAs that do not submit data will receive a 2 percentage point reduction in their annual HH market basket percentage increase.

Subsets of the quality measures generated from OASIS are reported on the Home Health Compare website, which provides information about the quality of care provided by HHAs throughout the

country.<sup>78</sup> Currently, 23 of the 97 OASIS measures are finalized for public reporting on Home Health Compare.

### Care Settings Included:

Medicare-certified home health agencies

### Statutory Mandate:

Section 1895(b)(3)(B)(v)(I) of the Social Security Act, as amended by section 5201 of the Deficit Reduction Act, established the requirement that HHAs that do not report quality data would not receive the full market basket payment increase.

### Statutory Requirements for Measures:

None

### MAP Pre-Rulemaking 2013 Input:

The following are MAP's recommendations on measures under consideration and currently finalized measures, as applicable.

**TABLE A26. MAP INPUT ON HOME HEALTH MEASURES UNDER CONSIDERATION**

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M2766 Not Endorsed</b>	Rehospitalization During First 30 Days of Home Health	MUC: HHQR FIN:	Support Direction: Not ready for implementation; measure concept is promising but requires modification or further development	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population.  Public comment from AOTA supports MAP's conclusion.

TABLE A26. MAP INPUT ON HOME HEALTH MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	Federal Program Alignment	MAP Conclusion and Rationale	Additional Findings
<b>M3047 Not Endorsed</b>	Home Health Emergency Department Use Without Readmission	MUC: HHQR FIN:	Support Direction: Not ready for implementation; measure concept is promising but requires modification or further development	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population.  Public comment from AOTA supports MAP's conclusion.

NOTES: M numbers are unique identifiers for measures that are not NQF-endorsed. MUC = measure under consideration; FIN = currently finalized measure.

## ENDNOTES

**1** Centers for Medicare & Medicaid Services (CMS). *Guide to Quality Performance Standards for Accountable Care Organizations Starting in 2012: Pay for Reporting and Pay for Performance*. Baltimore, MD: CMS;2012. Available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Guide-Quality-Performance-2012.PDF>. Accessed January 2013.

**2** HHS. *Accountable Care Organizations: Improving Care Coordination for People with Medicare*. Washington, DC: Healthcare.gov;2013. Available at <http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html>. Accessed January 2013.

**3** Medicare and Medicaid Extenders Act of 2010, Pub. L. 111-109. Washington, DC: GPO;2010. Available at <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>. Accessed January 2013.

**4** Medicare and Medicaid Extenders Act of 2010, Publ. L. 111-109. Washington, DC: GPO;2010. Available at <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>. Accessed January 2013.

**5** CMS. Physician Quality Reporting System: Analysis and Payment. Baltimore, MD: CMS;2013. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>. Accessed January 2013.

**6** CMS. Physician Quality Reporting System: Payment Adjustment Information. Baltimore, MD: CMS;2012. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html>. Accessed January 2013.

**7** CY 2013 PFS final rule. The Office of the Federal Register. <http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>

**8** CMS. Physician Quality Reporting System (PQRS). Measures Codes. Rockville, MD: CMS;2012. Available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>. CMS. *Eligible Professionals*. Baltimore, MD: CMS;2012. Available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/EligibleProfessionals.pdf>. Accessed March 2011.

**9** CY 2013 PFS final rule. The Office of the Federal Register. <http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>.

**10** CMS. Physician Quality Reporting System (PQRS). Baltimore, MD: CMS;2012. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html>. Accessed January 2013.

- 11** CMS. Physician Quality Reporting System: Measures Codes. Baltimore, MD: CMS;2013. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>. Accessed January 2013.
- 12** PFS Final Rule 2013.
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## APPENDIX B: MAP Background

### Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs. MAP was established pursuant to a statutory provision that requires HHS to contract with NQF (as the consensus-based entity) to “convene multi-stakeholder groups to provide input on the selection of quality measures” for various uses.<sup>1</sup>

MAP’s careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures HHS will receive varied and thoughtful input on performance measure selection. In particular, the statutorily-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a more global and strategic way.

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable.<sup>2</sup> Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP’s objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families.** MAP encourages the use of the best available measures that are high impact, relevant, and actionable. MAP has adopted a person-centered approach to measure

selection, promoting broader use of patient-reported outcomes, experience, and shared decision-making.

2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value.** MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden.** MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

### Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decision-making, aligning payment with value, rewarding providers and professionals for using health information technology (health IT) to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers,



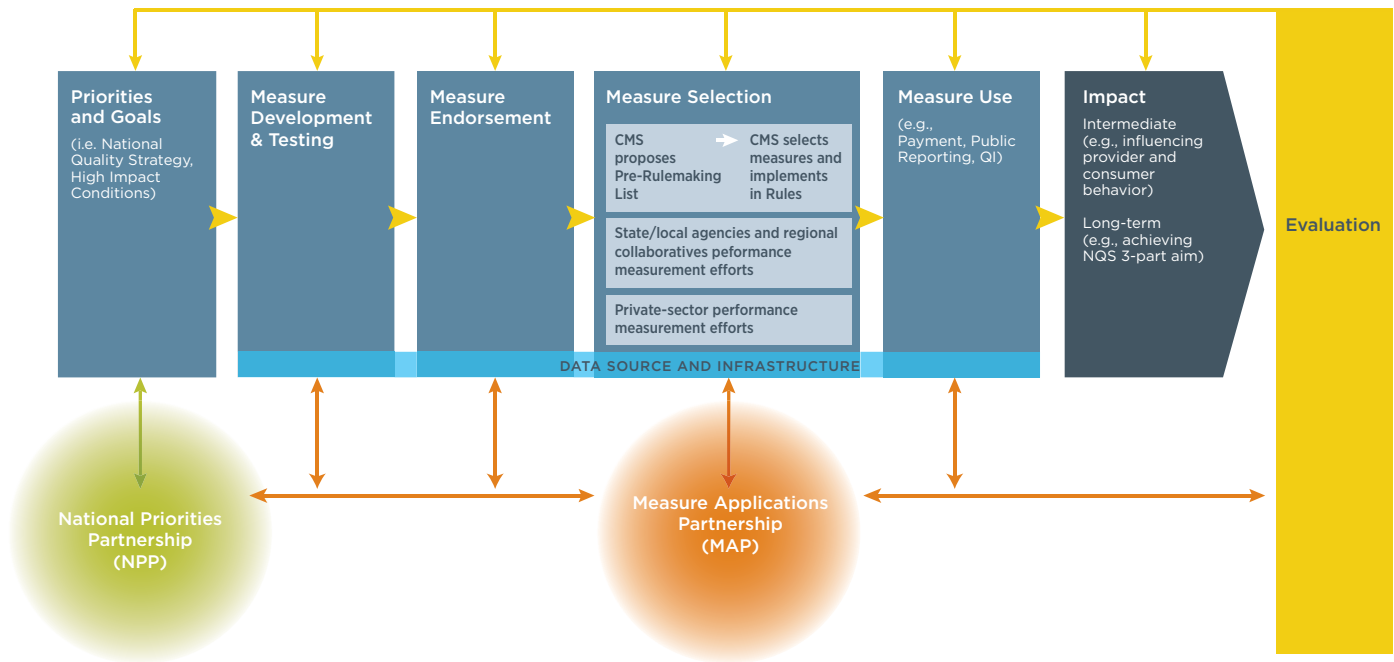
measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust Quality Enterprise (see Figure B1) that includes:

- **Setting priorities and goals.** The National Priorities Partnership (NPP) is a multi-stakeholder group convened by NQF to provide input to HHS on the NQS, by identifying priorities, goals, and global measures of progress. The priorities and goals established serve as a guiding framework for the Quality Enterprise.
- **Developing and testing measures.** Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).
- **Endorsing measures.** NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.
- **Measure selection and measure use.** Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the Quality Enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.
- **Impact.** Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate whether measures are having their intended impact and are driving improvement, transparency, and value.
- **Evaluation.** Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements.

MAP seeks to engage in bi-directional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

**FIGURE B1. FUNCTIONS OF THE QUALITY ENTERPRISE**

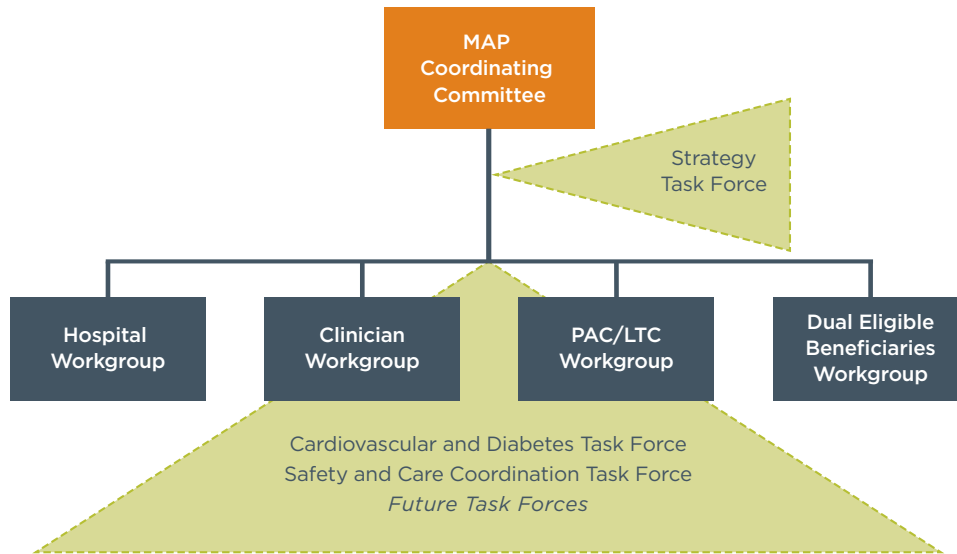


### Structure

MAP operates through a two-tiered structure (see Figure B2). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing

“Families of Measures”—related measures that cross settings and populations—and a multi-year strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multi-stakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

FIGURE B2. MAP 2012 STRUCTURE



The NQF Board of Directors oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness, but it will not review the Coordinating Committee's input to HHS. The Board selected the Coordinating Committee and workgroups based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups also was imperative.

All MAP activities are conducted in an open and transparent manner. The appointment process includes open nominations and a public comment period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decision-making is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed<sup>®</sup> Patient-Focused Episodes

of Care framework,<sup>3</sup> the HHS Partnership for Patients safety initiative,<sup>4</sup> the HHS Prevention and Health Promotion Strategy,<sup>5</sup> the HHS Disparities Strategy,<sup>6</sup> and the HHS Multiple Chronic Conditions framework.<sup>7</sup>

Additionally, the MAP Coordinating Committee has developed Measure Selection Criteria to help guide MAP decision-making. The MAP Measure Selection Criteria are intended to build on, not duplicate, the NQF endorsement criteria. The Measure Selection Criteria characterize the fitness of a measure set for use in a specific program by, among other things, how the measure set addresses the NQS's priority areas and the high-impact conditions, and by whether the measure set advances the purpose of the specific program without creating undesirable consequences.

### Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to

HHS by February 1 (**MAP 2012 Pre-Rulemaking Report**, submitted to HHS February 1, 2012).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP's pre-rulemaking input. To date MAP has:

- Engaged in **Strategic Planning** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.
  - **MAP Approach to the Strategic Plan**, submitted to HHS on June 1, 2012
  - **MAP Strategic Plan**, submitted to HHS on October 1, 2012
- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities and high-impact conditions—to facilitate coordination of measurement efforts.
  - **MAP Families of Measures: Safety, Care Coordination, Cardiovascular Conditions, Diabetes**, submitted to HHS on October 1, 2012
- Provided a measurement strategy and best available measures for evaluating the quality of care provided to Medicare/Medicaid **Dual Eligible Beneficiaries**, including high-need groups.
  - **Measuring Healthcare Quality for the Dual Eligible Beneficiary Population**, submitted to HHS on June 1, 2012
  - **Further Exploration of Healthcare Quality Measurement for the Dual Eligible Beneficiary Population**, submitted to HHS on December 21, 2012
- Developed **Coordination Strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives. Each coordination strategy addresses measures, gaps, and measurement issues; data sources and health information technology implications; alignment across settings and across public- and private-sector programs; special considerations for dual-eligible beneficiaries; and path forward for improving measure application.
  - **Coordination Strategy for Clinician Performance Measurement**, submitted to HHS on October 1, 2011
  - **Readmissions and Healthcare-Acquired Conditions Performance Measurement Strategy Across Public and Private Payers**, submitted to HHS on October 1, 2011
  - **MAP Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement**, submitted to HHS on February 1, 2012
  - **Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals**, submitted to HHS on June 1, 2012
  - **Performance Measurement Coordination Strategy for Hospice and Palliative Care**, submitted to HHS on June 1, 2012

## ENDNOTES

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- 7 HHS. *HHS Initiative on Multiple Chronic Conditions*. Washington, DC: HHS; 2011. Available at [www.hhs.gov/ash/initiatives/mcc/](http://www.hhs.gov/ash/initiatives/mcc/). Accessed January 2013.

## APPENDIX C: MAP Rosters

### Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)	
George Isham, MD, MS	
Elizabeth McGlynn, PhD, MPP	
ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	To be determined
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip N. Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
National Partnership for Women and Families	Christine Bechtel, MA
Pacific Business Group on Health	William Kramer, MBA
EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/Home Health/Hospice	Carol Raphael, MPA

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Gail Janes, PhD, MS
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	Ahmed Calvo, MD, MPH
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD
ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O'Kane, MHS
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

## Roster for the MAP Clinician Workgroup

CHAIR (VOTING)	
Mark McClellan, MD, PhD	
ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
American Academy of Family Physicians	Bruce Bagley, MD
American Academy of Nurse Practitioners	Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP
American College of Cardiology	Paul Casale, MD, FACC
American College of Emergency Physicians	Bruce Auerbach, MD
American College of Radiology	David Seidenwurm, MD
American Speech-Language-Hearing Association	Janet Brown, MA, CCC-SLP
Association of American Medical Colleges	Joanne Conroy, MD
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	Richard Salmon, MD, PhD
Consumers' CHECKBOOK	Robert Krughoff, JD
Kaiser Permanente	Amy Compton-Phillips, MD
Minnesota Community Measurement	Beth Averbeck, MD
Pacific Business Group on Health	David Hopkins, PhD
Physician Consortium for Performance Improvement	Mark Metersky, MD
The Alliance	Cheryl DeMars
EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Disparities	Marshall Chin, MD, MPH, FACP
Population Health	Eugene Nelson, MPH, DSc
Shared Decision Making	Karen Sepucha, PhD
Team-Based Care	Ronald Stock, MD, MA
Health IT/Patient Reported Outcome Measures	James Walker, MD, FACP
Measure Methodologist	Dolores Yanagihara, MPH
FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Darryl Gray, MD, ScD
Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Kate Goodrich, MD
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of the National Coordinator for HIT (ONC)	Jesse James, MD, MBA
Veterans Health Administration (VHA)	Joseph Francis, MD, MPH
MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)	
George J. Isham, MD, MS	
Elizabeth A. McGlynn, PhD, MPP	



## Roster for the MAP Dual Eligible Beneficiaries Workgroup

CHAIR (VOTING)	
Alice Lind, MPH, BSN	
ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Center for Medicare Advocacy	Alfred J. Chiplin, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt
EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN
FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Administration for Community Living	Henry Claypool
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Substance Abuse and Mental Health Services Administration	Frances Cotter, MA, MPH
Veterans Health Administration	Daniel Kivlahan, PhD
MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)	
George Isham, MD, MS	
Elizabeth McGlynn, PhD, MPP	

## Roster for the MAP Hospital Workgroup

CHAIR (VOTING)	
Frank G. Opelka, MD, FACS	
ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
American Hospital Association	Richard Umbdenstock
American Organization of Nurse Executives	Patricia Conway-Morana, RN
American Society of Health-System Pharmacists	Shekhar Mehta, PharmD, MS
Blue Cross Blue Shield of Massachusetts	Jane Franke, RN, MHA, CPHQ
Building Services 32BJ Health Fund	Barbara Caress
Iowa Healthcare Collaborative	Lance Roberts, PhD
Memphis Business Group on Health	Cristie Upshaw Travis, MSHA
Mothers Against Medical Error	Helen Haskell, MA
National Association of Children's Hospitals and Related Institutions	Andrea Benin, MD
National Rural Health Association	Brock Slabach, MPH, FACHE
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP
EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Health IT	Dana Alexander, RN, MSN, MBA
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD
FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Pamela Owens, PhD
Centers for Disease Control and Prevention (CDC)	Gail Janes, PhD, MS
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD
Veterans Health Administration (VHA)	Michael Kelley, MD
MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)	
George J. Isham, MD, MS	
Elizabeth A. McGlynn, PhD, MPP	

## Roster for the MAP Post-Acute Care/Long-Term Care Workgroup

CHAIR (VOTING)	
Carol Raphael, MPA	
ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Aetna	Randall Krakauer, MD
American Medical Rehabilitation Providers Association	Suzanne Snyder, PT
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
Kindred Healthcare	Sean Muldoon, MD
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Hospice and Palliative Care Organization	Carol Spence, PhD
National Transitions of Care Coalition	James Lett II, MD, CMD
Providence Health and Services	Robert Hellrigel
Service Employees International Union	Charissa Raynor
Visiting Nurses Association of America	Margaret Terry, PhD, RN
EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Clinician/Nephrology	Louis H. Diamond, MBChB, FCP (SA), FACP, FHIMSS
Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN
Care Coordination	Gerri Lamb, PhD
Clinician/Geriatrics	Bruce Leff, MD
State Medicaid	MaryAnne Lindeblad, MPH
Measure Methodologist	Debra Saliba, MD, MPH
Health IT	Thomas von Sternberg, MD
FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	
Agency for Healthcare Research and Quality (AHRQ)	D.E.B. Potter, MS
Centers for Medicare & Medicaid Services (CMS)	Shari Ling
Veterans Health Administration	Scott Shreve, MD
MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)	
George Isham, MD, MS	
Elizabeth McGlynn, PhD, MPP	

## APPENDIX D: MAP Measure Selection Criteria and Interpretive Guide

### MAP “Working” Measure Selection Criteria

#### 1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review

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*Measures within the program measure set are NQF-endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF-endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.*

**Response option:** Strongly Agree / Agree / Disagree / Strongly Disagree

Measures within the program measure set are NQF-endorsed or meet requirements for expedited review (including measures in widespread use and/or tested)

**Additional Implementation Consideration:** Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences.

#### 2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities

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*Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:*

**Response option for each subcriterion:** Strongly Agree / Agree / Disagree / Strongly Disagree: NQS priority is adequately addressed in the program measure set

**Subcriterion 2.1** Safer care

**Subcriterion 2.2** Effective care coordination

**Subcriterion 2.3** Preventing and treating leading causes of mortality and morbidity

**Subcriterion 2.4** Person- and family-centered care

**Subcriterion 2.5** Supporting better health in communities

**Subcriterion 2.6** Making care more affordable

### 3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)

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*Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Refer to tables 1 and 2 for Medicare High-Impact Conditions and Child Health Conditions determined by the NQF Measure Prioritization Advisory Committee.)*

**Response option:** Strongly Agree / Agree / Disagree / Strongly Disagree:

Program measure set adequately addresses high-impact conditions relevant to the program.

### 4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

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*Demonstrated by a program measure set that is applicable to the intended care setting(s), level(s) of analysis, and population(s) relevant to the program.*

**Response option for each subcriterion:** Strongly Agree / Agree / Disagree / Strongly Disagree

**Subcriterion 4.1** Program measure set is applicable to the program's intended care setting(s)

**Subcriterion 4.2** Program measure set is applicable to the program's intended level(s) of analysis

**Subcriterion 4.3** Program measure set is applicable to the program's population(s)

### 5. Program measure set includes an appropriate mix of measure types

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*Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, and structural measures necessary for the specific program attributes.*

**Response option for each subcriterion:** Strongly Agree / Agree / Disagree / Strongly Disagree

**Subcriterion 5.1** Outcome measures are adequately represented in the program measure set

**Subcriterion 5.2** Process measures are adequately represented in the program measure set

**Subcriterion 5.3** Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)

**Subcriterion 5.4** Cost/resource use/appropriateness measures are adequately represented in the program measure set

**Subcriterion 5.5** Structural measures and measures of access are represented in the program measure set when appropriate

### 6. Program measure set enables measurement across the person-centered episode of care<sup>1</sup>

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*Demonstrated by assessment of the person's trajectory across providers, settings, and time.*

**Response option for each subcriterion:** Strongly Agree / Agree / Disagree / Strongly Disagree

**Subcriterion 6.1** Measures within the program measure set are applicable across relevant providers

**Subcriterion 6.2** Measures within the program measure set are applicable across relevant settings

**Subcriterion 6.3** Program measure set adequately measures patient care across time

## 7. Program measure set includes considerations for healthcare disparities<sup>2</sup>

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*Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, age disparities, or geographical considerations (e.g., urban vs.rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).*

**Response option for each subcriterion:** Strongly Agree / Agree / Disagree / Strongly Disagree

**Subcriterion 7.1** Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

**Subcriterion 7.2** Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

## 8. Program measure set promotes parsimony

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*Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.*

**Response option for each subcriterion:** Strongly Agree / Agree / Disagree / Strongly Disagree

**Subcriterion 8.1** Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)

**Subcriterion 8.2** Program measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

**TABLE 1: NATIONAL QUALITY STRATEGY PRIORITIES**

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

**TABLE 2 HIGH-IMPACT CONDITIONS:**

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer’s Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes
6. Asthma
7. Depression
8. Behavior or Conduct Problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger’s, PDD, ASD
11. Developmental Delay (diag.)
12. Environmental Allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety Problems
15. ADD/ADHD
16. Vision Problems not Corrected by Glasses
17. Bone, Joint, or Muscle Problems
18. Migraine Headaches
19. Food or Digestive Allergy
20. Hearing Problems
21. Stuttering, Stammering, or Other Speech Problems
22. Brain Injury or Concussion
23. Epilepsy or Seizure Disorder
24. Tourette Syndrome

## MAP “Working” Measure Selection Criteria Interpretive Guide

### Instructions for applying the measure selection criteria:

The measure selection criteria are designed to assist MAP Coordinating Committee and workgroup members in assessing measure sets used in payment and public reporting programs. The criteria have been developed with feedback from the MAP Coordinating Committee, workgroups, and public comment. The criteria are intended to facilitate a structured thought process that results in generating discussion. A rating scale of Strongly Agree, Agree, Disagree, Strongly Disagree is offered for each criterion or sub-criterion. An open text box is included in the response tool to capture reflections on the rationale for ratings.

The eight criteria areas are designed to assist in determining whether a measure set is aligned with its intended use and whether the set best reflects ‘quality’ health and healthcare. The term “measure set” can refer to a collection of measures--for a program, condition, procedure, topic, or population. For the purposes of MAP moving forward, we will qualify all uses of the term measure set to refer to either a “program measure set,” a “core measure set” for a setting, or a “condition measure set.” The following eight criteria apply to the evaluation of program measure sets; a subset of the criteria apply to condition measure sets.

### For criterion 1 – NQF endorsement:

The optimal option is for all measures in the program measure set to be NQF endorsed or ready for NQF expedited review. The endorsement process evaluates individual measures against four main criteria:

1. **‘Importance to measure and report’**—how well the measure addresses a specific national health goal/priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;
2. **‘Scientific acceptability of the measurement properties’** – evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.
3. **‘Usability’**- the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.
4. **‘Feasibility’** – the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

**To be recommended by MAP, a measure that is not NQF-endorsed must meet the following requirements, so that it can be submitted for expedited review:**

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use
- whether the scope of the project/measure set is relatively narrow
- time-sensitive legislative/regulatory mandate for the measure(s)
- Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated with the use of the performance measure. Additional consideration and discussion by the MAP workgroup or Coordinating Committee may be appropriate prior to selection. To raise concerns on particular measures, please make a note in the included text box under this criterion.



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### For criterion 2 – Program Measure set addresses the National Quality Strategy priorities:

The program’s set of measures is expected to adequately address each of the NQS priorities as described in criterion 2.1-2.6. The definition of “adequate” rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. This assessment should consider the current landscape of NQF-endorsed measures available for selection within each of the priority areas.

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### For criterion 3 – Program Measure set addresses high-impact conditions:

When evaluating the program measure set, measures that adequately capture information on high-impact conditions should be included based on their relevance to the program’s intended population. High-priority Medicare and child health conditions have been determined by NQF’s Measure Prioritization Advisory Committee and are included to provide guidance. For programs intended to address high-impact conditions for populations other than Medicare beneficiaries and children (e.g., adult non-Medicare and dual eligible beneficiaries), high-impact conditions can be demonstrated by their high prevalence, high disease burden, and high costs relevant to the program. Examples of other on-going efforts may include research or literature on the adult Medicaid population or other common populations. The definition of “adequate” rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria.

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### For criterion 4 – Program Measure set promotes alignment with specific program attributes, as well as alignment across programs:

The program measure sets should align with the attributes of the specific program for which they intend to be used. Background material on the program being evaluated and its intended purpose are provided to help with applying the criteria. This should assist with making discernments about the intended care setting(s), level(s) of analysis, and population(s). While the program measure set should address the unique aims of a given program, the overall goal is to harmonize measurement across programs, settings, and between the public and private sectors.

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.
- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.
- **Populations include:** Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children’s Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

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### For criterion 5 – Program Measure set includes an appropriate mix of measure types:

The program measure set should be evaluated for an appropriate mix of measure types. The definition of “appropriate” rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. The evaluated measure types include:

1. **Outcome measures-** Clinical outcome measures reflect the actual results of care.<sup>3</sup> Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients’ understanding of treatment options and care plans, and their feedback on whether care made a difference.<sup>4</sup>

- 2. Process measures** – Process denotes what is actually done in giving and receiving care.<sup>5</sup> NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.<sup>6</sup> Experience of care measures—Defined as patients’ perspective on their care.<sup>7</sup>
- 3. Cost/resource use/appropriateness measures** –
- a. *Cost measures* – Total cost of care.
  - b. *Resource use measures* – Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).<sup>8</sup>
  - c. *Appropriateness measures* – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.<sup>9</sup>
- 4. Structure measures** – Reflect the conditions in which providers care for patients.<sup>10</sup> This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure (such as medical staff organizations, methods of peer review, and methods of reimbursement).<sup>11</sup> In this case, structural measures should be used only when appropriate for the program attributes and the intended population.

#### For criterion 6 – program measure set enables measurement across the person-centered episode of care:

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The optimal option is for the program measure set to approach measurement in such a way as to capture a person’s natural trajectory through the health and healthcare system over a period of time. Additionally, driving to longitudinal measures that address patients throughout their lifespan, from health, to chronic conditions, and when acutely ill should be emphasized. Evaluating performance in this way can provide insight into how effectively services are coordinated across multiple settings and during critical transition points.

When evaluating subcriteria 6.1-6.3, it is important to note whether the program measure set captures this trajectory (across providers, settings or time). This can be done through the inclusion of individual measures (e.g., 30-day readmission post-hospitalization measure) or multiple measures in concert (e.g., aspirin at arrival for AMI, statins at discharge, AMI 30-day mortality, referral for cardiac rehabilitation).

#### For criterion 7 – program measure set includes considerations for healthcare disparities:

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Measures sets should be able to detect differences in quality among populations or social groupings. Measures should be stratified by demographic information (e.g., race, ethnicity, language, gender, disability, and socioeconomic status, rural vs. urban), which will provide important information to help identify and address disparities.<sup>12</sup>

**Subcriterion 7.1** seeks to include measures that are known to assess healthcare disparities (e.g., use of interpreter services to prevent disparities for non-English speaking patients).

**Subcriterion 7.2** seeks to include disparities-sensitive measures; these are measures that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (e.g., race/ethnicity, language).

**For criterion 8 — program measure set promotes parsimony:**

The optimal option is for the program measure set to support an efficient use of resources in regard to data collection and reporting for accountable entities, while also measuring the patient's health and healthcare comprehensively.

**Subcriterion 8.1** can be evaluated by examining whether the program measure set includes the least number of measures required to capture the program's objectives and data submission that requires the least burden on the part of the accountable entities.

**Subcriterion 8.2** can be evaluated by examining whether the program measure set includes measures that are used across multiple programs (e.g., PQRS, MU, CHIPRA, etc.) and applications (e.g., payment, public reporting, and quality improvement).

**ENDNOTES**

**1** National Quality Forum (NQF), Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care, Washington, DC: NQF; 2010.

**2** NQF, *Healthcare Disparities Measurement*, Washington, DC: NQF; 2011.

**3** National Quality Forum. (2011). The right tools for the job. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/ABCs/The\\_Right\\_Tools\\_for\\_the\\_Job.aspx](http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx)

**4** Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance

**5** Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

**6** National Quality Forum. (2011). Consensus development process. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/Consensus\\_Development\\_Process.aspx](http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx)

**7** National Quality Forum. (2011). The right tools for the job. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/ABCs/The\\_Right\\_Tools\\_for\\_the\\_Job.aspx](http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx)

**8** National Quality Forum (2009). National voluntary consensus standards for outpatient imaging efficiency. Retrieved from

[http://www.qualityforum.org/Publications/2009/08/National\\_Voluntary\\_Consensus\\_Standards\\_for\\_Outpatient\\_Imaging\\_Efficiency\\_\\_A\\_Consensus\\_Report.aspx](http://www.qualityforum.org/Publications/2009/08/National_Voluntary_Consensus_Standards_for_Outpatient_Imaging_Efficiency__A_Consensus_Report.aspx)

**9** National Quality Forum. (2011). The right tools for the job. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/ABCs/The\\_Right\\_Tools\\_for\\_the\\_Job.aspx](http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx)

**10** National Quality Forum. (2011). The right tools for the job. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/ABCs/The\\_Right\\_Tools\\_for\\_the\\_Job.aspx](http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx)

**11** Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

**12** Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance.

## APPENDIX E: Adoption Across Federal Programs of the Evolving Core Set of Measures for Dual Eligible Beneficiaries

Measure # and NQF Status	Measure Title	Federal Programs: Under Consideration	Federal Program: Currently Finalized	MAP Pre-Rulemaking Guidance
<b>0004 Endorsed</b>	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	n/a	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; MU-EP; PQRS	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>0005 Endorsed</b>	CAHPS Clinician/Group Surveys	VBPM; Physician Compare	MSSP	VBPM: Support: NQF-endorsed measure. Physician Compare: Refer to guiding principles for clinician programs.
<b>0022 Endorsed</b>	Use of High Risk Medications in the Elderly	n/a	MU-EP; Medicare Part D Plan Rating; Physician Feedback; PQRS; VBPM	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>0028 Endorsed</b>	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	VBPM; Physician Compare	MU-EP; MSSP; PQRS	Physician Compare/VBPM: Refer to guiding principles for clinician programs.
<b>0097 Endorsed</b>	Medication Reconciliation	LTCHQR; Physician Compare; VBPM	MSSP; Physician Feedback; PQRS	LTCHQR: Support direction: Not ready for implementation; measure concept is promising but requires modification or further development for LTCH setting. Physician Compare/VBPM: Refer to guiding principles for clinician programs.
<b>0101 Endorsed Time-Limited</b>	Falls: Screening for Future Fall Risk	Physician Compare; VBPM	MU-EP; MSSP; PQRS	Physician Compare/VBPM: Refer to guiding principles for clinician programs.

Measure # and NQF Status	Measure Title	Federal Programs: Under Consideration	Federal Program: Currently Finalized	MAP Pre-Rulemaking Guidance
<b>0166 Endorsed</b>	HCAHPS	LTCHQR; PCHQR	IQR; HVBP	<p>LTCHQR: Support direction: not ready for implementation; measure concept is promising but requires modification or further development for LTCH setting.</p> <p>PCHQR: Support direction: not ready for implementation; more experience with the measure is needed. Cancer module of CAHPS survey currently being piloted by many PPS-exempt Cancer Hospitals.</p>
<b>0209 Endorsed</b>	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	PQRS	Hospice Quality Reporting	PQRS: Support: NQF-endorsed measure.
<b>0228 Endorsed</b>	3-Item Care Transition Measure (CTM-3)	HVBP; LTCHQR	IQR	<p>HVBP: Support: addresses an NQS priority not adequately addressed in the program measure set. Addresses a high-leverage opportunity for dual eligible beneficiaries. Enables measurement across the person-centered episode of care.</p> <p>LTCHQR: Support direction: not ready for implementation; measure concept is promising but requires modification or further development for LTCH setting.</p>
<b>0258 Endorsed</b>	CAHPS In-Center Hemodialysis Survey	End-Stage Renal Disease Quality Reporting	n/a	ESRD: Support: addresses an NQS priority not adequately addressed in the program measure set. There is a need for greater patient and family engagement in the dialysis facility setting.
<b>0260 Endorsed</b>	Assessment of Health-Related Quality of Life in Dialysis Patients	n/a	n/a	<i>Measure was not under consideration for pre-rulemaking.</i>

Measure # and NQF Status	Measure Title	Federal Programs: Under Consideration	Federal Program: Currently Finalized	MAP Pre-Rulemaking Guidance
<b>0326 Endorsed</b>	Advance Care Plan	LTCHQR	Physician Feedback; PQRS	LTCHQR: Support direction: not ready for implementation; measure concept is promising but requires modification or further development for LTCH setting.
<b>0418 Endorsed</b>	Screening for Clinical Depression	Physician Compare; VBPM	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; MU-EP; MSSP; Physician Feedback; PQRS; HRSA	Physician Compare/VBPM: Refer to guiding principles for clinician programs.
<b>0420 Endorsed</b>	Pain Assessment Prior to Initiation of Patient Therapy	n/a	Physician Feedback; PQRS	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>0421 Endorsed</b>	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Physician Compare; VBPM	MU-EP; MSSP; Physician Feedback; PQRS; HRSA	Physician Compare/VBPM: Refer to guiding principles for clinician programs.
<b>0430 Endorsed</b>	Change in Daily Activity Function as Measured by the AM-PAC:	n/a	n/a	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>0557 Endorsed</b>	HBIPS-6 Post Discharge Continuing Care Plan Created	n/a	IPHQR	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>0558 Endorsed</b>	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge	n/a	IPHQR	<i>Measure was not under consideration for pre-rulemaking.</i>

Measure # and NQF Status	Measure Title	Federal Programs: Under Consideration	Federal Program: Currently Finalized	MAP Pre-Rulemaking Guidance
<b>0576 Endorsed</b>	Follow-Up After Hospitalization for Mental Illness	IPHQR; Physician Compare; VBPM	CHIPRA Quality Reporting; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Physician Feedback; PQRS	<p>IPFQR: Support: addresses an NQS priority not adequately addressed in the program measure set. Addresses a high-leverage opportunity for dual eligible beneficiaries. Enables measurement across the person-centered episode of care. Measure is inclusive and encourages hospitals to develop stronger links to the community.</p> <p>Physician Compare/VBPM: Refer to guiding principles for clinician programs; generally favored because of alignment with additional Medicare programs (e.g., MSSP).</p>
<b>0647 Endorsed</b>	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	LTCHQR; PQRS	n/a	<p>LTCHQR: Support direction: not ready for implementation; measure concept is promising but requires modification or further development for LTCH setting.</p> <p>PQRS: Support: NQF-endorsed measure.</p>
<b>0648 Endorsed</b>	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	LTCHQR; PQRS	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults	<p>LTCHQR: Support direction: not ready for implementation; measure concept is promising but requires modification or further development for LTCH setting.</p> <p>PQRS: Support: NQF-endorsed measure.</p>
<b>0729 Endorsed</b>	Optimal Diabetes Care	Physician Compare; VBPM	MSSP; PQRS	<p>Physician Compare/VBPM: Refer to guiding principles for clinician programs; generally favored because it is an outcome measure aligned with additional Medicare programs.</p>

Measure # and NQF Status	Measure Title	Federal Programs: Under Consideration	Federal Program: Currently Finalized	MAP Pre-Rulemaking Guidance
<b>1626 Endorsed</b>	Patients Admitted to ICU Who Have Care Preferences Documented	PQRS	n/a	PQRS: Support: NQF-endorsed measure.
<b>1632 Endorsed</b>	CARE - Consumer Assessments and Reports of End of Life	n/a	n/a	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>1641 Endorsed</b>	Hospice and Palliative Care - Treatment Preferences	Hospice Quality Reporting; PQRS	n/a	Hospice Quality Reporting: Support: addresses a PAC/LTC core concept not adequately addressed in the program measure set. Measure has previously been supported in the MAP Hospice Coordination Strategy. PQRS: Support: NQF-endorsed measure.
<b>1741 Endorsed</b>	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) <sup>®</sup> Surgical Care Survey	PQRS	n/a	PQRS: Support: NQF-endorsed measure.
<b>1768 Endorsed</b>	Plan All-Cause Readmissions	n/a	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>1789 Endorsed</b>	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	IQR; PQRS	IQR	IQR: Support: new specifications are improvement over the existing finalized measure. Recommendation is contingent on NQF endorsement. PQRS: Support: NQF-endorsed measure.
<b>1825 Endorsed</b>	COPD - Management of Poorly Controlled COPD	n/a	n/a	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>1909 Endorsed</b>	Medical Home System Survey (MHSS)	n/a	n/a	<i>Measure was not under consideration for pre-rulemaking.</i>



Measure # and NQF Status	Measure Title	Federal Programs: Under Consideration	Federal Program: Currently Finalized	MAP Pre-Rulemaking Guidance
<b>1919 Endorsed</b>	Cultural Competency Implementation Measure	n/a	n/a	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>Not Endorsed</b>	Unhealthy Alcohol Use: Screening and Brief Counseling	n/a	n/a	<i>Measure was not under consideration for pre-rulemaking.</i>
<b>Not Endorsed</b>	SNP 6: Coordination of Medicare and Medicaid Coverage	n/a	n/a	<i>Measure was not under consideration for pre-rulemaking.</i>

NOTE: The Dual Eligible Beneficiaries Workgroup has made a standing recommendation that CAHPS tools be used whenever appropriate; the Evolving Core Set of Measures includes all versions except those not relevant to this population (i.e., pediatric). CAHPS-related measures that are under consideration appear in the table above. CAHPS-related measures not under consideration during the current pre-rulemaking cycle include:

- 0006: CAHPS Health Plan Survey v 4.0 - Adult Questionnaire
- 0007: NCQA Supplemental Items for CAHPS 4.0 Adult Questionnaire (CAHPS 4.0H)
- 0008: Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)
- 0517: CAHPS Home Health Care Survey
- 0691: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument
- 0692: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument
- 0693: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument
- 1902: Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
- 1904: Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set

## APPENDIX F: MAP Previously Identified Gaps

This document provides a synthesis of previously identified measure gaps compiled from all prior MAP reports. The gaps are grouped by NQS priority.

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### Safety

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- Composite measure of most significant Serious Reportable Events

### Healthcare-Associated Infections

- Ventilator-associated events for acute care, post-acute care, long-term care hospitals and home health settings
- Pediatric population: special considerations for ventilator-associated events and *C. difficile*
- Infection measures reported as rates, rather than ratios (more meaningful to consumers)
- Sepsis (healthcare-acquired and community-acquired) incidence, early detection, monitoring, and failure to rescue related to sepsis
- Post-discharge follow-up on infections in ambulatory settings
- Vancomycin Resistant Enterococci (VRE) measures (e.g., positive blood cultures, appropriate antibiotic use)

### Medication and Infusion Safety

- Adverse drug events
  - Injury/mortality related to inappropriate drug management
  - Total number of adverse drug events that occur within all settings (including administration of wrong medication or wrong dosage and drug-allergy or drug-drug interactions)
- Inappropriate medication use
  - Polypharmacy and use of unnecessary medications for all ages, especially high-risk medications

- Antibiotic use for sinusitis
- Use of sedatives, hypnotics, atypical-antipsychotics, pain medications (consideration for individuals with dementia, Alzheimer's, or residing in long-term care settings)

- Medication management

- Patient-reported measures of understanding medications (purpose, dosage, side effects, etc.)
- Medication documentation, including appropriate prescribing and comprehensive medication review
- Persistence of medications (patients taking medications) for secondary prevention of cardiovascular conditions
- Role of community pharmacist or home health provider in medication reconciliation

- Blood incompatibility

### Perioperative/Procedural Safety

- Air embolism
- Anesthesia events (inter-operative myocardial infarction, corneal abrasion, broken tooth, etc.)
- Perioperative respiratory events, blood loss, and unnecessary transfusion
- Altered mental status in perioperative period

### Venous Thromboembolism

- VTE outcome measures for ambulatory surgical centers and post-acute care/long-term care settings
- Adherence to VTE medications, monitoring of therapeutic levels, medication side effects, and recurrence

### Falls and Immobility

- Standard definition of falls across settings to avoid potential confusion related to two different fall rates

- Structural measures of staff availability to ambulate and reposition patients, including home care providers and home health aides

### Obstetrical Adverse Events

- Obstetrical adverse event index
- Measures using National Health Safety Network (NHSN) definitions for infections in newborns

### Pain Management

- Effectiveness of pain management paired with patient experience and balanced by overuse/misuse monitoring
- Assessment of depression with pain

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## Patient & Family Engagement

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### Person-Centered Communication

- Information provided at appropriate times
- Information is aligned with patient preferences
- Patient understanding of information, not just receiving information (considerations for cultural sensitivity, ethnicity, language, religion, multiple chronic conditions, frailty, disability, medical complexity)
- Outreach to non-compliant patients

### Shared Decision-Making and Care Planning

- Person-centered care plan, created early in the care process, with identified goals for all people
- Integration of patient/family values in care planning
- Plan agreed to by the patient and provider and given to patient, including advanced care plan
- Plan shared among all providers seeing the patient (integrated); multidisciplinary
- Identified primary provider responsible for the care plan
- Fidelity to care plan and attainment of goals
  - Treatment consistent with advanced care plan
- Social care planning addressing social, practical, and legal needs of patient and caregivers

- Grief and bereavement care planning

### Advanced Illness Care

- Symptom management (nausea, shortness of breath, nutrition)
- Comfort at end of life

### Patient-Reported Measures

- Functional status
  - Particularly for individuals with multiple chronic conditions
  - Optimal functioning (e.g., improving when possible, maintaining, managing decline)
- Pain and symptom management
- Health-related quality of life
- Patient activation/engagement

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## Healthy Living

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- Life enjoyment
- Community inclusion/participation for people with long-term services and supports needs
- Sense of control/autonomy/self-determination
- Safety risk assessment

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## Care Coordination

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### Communication

- Sharing information across settings
  - Address both the sending and receiving of adequate information
  - Sharing medical records (including advance directives) across all providers
  - Documented consent for care coordination
  - Coordination between inpatient psychiatric care and alcohol/substance abuse treatment
- Effective and timely communication (e.g., provider-to-patient/family, provider-to-provider)
  - Survey/composite measure of provider perspective of care coordination

- Comprehensive care coordination survey that looks across episode and settings (includes all ages; recognizes accountability of the multidisciplinary team)

### Care Transitions

- Measures of patient transition to next provider/site of care across all settings, beyond hospital transitions (e.g., primary care to specialty care, clinician to community pharmacist, nursing home to home health) as well as transitions to community services
- Timely communication of discharge information to all parties (e.g., caregiver, primary care physician)
- Transition planning
  - Outcome measures for after care
  - Primary care follow-up after discharge measures (e.g., patients keeping follow-up appointments)
  - Access to needed social supports

### System and Infrastructure Support

- Interoperability of EHRs to enhance communication
- Measures of “systemness,” including accountable care organizations and patient-centered medical homes
- Structures to connect health systems and benefits (e.g., coordinating Medicare and Medicaid benefits, connecting to long-term supports and services)

### Avoidable Admissions and Readmissions

- Shared accountability and attribution across the continuum
- Community role; patient’s ability to connect to available resources

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### Affordability

- Ability to obtain follow-up care
- Utilization benchmarking (e.g., outpatient/ED/nursing facility)
- Consideration of total cost of care, including patient out-of-pocket cost

- Appropriateness for admissions, treatment, over-diagnosis, under-diagnosis, misdiagnosis, imaging, procedures
- Chemotherapy appropriateness, including dosing
- Avoiding unnecessary end-of-life care
- Use of radiographic imaging in the pediatric population

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## Prevention and Treatment for the Leading Causes of Mortality

### Primary and Secondary Prevention

- Lipid control
- Outcomes of smoking cessation interventions
- Lifestyle management (e.g., physical activity/exercise, diet/nutrition)
- Cardiometabolic risk
- Modify Prevention Quality Indicators (PQI) measures to assess accountable care organizations; modify population to include all patients with the disease (if applicable)

### Cancer

- Cancer- and stage-specific survival as well as patient-reported measures
- Complications such as febrile neutropenia and surgical site infection
- Transplants: bone marrow and peripheral stem cells
- Staging measures for lung, prostate, and gynecological cancers
- Marker/drug combination measures for marker-specific therapies, performance status of patients undergoing oncologic therapy/pre-therapy assessment
- Disparities measures, such as risk-stratified process and outcome measures, as well as access measures
- Pediatric measures, including hematologic cancers and transitions to adult care

### Cardiovascular Conditions

- Appropriateness of coronary artery bypass graft and PCI at the provider and system levels of analysis
- Early identification of heart failure decompensation
- ACE/ARB, beta blocker, statin persistence (patients taking medications) for ischemic heart disease

### Depression

- Suicide risk assessment for any type of depression diagnosis
- Assessment and referral for substance use
- Medication adherence and persistence for all behavioral health conditions

### Diabetes

- Measures addressing glycemic control for complex patients (e.g., geriatric population, multiple chronic conditions) at the clinician, facility, and system levels of analysis
- Pediatric glycemic control
- Sequelae of diabetes

### Musculoskeletal

- Evaluating bone density, and prevention and treatment of osteoporosis in ambulatory settings

## APPENDIX G: MAP Pre-Rulemaking Stepwise Approach

MAP enhanced its approach to pre-rulemaking for 2013. Table 4 lists the programs MAP reviewed during this pre-rulemaking cycle and the corresponding workgroups assigned to conduct the initial review of measures under consideration.

### 1. Build on MAP's Prior Recommendations

MAP's prior strategic input and pre-rulemaking decisions are important to MAP's ongoing deliberations. Each of MAP's prior inputs and how they contributed to the pre-rulemaking process are described below. Table G1 illustrates how MAP's prior work served as an input to MAP's pre-rulemaking deliberations.

**Coordination Strategies** elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives. Each coordination strategy addresses available measures, gaps, and measurement issues; data sources and health information technology implications; alignment opportunities across settings and across public- and private-sector programs; special considerations for dual eligible beneficiaries; and approaches for improving measure application. The recommendations provided setting-specific considerations that served as background information to MAP's pre-rulemaking deliberations.

**2012 Pre-Rulemaking Report** provides program-specific input that included recommendations about measures previously finalized for the programs and about measures on the list of measures under consideration for implementation by HHS. The high-level recommendations in this report served as useful background while measure-specific recommendations were incorporated into measure-by-measure

deliberations.

**Families of Measures** facilitate coordination of measurement efforts. These measure sets are composed of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities (i.e., safety, care coordination families of measures), vulnerable populations (i.e., dual eligible beneficiaries, hospice families), and high-impact conditions (i.e., cardiovascular, diabetes, and cancer families). The families of measures reflect the highest-leverage opportunities for improvement in a particular area; the IOM criteria of impact, inclusiveness, and improvability<sup>1</sup> guided the identification of measures for inclusion in a family. Setting- and level-of-analysis-specific core sets are drawn from the families. These core measure sets served as an initial starting place for evaluation of program measure sets, identifying measures that should be added to the program measure set or measures that should replace previously finalized measures in the program measure set.

Figure G1 illustrates how core measure sets and program measure sets are populated from the families of measures. The boxes represent individual performance measures. In this example, the orange boxes represent measures that are specified for individual clinician or group practice levels of analysis. The dark orange boxes in the clinician program measure sets (i.e., PQRS, Value Based Payment Modifier, Meaningful Use) represent measures recommended for those programs from the clinician core measure set, while the light orange boxes represent measures recommended for those programs that are not included in the clinician core measure set, but fit the specific purpose of the program.

**FIGURE G1. FAMILIES OF MEASURES POPULATING A CORE MEASURE SET AND PROGRAM MEASURE SETS**

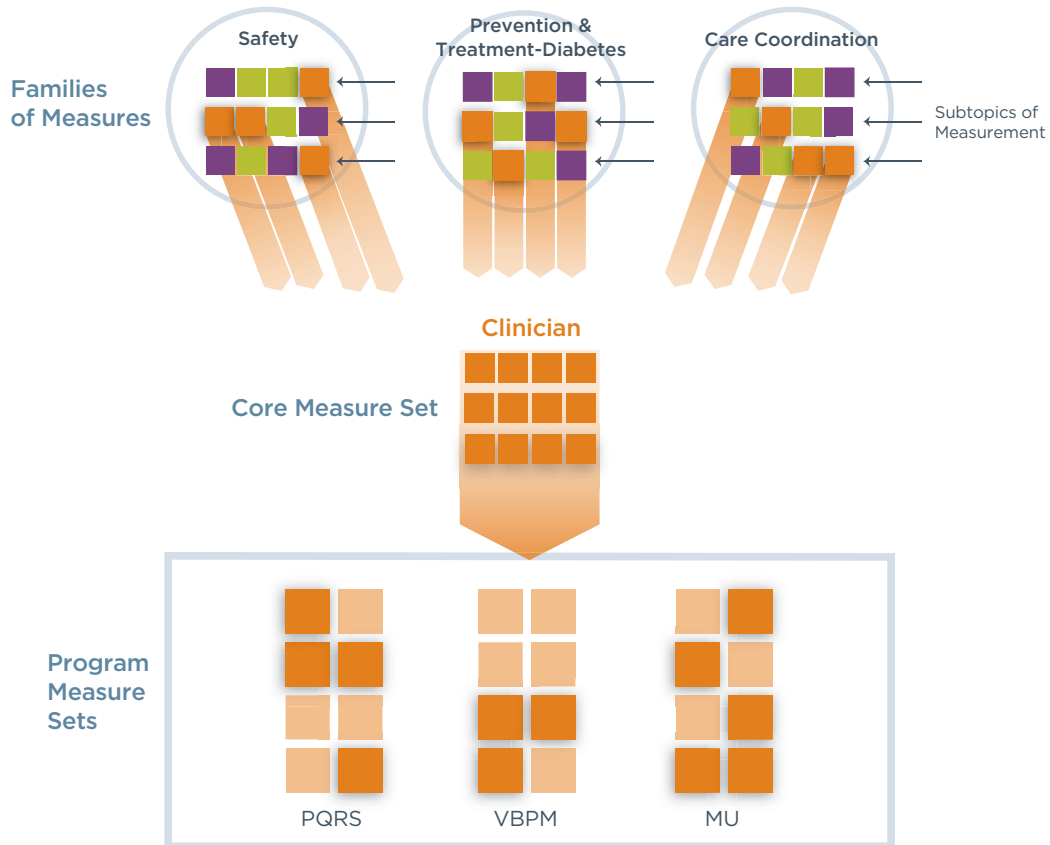
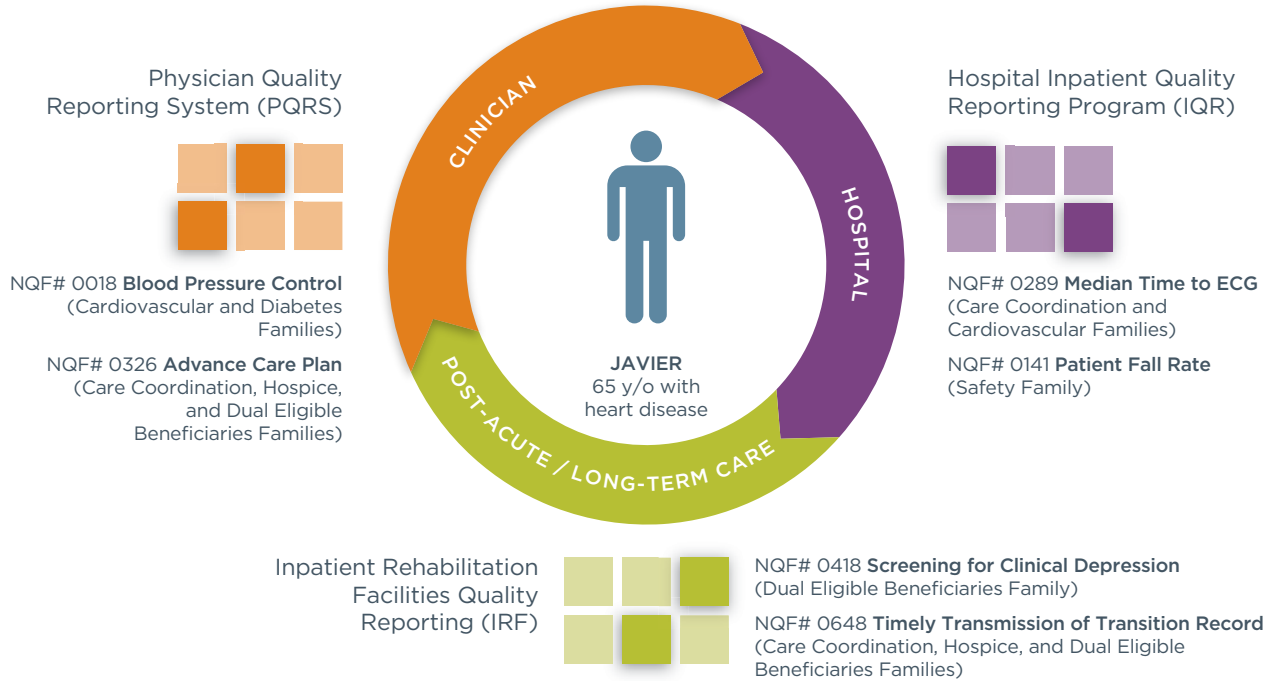


Figure G2 below demonstrates how families of measures and core measure sets relate to patients as they interact with the healthcare system. The dark colored boxes represent measures that are relevant to patients' underlying conditions or aspects of care received as they interact with

the system. Additionally, federal performance measurement programs, and illustrative measures from the families and core measures sets, are also depicted, further highlighting the relevancy and importance of encouraging the use of these measure constructs.

**FIGURE G2. PERSON-CENTERED MEASUREMENT USING FAMILIES OF MEASURES, CORE MEASURE SETS, AND SETTING-SPECIFIC FEDERAL PROGRAMS**



**Measure gaps** have been identified across all MAP reports. When reviewing program measure sets, MAP re-evaluated the previously identified gaps, noting where gaps persisted.

Table G1 below illustrates how MAP’s prior work served as an input to MAP’s pre-rulemaking deliberations.



**TABLE G1. USING MAP’S PRIOR WORK IN PRE-RULEMAKING**

MAP’s Prior Efforts	Pre-Rulemaking Use
Coordination Strategies (i.e., Safety, Clinician, PAC-LTC, Dual Eligible Beneficiaries Cross-Cutting Input)	<ul style="list-style-type: none"> <li>• Provided setting-specific considerations that served as background information for MAP’s pre-rulemaking deliberations.</li> <li>• Key recommendations from each coordination strategy were compiled in background materials.</li> </ul>
Families of Measures NQS priorities (safety, care coordination) Vulnerable populations (dual eligible beneficiaries, hospice) High-impact conditions (cardiovascular, diabetes, cancer)	<ul style="list-style-type: none"> <li>• Represented a starting place for identifying the highest-leverage opportunities for addressing performance gaps within a particular content area.</li> <li>• Setting- and level-of-analysis-specific core sets were compiled, drawn from the families and population cores. Core measures were flagged in the individual measure information.</li> <li>• MAP compared the setting and level-of-analysis cores against the program measure sets.</li> </ul>
2012 Pre-Rulemaking Decisions	<ul style="list-style-type: none"> <li>• Provided historical context and represented a starting place for pre-rulemaking discussions.</li> <li>• Prior MAP decisions were noted in the individual measure information.</li> </ul>
Gaps Identified Across All MAP Efforts	<ul style="list-style-type: none"> <li>• Provided historical context of MAP gap identification activities.</li> <li>• Served as a foundation for measure gap prioritization.</li> <li>• A universal list of MAP’s previously identified gaps was compiled and provided in background materials.</li> </ul>

## 2. Use of MAP Measure Selection Criteria and Additional Information to Evaluate Currently Finalized Program Measure Sets

The Measure Selection Criteria (MSC) is intended to facilitate structured discussion and decision-making processes. Additionally, the MSC assist MAP members in identifying measures that will accelerate improvement and achieve desired impacts of better care, affordable care, and healthy people/communities—the NQS aims. For example, criteria #5 and #6 help drive toward outcomes, an indicator of impact, by emphasizing outcome measures or process measures most proximal to outcomes and by highlighting measures that assess care across patient-focused episodes of care. Similarly, criteria #3 and #7 seek to address impact by ensuring the inclusion

of measures that address conditions that have high burden and high cost to patients and the system and measures that address known disparities in health care. Criterion #1 seeks to include NQF-endorsed measures, which have been evaluated for importance (i.e., measures that are evidence-based, address a performance gap, are high-impact), while criterion #2 seeks to include measures that address NQS priorities that have been determined to be high-impact based on evidence and multi-stakeholder input. Finally, criteria #4 and #8 seek to reduce the burden of measure reporting.

In the second year of pre-rulemaking input, MAP used the MSC in a more purposeful way. Table G2 below identifies inputs available to MAP to evaluate program measure sets against the MSC.

**TABLE G2. INFORMATION AVAILABLE TO EVALUATE PROGRAMS AGAINST THE MAP MEASURE SELECTION CRITERIA**

Measure Selection Criterion	Inputs Available to MAP
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	NQF endorsement status was noted for each measure, along with links to additional measure details via NQF's Quality Positioning System (QPS)
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	Provided for each individual measure MAP discussion determined adequacy of each program measure set
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Provided for each individual measure MAP discussion determined adequacy of each program measure set
4. Program measure set promotes alignment with specific program attributes as well as alignment across programs	For each program, a 1-page program summary was provided including: <ul style="list-style-type: none"> <li>• Statutory requirements</li> <li>• Program goals provided by CMS</li> <li>• Additional information provided in federal rules</li> <li>• MAP's prior key recommendations regarding the program</li> </ul> For individual measures, the following information was also provided: <ul style="list-style-type: none"> <li>• MAP decision history (e.g., supported/not supported, included in a family of measures)</li> <li>• Measure use in private sector initiatives (where available)</li> <li>• Measure use in public programs (where available)</li> </ul>
5. Program measure set includes an appropriate mix of measure types	Type provided for each individual measure MAP discussion determined if the mix of measure types is appropriate for each program
6. Program measure set enables measurement across the person-centered episode of care	Provided for each individual measure, based upon the principles in the NQF-endorsed Patient-focused Episode of Care model MAP discussion determined if the program measure set spanned the episode of care
7. Program measure set includes considerations for healthcare disparities	Provided for each individual measure, based upon NQF's Disparities Consensus Development Project MAP discussion determined the adequacy for each program
8. Program measure set promotes parsimony	Parsimony will be evaluated through MAP discussion for each program

Using the available inputs, MAP evaluated each finalized program measure set against the MAP Measure Selection Criteria and identified:

- Gaps—implementation gaps (core measures not in the set) and other gaps (e.g., development, endorsement) along the measure lifecycle
- Potential measures for inclusion (e.g., from core sets, newly endorsed measures)
- Potential measures for removal
- Additional programmatic considerations (e.g., guidance on implementing MAP recommendations, data collection and transmission, attribution methods)

### 3. Evaluate Individual Measures Under Consideration

The evaluation of each finalized program measure set served as a starting point for reviewing the measures under consideration. Next, MAP determined whether the measures under consideration enhanced the program measure sets. As in step 2, MAP members used the MSC as a guide for considering if measures will accelerate improvement and achieve desired impacts. For each measure under consideration, MAP indicated a decision and rationale as well as noted any additional comments or considerations. Table G3 below lists MAP’s decision categories and rationale.

**TABLE G3. MAP DECISION CATEGORIES AND RATIONALE**

MAP Decision (Standardized Options)	MAP Rationale (Standardized Options)	MAP Findings (Open Text)
Support	<ul style="list-style-type: none"> <li>• NQF-endorsed measure</li> <li>• Addresses a NQS priority not adequately addressed in the program measure set</li> <li>• Addresses a high-impact condition not adequately addressed in the program measure set (Note: for PAC/LTC high-impact condition will be replaced with PAC/LTC core concept)</li> <li>• Promotes alignment across programs, settings, and public and private sector efforts</li> <li>• Addresses specific program attributes</li> <li>• Addresses a measure type not adequately represented in the program measure set</li> <li>• Enables measurement across the person-centered episode of care</li> <li>• Addresses healthcare disparities</li> <li>• Promotes parsimony</li> <li>• Addresses a high-leverage opportunity for dual eligible beneficiaries</li> <li>• Core measure not currently included in the program measure set</li> <li>• Addresses a high-volume diagnosis or procedure</li> <li>• New specifications are improvement over the existing finalized measure</li> </ul>	<p><i>MAP findings will highlight additional considerations raised by the group.</i></p>

TABLE G3. MAP DECISION CATEGORIES AND RATIONALE (continued)

MAP Decision (Standardized Options)	MAP Rationale (Standardized Options)	MAP Findings (Open Text)
Support Direction	<ul style="list-style-type: none"> <li>• Not ready for implementation; measure concept is promising but requires modification or further development</li> <li>• Not ready for implementation; should be submitted for and receive NQF endorsement</li> <li>• Not ready for implementation; data sources do not align with program's data sources</li> <li>• Not ready for implementation; more experience with the measure is needed</li> <li>• Not ready for implementation; concerns regarding feasibility of data collection</li> </ul>	<p><i>MAP findings will include suggestions for modifications to measures/measure concept, or indicate that the measure is not currently endorsed for the program's setting.</i></p>
Phased Removal	<ul style="list-style-type: none"> <li>• NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)</li> <li>• NQF endorsement retired (the measure is no longer maintained by the steward)</li> <li>• NQF endorsement placed in reserve status (performance on this measure is topped out)</li> <li>• A 'supported' measure under consideration addresses a similar topic and better addresses the needs of the program promotes alignment</li> <li>• Measure requires modification or further development</li> <li>• Performance on this measure is likely topped out</li> </ul>	<p><i>MAP findings will indicate the timing of removal.</i></p>
Do Not Support	<ul style="list-style-type: none"> <li>• Measure does not adequately address any current needs of the program</li> <li>• A finalized measure addresses a similar topic and better addresses the needs of the program</li> <li>• A supported measure under consideration addresses as similar topic and better addresses the needs of the program</li> <li>• NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)</li> <li>• NQF endorsement retired (the measure is no longer maintained by the steward)</li> <li>• NQF endorsement placed in reserve status (performance on this measure is topped out)</li> <li>• Measure previously submitted for endorsement and was not endorsed</li> <li>• Measure has not been submitted for NQF endorsement</li> <li>• More experience with the measure is needed</li> </ul>	<p><i>MAP findings will refer to the finalized or supported measure under consideration that is preferred.</i></p>
Insufficient Information	<ul style="list-style-type: none"> <li>• MAP has insufficient information (e.g., specifications, measure testing, measure use) to evaluate the measure</li> </ul>	

Measure recommendation descriptions:

- **Support** indicates measures for immediate inclusion in the program measure set, or for continued inclusion in the program measure set in the case of measures that have previously been finalized for the program.
- **Support Direction** indicates measures, measure concepts, or measure ideas that should be phased into the program measure set over time, after specific issues are addressed.
- **Phased Removal** indicates measures that should be phased out of the program measure set.
- **Do Not Support** indicates measures or measure concepts that are not recommended for

inclusion in the program measure set.

- **Insufficient information** indicates measures, measure concepts, or measure ideas for which MAP does not have sufficient information (e.g., measure description, numerator or denominator specifications, exclusions) to determine what recommendation to make.

#### 4. Identify High-Priority Measure Gaps

MAP continued to identify gaps within each program, and provided measure ideas to spur development. MAP also considered the gaps across settings, prioritizing by importance and feasibility of addressing the gap when possible.

**TABLE G4. FEDERAL PROGRAMS REVIEWED FOR PRE-RULEMAKING AND CORRESPONDING MAP WORKGROUP**

Federal Program	Measures Under Consideration	Workgroup
Ambulatory Surgical Center Quality Reporting	5	PAC/LTC
End Stage Renal Disease Quality Improvement Program	21	PAC/LTC
Home Health Quality Reporting	2	PAC/LTC
Hospice Quality Reporting	7	Hospital
Hospital-Acquired Condition Payment Reduction (ACA 3008)	25	Hospital
Hospital Inpatient Quality Reporting	20	Hospital
Hospital Outpatient Quality Reporting	7	Hospital
Hospital Readmission Reduction Program	6	Hospital
Hospital Value-Based Purchasing	17	Hospital
Inpatient Psychiatric Facility Quality Reporting	5	Hospital
Inpatient Rehabilitation Facility Quality Reporting	10	PAC/LTC
Long-Term Care Hospital Quality Reporting	29	PAC/LTC
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	2	Clinician
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	1	Hospital
Medicare Physician Quality Reporting System (PQRS)	281	Clinician
Medicare Shared Savings Program	0	Clinician, Hospital
Nursing Home Quality Initiative and Nursing Home Compare Measures	5	PAC/LTC
Physician Compare/Physician Feedback/Value-Based Modifier Program	50	Clinician
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	19	Hospital

## ENDNOTES

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1 Institute of Medicine. Priority Areas for National Action: Transforming Health Care Quality. Available at: <http://iom.edu/Reports/2003/Priority-Areas-for-National-Action-Transforming-Health-Care-Quality.aspx>. Last accessed August 2012.

## APPENDIX H: Clinician Workgroup's Guiding Principles for Applying Measures to Clinician Programs

The MAP Clinician Workgroup developed these principles to serve as guidance for applying performance measures to specific clinician measurement programs. The principles are not absolute rules; rather, they are meant to guide measure selection decisions. The principles are intended to complement program-specific statutory and regulatory requirements and the MAP Measure Selection Criteria. These principles will inform future revisions to the MAP Measure Selection Criteria.

### Physician Quality Reporting System (PQRS)

- For endorsed measures, whether currently finalized or under consideration:
  - Include NQF-endorsed measures relevant to clinician reporting to encourage engagement (the endorsement process addresses harmonization of competing measures)
- For measures that are not endorsed:
  - Measures currently finalized for the program:
    - » Remove measures that have had endorsement removed or have been submitted for endorsement and were not endorsed
    - » Remove measures that are in endorsement reserve status (i.e., topped out), unless the measures are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures
  - Include measures under consideration that are fully specified and that:

- » Support alignment (e.g., measures used in MOC programs, registries)
- » Are outcome measures that are not already addressed by outcome measures included in the program
- » Are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures
- Measures selected for the program that are not NQF-endorsed should be submitted for endorsement

### Physician Compare

- NQF-endorsed measures are preferred for public reporting programs over measures that are not endorsed or are in reserve status (i.e., topped out); measures that are not NQF-endorsed should be submitted for endorsement or removed
- Include measures that focus on outcomes and are meaningful to consumers (i.e., have face validity) and purchasers
- Focus on patient experience, patient-reported outcomes (e.g., functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care measures
- To generate a comprehensive picture of quality, measure results should be aggregated (e.g., composite measures), with drill-down capability for specific measure results

### Value-Based Payment Modifier (VBPM)

- NQF-endorsed measures are strongly preferred for pay-for-performance programs; measures

that are not NQF-endorsed should be submitted for endorsement or removed

- Include measures that have been reported in a national program for at least one year (e.g., PQRS) and ideally can be linked with particular cost or resource use measures to capture value
- Focus on outcomes, composites, process measures that are proximal to outcomes, appropriate care (e.g., overuse), and care coordination measures (measures included in the MAP Families of Measures generally reflect these characteristics)
- Monitor for unintended consequences to vulnerable populations (e.g., through stratification)

### Medicare and Medicaid EHR Incentive Program for Eligible Professionals (Meaningful Use)

- Include endorsed measures, whether currently finalized for the program or under consideration, that have eMeasure specifications available (the endorsement process addresses issues of harmonization and competing measures)
- Over time, as health IT becomes more effective and interoperable, focus on:
  - Measures that reflect efficiency in data collection and reporting through the use of health IT

- Measures that leverage health IT capabilities (e.g., measures that require data from multiple settings/providers, patient-reported data, or connectivity across platforms to be fully operational)
- Innovative measures made possible by the use of health IT

### General Considerations

- Work toward a core set of measures that all clinicians, regardless of specialty, can report across all programs. The core set should focus on patient experience and engagement, patient-reported outcomes, other outcomes, care coordination, appropriate care, and population health (e.g., health risk assessment, prevention).
- To promote parsimony and alignment, the same measures should serve multiple programs, where possible (e.g., Meaningful Use and PQRS; Medicare Shared Savings and Medicare Advantage).
- Measures should be tested at the appropriate level of analysis (e.g., individual, group, system) before inclusion in public reporting or payment programs. PQRS can serve as a mechanism for testing measures.



## APPENDIX I: Hospital Workgroup's Guiding Principles for Applying Measures to Hospital Programs

The MAP Hospital Workgroup developed these principles to serve as guidance for applying performance measures to specific hospital measurement programs. The principles are not absolute rules; rather, they are meant to guide measure selection decisions. The principles are intended to complement program-specific statutory and regulatory requirements and the MAP Measure Selection Criteria. These principles will inform future revisions to the MAP Measure Selection Criteria.

### Pay for Reporting

#### Inpatient Quality Reporting Program

- Gain experience collecting and publicly reporting measures, prior to application in pay-for-performance programs, unless compelling evidence suggests a measure should be applied to a pay-for-performance program more rapidly
- Particularly salient points from the MAP Measure Selection Criteria:
  - NQF-endorsed measures are preferred over measures that are not endorsed or are in reserve status (i.e., topped out); measures that are not NQF-endorsed should be submitted for endorsement or removed
  - Include measures that are meaningful to consumers, purchasers, and providers to fulfill the program's public reporting purpose
  - To minimize burden and confusion, keep the program measure set parsimonious, focusing on measures that address the NQS priorities and high-impact conditions

### Pay for Performance

#### Hospital Value-Based Purchasing Program

- Include measures that address areas of variation in quality with opportunities for improvement
- Certain measures are more appropriate for the Hospital Value-Based Purchasing program than for payment adjustment programs without an improvement component:
  - Topics where hospitals are earlier in their improvement efforts
  - There is evidence of potential unintended consequences; include balancing measures when unintended consequences are anticipated
  - Benchmark for the topic is yet to be determined—may not be zero
- Particularly salient points from the MAP Measure Selection Criteria:
  - NQF-endorsed measures are strongly preferred for pay-for-performance programs; measures that are not NQF-endorsed should be submitted for endorsement or removed
  - Include outcome measures, ideally linked with cost measures to capture value
  - To avoid diluting the incentive, keep the program measure set parsimonious, focusing on areas of performance that need improvement or are important to reward for high attainment

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## Readmission Reduction and HAC Payment Adjustment Programs

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- Include measures that address high incidence, severity, or cost areas where there is variation in quality with opportunities for improvement
- Consider potential unintended consequences related to overlapping incentives when applying measures to more than one pay-for-performance program (e.g., overuse of antibiotics to avoid any healthcare-acquired infection)
- Particularly salient points from the MAP Measure Selection Criteria:
  - NQF-endorsed measures are strongly preferred for pay-for-performance programs; measures that are not NQF-endorsed should be submitted for endorsement or removed
  - Include measures that address high-impact conditions
  - Include measures of preventable harm to fulfill the program’s purpose
  - Include measures that cross the patient-centered episode of care
- Particularly salient points from MAP’s prior Guidance for the Selection of Readmission Measures:
  - Readmission measures should be part of a suite of measures to promote a system of patient-centered care coordination
  - Readmission measures should exclude planned readmissions
  - Program implementers should consider stratifying readmission measures by factors such as race, gender, and socioeconomic status to enable fair comparisons

## General Considerations

- If a composite is selected for a program, then individual measures that are part of the composite should not be included in the program.
- Prior to application, measures under consideration for a program should be tested for reliability and validity with data from the relevant population.
- Program implementers should be sensitive to hospitals with low patient volumes when applying program structures and measure sets.
- Program implementers should monitor to identify and mitigate potential unintended consequences.

## APPENDIX J: Glossary

<b>AAD:</b> American Academy of Dermatology	<b>AMA:</b> American Medical Association
<b>AAECEE:</b> American Association of Eye and Ear Centers of Excellence	<b>AMGA:</b> American Medical Group Association
<b>AAHPM:</b> American Academy of Hospice and Palliative Medicine	<b>AMI:</b> Acute Myocardial Infarction
<b>AAMC:</b> Association of American Medical Colleges	<b>AMP:</b> Association for Molecular Pathology
<b>AAN:</b> American Academy of Neurology	<b>AMRPA:</b> American Medical Rehabilitation Providers Association
<b>AANS:</b> American Association of Neurological Surgeons	<b>ANA:</b> American Nurses Association
<b>AAO:</b> American Academy of Ophthalmology	<b>AOA:</b> American Optometric Association
<b>AAO-HNS:</b> American Academy of Otolaryngology-Head and Neck Surgery	<b>AOTA:</b> American Occupational Therapy Association
<b>AAPM&amp;R:</b> American Academy of Physical Medicine and Rehabilitation	<b>APC:</b> Association of Pathology Chairs
<b>ABIM:</b> American Board of Internal Medicine	<b>APIRE:</b> American Psychiatric Institute for Research and Education
<b>ABMS:</b> American Board of Medical Specialties	<b>ARN:</b> Association of Rehabilitation Nurses
<b>ABR:</b> American Board of Radiology	<b>ARRA:</b> American Recovery and Reinvestment Act
<b>ACA:</b> Affordable Care Act	<b>ASBMR:</b> American Society for Bone and Mineral Research
<b>ACC:</b> American College of Cardiology	<b>ASC:</b> Ambulatory Surgery Center
<b>ACCP:</b> American College of Chest Physicians	<b>ASC:</b> American Society of Cytopathology
<b>ACOs:</b> Accountable Care Organizations	<b>ASCP:</b> American Society for Clinical Pathology
<b>ACPE:</b> American College of Physician Executives	<b>ASCQC:</b> Ambulatory Surgery Centers Quality Collaboration
<b>ACR:</b> American College of Radiology	<b>ASCQR:</b> Ambulatory Surgical Center Quality Reporting
<b>ACR:</b> American College of Rheumatology	<b>ASCRS:</b> American Society of Cataract and Refractive Surgery
<b>ACS:</b> American College of Surgeons	<b>ASGE:</b> American Society for Gastrointestinal Endoscopy
<b>ADCC:</b> Alliance of Dedicated Cancer Centers	<b>ASHA:</b> American Speech-Language-Hearing Association
<b>AGA:</b> American Gastroenterological Association	<b>ASN:</b> American Society of Nephrology
<b>AHA:</b> American Hospital Association	<b>ASPEN:</b> American Society of Pediatric Nephrology
<b>AHCA:</b> American Health Care Association	<b>BRFSS:</b> Behavioral Risk Factor Surveillance System
<b>AHIP:</b> America's Health Insurance Plans	
<b>AHRQ:</b> Agency for Healthcare Research and Quality	

<b>BWH:</b> Brigham and Women's Hospital	<b>ESRD QIP:</b> End State Renal Disease Quality Improvement Program
<b>CABG:</b> Coronary Artery Bypass Graft	<b>FAH:</b> Federation of American Hospitals
<b>CAH:</b> Critical Access Hospital	<b>FFS:</b> Fee-For-Service
<b>CAHPS:</b> Consumer Assessment of Healthcare Providers and Systems	<b>FIN:</b> Finalized Measure
<b>CAP:</b> College of American Pathologists	<b>GNHYA:</b> Greater New York Hospital Association
<b>CAPC:</b> Center to Advance Palliative Care	<b>GSK:</b> GlaxoSmithKline
<b>CAUTI:</b> Catheter Associated Urinary Tract Infection	<b>HAC:</b> Healthcare-Acquired Condition
<b>CDC:</b> Centers for Disease Control and Prevention	<b>HANYS:</b> Healthcare Association of New York State Quality Institute
<b>CDP:</b> Consensus Development Project	<b>HCAHPS:</b> Hospital Consumer Assessment of Healthcare Providers and Systems
<b>CIED:</b> Cardiac Implantable Electronic Device	<b>HH:</b> Home Health
<b>CG-CAHPS:</b> Clinician/Group—Consumer Assessment of Healthcare Providers and Systems	<b>HHA:</b> Home Health Agency
<b>CHA:</b> California Hospital Association	<b>HHQR:</b> Home Health Quality Reporting
<b>CHA:</b> Children's Hospital Association	<b>HHS:</b> Department of Health and Human Services
<b>CHOP:</b> Children's Hospital of Philadelphia	<b>HIT:</b> Health Information Technology
<b>CLABSI:</b> Central Line-Associated Bloodstream Infection	<b>HITECH:</b> Health Information Technology for Economic and Clinical Health Act
<b>CMS:</b> Centers for Medicare & Medicaid Services	<b>HRS:</b> Heart Rhythm Society
<b>CNSC-Anderson:</b> Cardiopulmonary, Neurology, Sleep Center - Anderson Hospital	<b>HRSA:</b> Health Resources and Services Administration
<b>COA:</b> Central Ohio Anesthesia, Inc.	<b>HVBP:</b> Hospital Value-Based Purchasing
<b>COPD:</b> Chronic Obstructive Pulmonary Disease	<b>ICS:</b> Inpatient Consumer Survey
<b>CPDP:</b> Consumer-Purchaser Disclosure Project	<b>IHC:</b> Intermountain Healthcare
<b>CTM-3:</b> Three-Item Care Transitions Measure	<b>IOM:</b> Institute of Medicine
<b>CUSPP:</b> Consumers Union Safe Patient Project	<b>IPF:</b> Inpatient Psychiatric Facility
<b>Dartmouth:</b> Dartmouth College	<b>IPFQR:</b> Inpatient Psychiatric Facility Quality Reporting
<b>DRG:</b> Diagnosis-Related Group	<b>IPPS:</b> Inpatient Prospective Payment System
<b>DRMC:</b> DeKalb Regional Medical Center	<b>IQR:</b> Hospital Inpatient Quality Reporting
<b>DVT:</b> Deep Vein Thrombosis	<b>IRF:</b> Inpatient Rehabilitation Facility
<b>ED:</b> Emergency Department	<b>IRFQR:</b> Inpatient Rehabilitation Facility Quality Reporting
<b>EHR:</b> Electronic Health Record	<b>KCP:</b> Kidney Care Partners
<b>EOC:</b> Episode of Care	<b>LTC:</b> Long-Term Care
<b>ESRD:</b> End Stage Renal Disease	

<b>LTCH:</b> Long-Term Care Hospital	<b>NHANES:</b> National Health and Nutrition Examination Survey
<b>LTCHQR:</b> Long-Term Care Hospital Quality Reporting	<b>NHSN:</b> National Healthcare Safety Network
<b>LTSS:</b> Long-Term Supports and Services	<b>NOF:</b> National Osteoporosis Foundation
<b>MAME:</b> Mothers Against Medical Error	<b>NPP:</b> National Priorities Partnership
<b>MAP:</b> Measure Applications Partnership	<b>NQF:</b> National Quality Forum
<b>MDS:</b> Minimum Data Set	<b>NQS:</b> National Quality Strategy
<b>MEPS:</b> Medical Expenditure Panel Survey	<b>NSQIP:</b> National Surgical Quality Improvement Program
<b>MIPPA:</b> Medicare Improvements for Patients and Providers Act of 2009	<b>OASIS:</b> Outcome Assessment Information Set
<b>MITA:</b> Medical Imaging & Technology Alliance	<b>OBRA:</b> Omnibus Budget Reconciliation Act
<b>MMA:</b> Medicare Prescription Drug, Improvement, and Modernization Act of 2003	<b>OOSS:</b> Outpatient Ophthalmic Surgery Society
<b>MMSEA:</b> Medicare, Medicaid, and SCHIP Extension Act of 2008	<b>OPPS:</b> Outpatient Prospective Payment System
<b>MOC:</b> Maintenance of Certification	<b>OQR:</b> Hospital Outpatient Quality Reporting
<b>MRSA:</b> Methicillin-Resistant Staphylococcus aureus	<b>PAC:</b> Post-Acute Care
<b>MSC:</b> MAP Measure Selection Criteria	<b>PCH:</b> Prospective Payment System-Exempt Cancer Hospital
<b>MSKCC:</b> Memorial Sloan Kettering Cancer Center	<b>PCHQR:</b> Prospective Payment System-Exempt Cancer Hospital Quality Reporting
<b>MSSP:</b> Medicare Shared Saving Program	<b>PCPI:</b> AMA-convened Physician Consortium for Performance Improvement
<b>MU:</b> Meaningful Use	<b>PE:</b> Pulmonary Embolism
<b>MUC:</b> Measure Under Consideration	<b>PHS:</b> Partners HealthCare System
<b>MU-EP:</b> Medicare and Medicaid EHR Incentive Program for Eligible Professionals	<b>PPAHS:</b> Physician-Patient Alliance for Health & Safety
<b>MU-Hospitals:</b> Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	<b>PPS:</b> Prospective Payment System
<b>NAPHS:</b> National Association of Psychiatric Health Systems	<b>PQI:</b> Prevention Quality Indicator
<b>NBHA:</b> National Bone Health Alliance	<b>PQRS:</b> Physician Quality Reporting System
<b>NCHPC:</b> National Coalition for Hospice and Palliative Care	<b>PRO:</b> Patient-Reported Outcomes
<b>NCQA:</b> National Committee for Quality Assurance	<b>PSI:</b> Patient Safety Indicator
<b>NDNQI:</b> National Database of Nursing Quality Indicators	<b>QASC:</b> Quality Alliance Steering Committee
<b>NF:</b> Nursing Facilities	<b>QPS:</b> Quality Positioning System
<b>NH Compare:</b> Nursing Home Compare	<b>RPA:</b> Renal Physicians Association
<b>NH:</b> Nursing Home	<b>RU-CDP:</b> NQF's Cost and Resource Use Consensus Development Project
	<b>San Diego PSC:</b> San Diego Patient Safety Council

**SHM:** Society of Hospital Medicine

**SIR:** Standardized Infection Ratio

**SNF:** Skilled Nursing Facilities

**SSI:** Surgical Site Infection

**SSR:** Surgeon Specific Registry

**TJC:** The Joint Commission

**TPUSA:** Takeda Pharmaceuticals

**TRH:** Takoma Regional Hospital

**TRHCA:** 2006 Tax Relief and Healthcare Act

**UM Physicians:** University of Minnesota Physicians

**UT-MD Anderson:** University of Texas-MD Anderson Cancer Center

**VAE:** Ventilator-Associated Events

**VBPM:** Value-Based Payment Modifier

**VRE:** Vancomycin-Resistant Enterococci

**VTE:** Venous Thromboembolism

## APPENDIX K: Public Comments

### Section 1: Progress on Measure Alignment

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#### American Academy of Physical Medicine and Rehabilitation

##### Elliot Roth

The American Academy of Physical Medicine & Rehabilitation (AAPM&R) supports the initiatives for further alignment for high quality care for dual eligible beneficiaries. Psychiatrists often become involved as care team leaders after a patient suffers a traumatic or catastrophic event and provide and coordinate complex care across a care continuum. Psychiatrists support the MAP's strong focus on fostering and propagation of creative methods for engaging beneficiaries and their social support systems in person-centered, goal-directed care. AAPM&R applauds MAP's emphasis on filling identified measure gap areas including: shared accountability for care coordination through transitions, measurement of functional status, advanced care planning, mental/behavioral health, and structural measures as they apply to providers and health plans integrating with community organizations or other providers of long-term supports and services (LTSS). AAPM&R is especially committed to partnering on issues of care coordination across care settings and an increased focus on functional status as it is important to patients and their families and it can be a measure of healthcare effectiveness. The discussion of inclusion of disability status with socioeconomic, racial/ethnic, and other demographic factors is strongly supported by AAPM&R. The Academy supports the MAP recommendation to have "program implementers... explore appropriate risk adjustment and stratification methodologies to better understand the relationships between demographic factors and health outcomes."

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#### American Medical Rehabilitation Providers Association

##### Marsha Lommel

AMRPA believes that staff and patient immunization measures are process measures which carry unintended negative consequences and, therefore, do not align with the MAP's goal of improving outcomes. For example, a hospital chain in Indiana fired several staff that refused the vaccination for religious reasons. Further, vaccinations may not be appropriate for all patients. A measure designed to capture incidence of vaccination for illnesses such as the flu or pneumonia may unfairly penalize providers who determine that the patient's condition would be negatively affected by the administration of a vaccine. In addition, such measures do not align with the mission of inpatient rehabilitation, namely to improve patients' functional status so that they can return to their community. Also, it would not improve quality because vaccines are already required under many of the survey and certification processes required by the Medicare program and others. In the spirit of parsimony and to drive true quality improvement, we continue to recommend that the MAP and CMS consider other measures that allow inpatient rehabilitation providers to focus on their core mission.

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#### American Nurses Association

##### Maureen Dailey

ANA applauds the work of the MAP to identify a parsimonious list of measures to drive improvement, transparency, and value in health care. ANA believes that alignment between quality reporting and payment across care settings and programs and between private and public payors will facilitate achievement of the Triple Aim.

In addition to the measure selection criteria,

workgroups developed guiding principles to help inform the selection of measures. ANA recommends that the MAP integrate, to the degree that it is relevant to the program area, the guiding principles and measure selection criteria.

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### **America's Health Insurance Plans**

#### **Carmella Bocchino**

While we are supportive of the progress in measure alignment and the MAP families of measures and we have a broad set of comments that apply across these measurement areas. We encourage continued measure harmonization and development of a more parsimonious measure set where appropriate. Such a parsimonious measure set should be inclusive enough to address the quality of care delivered to poor and vulnerable populations. For example, we are pleased with the efforts undertaken by the measure developers to harmonize measures in the areas of medication reconciliation and readmissions and encourage similar harmonization efforts moving forward. Families of measures selected and recommended by the MAP should minimize reporting burden, which can be accomplished by developing a prioritized set of metrics from the MAP families of measure areas and by better alignment of public and private-sector measurement efforts. It is critical to ensure consistency in measurement across different settings in order to support the patient experience across the care continuum. Such consistency can help reduce the measurement burden and confusion to users of these measures. It is important to develop and implement metrics that measure the quality of care delivered to patients with multiple co-morbid conditions. Emphasis should be placed on selecting outcomes measures, as opposed to process metrics, and the use of composite measures until outcome measures are developed/endorsed.

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### **AmeriHealth Mercy Family of Companies**

#### **Thomas James**

AmeriHealth Mercy Family of Companies appreciates the work of the MAP. This report does draw together well much of the work of the MAP over the past year. But it also demonstrates the need measures where there may be multiple comorbidities and individual patient preference placing different priorities. With

such complexities then conflict may arise among the measures.

The last line of the section (Page 9) indicates that "program implementers should explore appropriate risk adjustment." Such a statement should be amended to include consistent use of a standardized risk adjustment tool by all entities using these measures.

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### **Association of American Medical Colleges**

#### **Jennifer Faerberg**

The AAMC is very supportive of alignment of measures between programs. During the MAP deliberations however, there was one obvious omission being alignment with MU measures. The AAMC continues to call for the measure cycles to be modified in order to make the review of the MU measures more relevant. At this point that is not occurring and the inconsistency is having significant impact on providers. A comment was made during the Coordinating Committee meeting that maybe the MU measures should not even be included in the MAP review process. The AAMC believes this would be a major misstep and would miss an important opportunity to truly get at alignment across programs as a stated CMS/HHS goal.

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### **California Hospital Association**

#### **Alyssa Keefe**

Add Value by Charting the Pathway for Alignment: CHA appreciates the progress of the MAP in improving the alignment of quality reporting efforts across programs this year. One important area where the MAP can bring additional value going forward is in the intersection of the clinical quality measure reporting required for Meaningful Use and the requirements of the traditional hospital and physician quality reporting programs. CHA is disappointed with the level of discussion regarding this critically important intersection and urges the MAP to take on this charge in 2013. More specifically we would urge MAP to lay out guiding principles for meaningful use clinical quality measurement and to strategically align them with both the measure selection criteria and the newly created principles. The MAP can play a critically important role in working with CMS and



ONC on a shared vision and pathway to meeting our broad goals of alignment across ALL programs so that the objectives of reducing data collection burden and measurement parsimony can be fully realized in the years to come.

Reflect on Past and Future MAP Recommendations: CHA continues to be concerned regarding the silo nature of the measurement recommendations and its ability to impact change. This is likely due in part to how the measures are presented to the MAP by CMS and then processed by the workgroups. CHA believes the growing lists of measure gaps and priorities must be more narrowly defined so that we can move strategically in meeting the goals of the National Quality Strategy. CHA urges the Coordinating Committee in consultation with the Workgroups and CMS to undertake an exercise that reflects on the past two years of recommendations with the goal of accelerating change by refining and prioritizing a narrow set of strategic measurement priorities. More specifically, the MAP should revisit the 2012 measures under consideration with the 2013 measures and organize the list by condition or another category like infections rather than by Medicare program. Then add the current status of the measure (current in the program, slated for a future year etc.) and its MAP recommendation. The MAP should then further narrow and prioritize its recommendations to accelerate a common set of measure priorities across all the programs taking into consideration the newly created guiding principles that will only help to shape program implementation and drive performance improvement.

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### **Children's Hospital Association**

#### **Ellen Schwalenstocker**

The Children's Hospital Association believes that the MAP has made considerable progress on measure alignment and that the family of measures approach is useful in supporting such alignment. The Association agrees with the concept of expanding experience with care tools across settings and notes that pediatric-specific tools should be included wherever appropriate. At the same time, while expanding the use of these measures is important and desirable, the point that this approach will not dramatically shift the number of measures (p. 5) is

incomplete. Collection of the data through survey tools will still be needed. We believe that exploration of other methods (e.g., on-line surveys) may be beneficial.

Although not an issue for pediatric care (particularly inpatient care) - where there are considerable gaps in measures - the number of measure topics included in some programs seems challenging. The Association believes that measures should be tested for use in any program they are recommended for.

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### **Consumer-Purchaser Disclosure Project**

#### **Tanya Alters**

The last sentence in this section states the following "Program implementers should explore appropriate risk adjustment and stratification methodologies to better understand the relationships between demographic factors and health outcomes. We certainly agree that all consumers, regardless of RELGD status should receive the highest quality care, but we are concerned that this statement could be interpreted as NQF/MAP opening the door to including SES in risk adjustment methodologies which we do not believe was the consensus of the MAP. We ask for clarification on this in the final report.

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### **GlaxoSmithKline**

#### **Deborah Fritz**

GSK supports the 2013 MAP Pre-Rulemaking Report and commends MAP for its work to improve outcomes in high-leverage areas for patients and their families and to align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement. We also support MAP's goals of informing consumer choice, and enabling purchasers and payers to buy on value, accelerating improvement, enhance system efficiency, and reducing provider data collection burden.

GSK strongly supports the use of evidence-based measures that are NQF endorsed and that can improve longer-term patient outcomes. We also commend the MAP for suggesting that current measures be revised and tested, as needed, for the populations served by CMS programs.

To enhance the impact of this work to improve patient outcomes, GSK strongly recommends MAP add further emphasis on measure that address coordination of care, including comprehensive medication management; cultural competency; appropriate immunizations; and management of chronic co morbidities.

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### **Greater New York Hospital Association**

#### **Lorraine Ryan**

Numerous, redundant, overlapping, inconsistent, and impractical measures compromise the goals of HHS' regulatory programs. GNYHA urges MAP to continue to encourage HHS to harmonize its specifications for measures across programs to avoid inefficiencies and confusion. For MAP to urge HHS to align core measures and meaningful use measures with a single specification manual, rather than the existing multiple manuals (e.g. core measures manual, the Health Information Technology Standards Panel (HITSP) manual, and individual core measure vendors' e-specifications manuals). When reviewing measures for consideration, we urge HHS to consider the practical feasibility of implementing measures within a hospital setting. Measure testing, including a test of what hospital resources might be required to capture data points and abstract measures should, also be strongly considered before approving a measure. GNYHA urges MAP to emphasize with HHS' avoiding duplication and inconsistencies across policy programs, specifically so hospitals are not penalized multiple times for performance on the same measure, and for HHS to be mindful of conflicting scores being assigned for the same performance in different programs. These types of inconsistencies undermine the overarching goals of quality policy and detract from quality improvement work in hospitals. For MAP to carefully review HHS' use of measures, and make sure that the measure is used in the same manner the measure was endorsed and intended for by NQF. For MAP to apply the American Hospital Association (AHA)'s logical sequence of actions for implementing measures, described in Item #4 on pages 3 and 4 of AHA's comment letter to the MAP report. Electronic reporting adds to the challenges faced by hospitals in collecting and reporting quality measures. GNYHA recommends that HHS should consider any electronically specified version of a measure

(e-measure) a "new" measure and have that measure be put through the same endorsement process applied to the non-electronic health record version of the measure. This should include evaluating whether there is agreement between the electronic specifications with current clinical guidelines, the accuracy of the electronic specifications, and the feasibility of electronic data collection through field-testing the measure. GNYHA urges MAP to reinforce the importance of electronic measure validity with HHS as part of their consideration of quality measures for the Electronic Health Record (EHR) Incentive Program, as well as a potential move to electronic submission of measures for other HHS programs.

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### **PhRMA**

#### **Jennifer Van Meter**

PhRMA supports the MAP's progress in aligning measures across the healthcare delivery system and the various federal reporting programs. This alignment is key to making advances in quality improvement and being able to demonstrate improvements system-wide; goals must be complementary, rather than contradictory, in order to achieve improvement. Further, alignment is important in the drive toward a high-value, parsimonious measure set that can evaluate the care being provided to beneficiaries in the federal programs. We believe that the creation and use of families of measures will aid in this endeavor.

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### **Takeda Pharmaceuticals**

#### **Deborah Walter**

Takeda Pharmaceuticals America, Inc. and Lundbeck LLC recognize the work of the Measures Application Partnership (MAP) Dual Eligible Beneficiaries Workgroup and agree that mental health is a key area where performance measurement could improve the quality of healthcare. Depression is a highly burdensome condition with economic consequences estimated at \$83 billion per year in the United States.[1] Depression often occurs alongside other psychiatric and medical co-morbidities and frequently requires the support of a network of caregivers, including primary care practitioners, specialists, nurses, hospital providers, as well as

nursing home providers or social workers, among others. Due to the complexity of this condition and the fact that it is frequently diagnosed in the primary care setting but may be managed elsewhere, care coordination is extremely important. This is particularly true for the dual eligible population, for whom care is often disjointed. In 2009, the National Quality Forum (NQF) and the Centers for Medicare & Medicaid Services (CMS) identified major depressive disorder as a top 20 high-impact Medicare condition, accounting for 95 percent of Medicare costs. As such, we agree that NQF 0418, “Screening for Clinical Depression” (developed by CMS), should be a core measure to promote the proper screening and diagnosis of depression among the 9 million patients who make up the dual eligible population. This measure also calls for documentation of a follow-up plan, which may

help ensure follow-up care for beneficiaries. Our companies are committed to improving the quality of life for patients with depression, and we further agree that a key measurement gap area for this high-impact, high-burden population includes more effective measurement of functional status and coordination through transitions. Care coordination for patients with depression should be supported through follow-up assessments to monitor their co-morbidities, response to treatment, and changes in functional status, which would enable providers to evaluate patient outcomes and adjust treatment as necessary. CMS’ Medicaid health homes include care coordination as a basic principle and may be an effective delivery system for improved outcomes on mental health measures such as NQF measure 0418 “Screening for Clinical Depression.”

## Section 2: Affordability

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### American Academy of Physical Medicine and Rehabilitation

#### Elliot Roth

The American Academy of Physical Medicine & Rehabilitation (AAPM&R) supports the MAP objective of developing an Affordability Family of Measures to promote alignment of measures. Clearly this mandated objective of many of the ACA programs has been a critical measure gap. Setting standard definitions for Resource Use and Efficiency is applauded, and this will promote standard unit analysis to go beyond what is charged for care. This will require significant exploration of risk-adjustment for medically complex patient groups and attribution methodologies to align across populations. The AAPM&R would encourage factors such as return to home and community activities and return to school or work, for example, to be included in cost algorithms as these critical measures are being developed. The financial burden on caregivers would also be an important patient- and family-centered measure. The Academy would advocate for looking at affordability across the care continuum as opposed to focusing on acute episodes of care only.

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### American Nurses Association

#### Maureen Dailey

ANA strongly supports a focus on affordability measures as a topic for one of the 2013 MAP Task Forces. ANA agrees that measures of system efficiency, or resource use (RU), should occur in the context of quality. The MAP astutely suggested assessing resource use in relation to the five IOM quality care aims (i.e., safety, equity, patient-centeredness, effectiveness, and timeliness) in order to ensure care value. ANA urges broad stakeholder representation, including nursing, on this task force and all the MAP Task Forces. ANA suggests that the MAP consider appropriate members, such as nurse members of CMS TEPs, as having valuable expertise that may not be on current MAP groups. This will help to ensure a balance of task force representation. The NQF RU-Steering Committee roster is another source of appropriate task force members to promote integration across NQF quality activities.

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### American Optometric Association

#### Kara Webb

The AOA appreciates the MAP effort to develop an Affordability Family of Measures to promote alignment of measurement efforts. The MAP’s

intention to look to the private sector for models regarding measurement of cost and resource use is prudent.

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### **America's Health Insurance Plans**

#### **Carmella Bocchino**

We appreciate MAP's efforts to develop an Affordability Family of Measures to promote alignment of measurement efforts and we are supportive of cost and resource use measurement to assess the value of health care services provided to patients.

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### **AmeriHealth Mercy Family of Companies**

#### **Thomas James**

AmeriHealth Mercy Family of Companies appreciates the balance of priorities within this section. We are supportive of this section.

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### **Children's Hospital Association**

#### **Ellen Schwalenstocker**

The development of an affordability family of measures is important and methodologically complex. It will be critically important that these measures incorporate both cost and quality. Additionally, affordability measures should consider long-term costs and benefits of care. The Children's Hospital Association strongly supports the need to consider individuals with multiple chronic conditions in the development of affordability measures as well as to consider how condition-specific measures address (or do not address) multiple chronic conditions.

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### **Consumer-Purchaser Disclosure Project**

#### **Tanya Alteras**

The report states the following "emerging methods of assessing resource use for patients with multiple chronic conditions may include methods for rolling up procedural episodes into acute episodes, or acute episodes into chronic episodes, to gain a better understanding of the total cost for a patient. MAP requests that the RU-CDP Steering Committee consider how condition-specific measures address multiple chronic conditions when evaluating

measures for endorsement." We strongly recommend that in order to assess efficiency, resource use also be linked to functional status measures for specific conditions.

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### **GlaxoSmithKline**

#### **Deborah Fritz**

In alignment with the National Quality Strategy, GSK agrees with MAP that cost and affordability are important cross-cutting measurement areas that can be addressed through measures such as overuse, appropriateness, resource use, and efficiency. We support the development of an Affordability Family of Measures to promote alignment of measurement efforts. GSK strongly supports: (1) further development of cost and resource use measures; (2) reporting paired cost/resource use measures with quality measures, rather than reporting them separately, in order to reflect value and reduce misinterpretation that could negatively impact patient care and outcomes; (3) measures focused on the care of the whole patient, as opposed to one specific condition to help ensure that improvements made in one aspect of the care are not achieved at the sacrifice of something else.

Efficiency and relative resource use (RRU) measures play an important role in gauging the impact of treatment and services to the healthcare system. GSK supports the use of measures that apply an appropriate risk-adjustment methodology, are episode-based, and focus on all aspects of patient care, versus siloed costs or utilization measures. GSK believes RRU measures are one of the best examples of appropriate efficiency measures. Furthermore, episode-based relative resource use measures may be a better measure of efficiency in patient care than cost or utilization measures, because they reflect patient care across settings and encourage care coordination. GSK believes that reporting utilization rates alone perpetuates and rewards component management by encouraging physicians to reduce utilization rates at a point-in-time rather than considering what may reduce utilization over the entire episode of patient care. For this reason, reporting utilization rates alone is also not meaningful in assessing plan performance, patient care or appropriate decision-making. Therefore, GSK

believes measures of successful patient management including episode-based relative resource use measures are better predictors of quality and plan performance.

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### **Greater New York Hospital Association**

#### **Lorraine Ryan**

Hospitals are also concerned about the financial impact for not complying with the measures tied to these policy programs. A shift from pay-for-reporting to pay-for-performance programs is of great concern to hospitals as their ability to comply accurately with complex reporting requirements and specifications, along with their performance on specific measures, now impacts payments received and penalties incurred. Since these measures have financial implications, appropriate measure selection is critical to ensuring that hospital performance is accurately reflected, and unnecessary burdens are not placed on hospitals to report on these measures.

#### **GNYHA Recommendations**

GNYHA urges MAP to continue maintaining measure and program integrity through their rigorous process of vetting each and every measure in pay-for-performance programs, but at the same time, be continuously mindful that hospitals have a great deal at stake in participating in each of these regulatory programs. GNYHA also urges MAP to recommend to NQF to carefully review and study measurement burden. This was also recommended by the AHA in order to better understand the labor, time, costs, and barriers hospitals need to allot for quality measurement.

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### **Pfizer**

#### **Eleanor Perfetto**

The MAP Pre-Rulemaking Report states that, “NQF supports using and reporting resource use measures in the context of quality performance, preferably outcomes measures. Using resource use measures independent of quality measures does not provide an accurate assessment of efficiency or value and may lead to adverse unintended consequences.” The

report also highlights the importance of ensuring resource-use and efficiency measures are patient centered to address patient concerns and avoid unintentionally compromising patient care.

Pfizer supports these statements regarding selection and use of resource use/cost measures. Use and presentation of resource-use measures alone (without quality measures) can inappropriately incentivize cost reduction at the expense of care quality. Thus, Pfizer recommends continued refinement and appropriate application and presentation of these measures to provide context for accurate interpretation.

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### **PhRMA**

#### **Jennifer Van Meter**

The MAP Pre-rulemaking Report states that “NQF supports using and reporting resource use measures in the context of quality performance, preferably outcomes measures. Using resource use measures independent of quality measures does not provide an accurate assessment of efficiency or value and may lead to adverse unintended consequences.” PhRMA supports these statements and we encourage MAP to follow NQF’s lead regarding the selection and use of resource use/ cost measures. To that end, continued development and refinement of these measures is necessary to ensure that a proper linkage between quality and resource use measures is made. Additionally, resource use/ cost measures and their paired quality measures should be endorsed by a multi-stakeholder, consensus-based organization like NQF before they are implemented to ensure that they meet the rigorous criteria and scrutiny required of such measures.

We also note that cost/resource use measures are not the same as affordability. Many other factors are involved with affordability, including benefit design, which is not reflected in cost or resource use measures. Rather, we are collectively attempting to demonstrate and evaluate value in achieving targeted health outcomes.

## Section 3: Measure Gaps

### American Academy of Hospice and Palliative Medicine

#### Dale Lupu

The American Academy of Hospice and Palliative Care (AAHPM) concurs with the gaps identified. We suggest supplementing the list under Advanced Illness Care to note gaps in: Assessment, management and follow-up of psychosocial burden of illness and treatment-Assessment, management and follow-up of spiritual needs-Provision of family caregiver support, including bereavement support if applicable-Appropriate and timely access to palliative care-Appropriate and timely referral to hospice care- Patient and/or caregiver experience of care from perspective of palliative care (symptom burden, psychosocial and spiritual concerns) and/or hospice care, including end of life period if applicable. As noted in the MAP report on Hospice and Palliative Care, several of the gaps above (e.g., spiritual counseling, shared decision making) are hampered by lack of evidence needed to develop quality measures. MAP suggested using structural and process measures while research and evidence continues to build. We reiterate the call for funding and resources to build the evidence in the domains of psychosocial and spiritual care to elucidate the association of psychosocial and spiritual domains with outcomes important to patients. Under Advanced Illness Care, we question the inclusion of “nutrition” as a high priority symptom. Issues around nutritional support that have been identified in the literature do not belong under the concept of “symptoms” and would more appropriately be placed under the concepts of matching patient goals and overuse. For instance, the high rate of use of total parenteral nutrition in late stage cancers is common but is not associated with improved survival, is associated with increased risk of infection, sepsis and hospitalization, and routinely prevents patients from being at home. A measure about appropriate use of TPN would belong in the overuse category, not the high priority symptom category. Under “Affordability” we suggest that “Avoiding unnecessary end-of-life care” be renamed “avoiding end-of-life care inconsistent with patient values” Regarding patient and caregiver experience of care,

we note that many of the current CAHPS surveys systematically miss patients who have died or are too ill to respond. Therefore, even when CAHPS includes questions relevant to serious illness and palliative care, it provides little information on the actual performance of institutions in regard to these patients. In particular, a supplementary module to HCAHPS is needed in order to gather information on the experience of these sickest patients and their end of life experience. Models for such surveys are available (CARE, the Bereaved Family Survey, and the Family Experience of Hospice Care) and should be incorporated as supplementary modules into the CAHPS family of surveys, especially for hospitals, LTCH, and nursing homes.

### American Academy of Physical Medicine and Rehabilitation

#### Elliot Roth

The American Academy of Physical Medicine & Rehabilitation (AAPM&R) applauds the initiatives to highlight high-priority measure gaps and collaborate for gap-filling. Despite the large number of performance measures that have been developed, very few are applicable to physiatry. Process measures that focus only on biometrics are not frequently applicable to the many patient populations seen by physiatrists or to measure the effectiveness of the interventions they utilize in their practices. In addition, while there may be measurement sets applicable to various settings of rehabilitative care, there is no generally accepted or universally applicable outcome measure or measures for disability or functional status that have been nationally endorsed for quality incentive reimbursement. There remains a critical lack of outcome measures that can be used to longitudinally measure functional status across care settings and within diagnostic groups. Measures for patients with complex conditions with multiple co-morbidities continue to be lacking as presently these patients fall into exception categories. Measures for patients with disabilities have not been fully developed or tested. As such, unlike many other physicians who are held to diagnostic-specific quality measures or

process measures related to a diagnosis, physiatrists concentrate on improving functional outcomes within populations with a wide degree of inter- and intra-patient group variability. This poses a unique challenge to the field, i.e., to choose or to create meaningful and specific quality measures for both the physicians providing the care and that reflect the outcomes of care important to patients with disabling conditions caused by many different diagnoses. In summary, the majority of performance measures to date are process-focused, whereas the primary focus of the practice of physiatry is improving each patient's unique functional status. Measures that would capture these outcomes of care significantly impact overall health of patients and potentially have huge societal impacts.

AAPM&R does commend the MAP for further defining the measure development process and implementation gaps, while focusing on reducing measure burden.

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### **American Medical Rehabilitation Providers Association**

#### **Marsha Lommel**

At this time there are many gaps in quality measurement for inpatient rehabilitation and no appropriate NQF endorsed measures available to fill them. However, AMRPA believes that measures addressing health-related quality of care, healthy living, patient engagement, goal attainment, patient sense of control/autonomy, care coordination, cost and access to care, medication, falls, pain, person-centered communication, shared decision-making and care planning between clinician and patient, and affordability should be target areas for quality improvement for rehabilitation.

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### **American Nurses Association**

#### **Maureen Dailey**

ANA strongly supports the creation of a virtual "measure incubator" as an excellent strategy to bring together stakeholders interested in filling priority measure gaps, such as safety, care coordination and patient engagement. ANA agrees with the MAP's support of the NQF shifting from a role of referee to coach in order to stimulate development and testing

of high priority measures.

A key stakeholder group the MAP identified for NQF to engage with is measure developers. ANA requests that the MAP collaborate with and seek input from the National Database of Nursing Quality Indicators (NDNQI) to advance this incubator work. The NDNQI is involved in innovative measure work to advance patient safety outcomes to the state of the science.

The MAP has identified the need for broad participation of stakeholders to accelerate progress on the "next generation" of measures, including team-based measures and eMeasures. ANA considers care planning to be a key area for team-based measures. ANA agrees with the NQF Critical Paths Care Coordination TEP's recognition of the need to advance interoperable, patient-centered longitudinal care planning through meaningful use of HIT by the interprofessional teams within settings and transitional care. ANA stands ready to contribute to more robust measure concepts for care coordination, including transitional care in 2013. To support this discussion, ANA is convening a Professional Issues Panel focused on care coordination measurement in 2013.

ANA acknowledges the limited NQF resources to convene numerous MAP Task Forces in 2013. However, the continued work of the NQF Care Coordination Steering Committee slated for 2013 should continue to inform the MAP's ongoing work and to advise HHS on more robust measures of care coordination.

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### **American Optometric Association**

#### **Kara Webb**

The MAP noted that efforts to close measurement gap areas are beginning to bear fruit, but more work is still needed. The MAP notes that collaborating with stakeholders will assist in the effort to address measurement gap areas. The AOA stands ready to assist NQF with this effort.

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### **American Society for Bone and Mineral Research**

#### **Douglas Fesler**

ASBMR believes that patients with osteoporosis or low bone mass and at risk for fracture would greatly

benefit from enhanced osteoporosis measures that would lead to greater coordination of care and improved quality care and health outcomes while reducing cost. ASBMR is pleased that MAP recognizes the need for evaluating bone density, and prevention and treatment of osteoporosis in ambulatory settings as care gaps under the NQF priority Prevention and Treatment for the Leading Causes of Mortality.

In 2012, CMS enhanced the prominence of osteoporosis quality measurement and reporting within the Physician Quality Reporting System (PQRS) by adding a measure group and composite measure, but more can be done to create incentives and opportunities that enhance the tracking and reporting of patient activities related to osteoporosis and fractures that improve post-fracture care. Additionally, the Joint Commission has recently developed evidence-based osteoporosis performance measures for both in-patient and out-patient populations that NQF and HHS could consider as an additional way to enhance post-fracture care.

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### **America's Health Insurance Plans**

#### **Carmella Bocchino**

We are supportive of the concept of a measure incubator that would focus developers on high-priority gap areas and we recommend development of measures that assess multiple co-morbid conditions such as cardiovascular care and diabetes. More specifically, care coordination measures that are not disease focused should be developed to assess the care patients are receiving at a system level. We also support next generation measures including those derived from registries.

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### **AmeriHealth Mercy Family of Companies**

#### **Thomas James**

AmeriHealth Mercy Family of Companies recognizes the need for identification of gaps and finding ways to fill them. This may not come easily without deploying a large number of measures, which would create greater burden. However the report calls for "support for next generation measures" There should be discussion at NQF and at the MAP of measures derived from registries or even from the social

sciences as ways of getting to identification of gaps on a larger, more holistic basis.

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### **AMGEN Inc.**

#### **Sharon Isonaka**

Amgen supports the ongoing efforts of the National Quality Forum (NQF) Measure Application Partnership (MAP) to address priority measure gaps that have previously been identified by the MAP. The NQF MAP identified complications (such as febrile neutropenia) as a measure gap for cancer in the NQF MAP June 2012 report for a Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals and restated this gap in Appendix F to the January 2013 Pre-Rulemaking Report. Amgen would like to reiterate our prior comments to the NQF and to CMS and ask that both organizations advance the development of a measure that addresses the risk and prevention of febrile neutropenia in cancer patients undergoing myelosuppressive chemotherapy.

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### **Center to Advance Palliative Care**

#### **Diane Meier**

\*Note on language: the Gap report refers to Advanced Illness Care. CAPC strongly prefers to use the term Serious Illness. The concern is that if you wait until an illness is "advanced"--an unspecific time that many providers may not recognize--you may miss the opportunity to provide quality symptom management and comfort when it is needed.

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### **Center to Advance Palliative Care**

#### **Diane Meier**

The Center to Advance Palliative Care (CAPC) concurs with the gaps identified. We suggest supplementing the list under Advanced Illness Care\* to note gaps in:-Assessment, management and follow-up of psychosocial burden of illness and treatment-Assessment, management and follow-up of spiritual needs-Provision of family caregiver support, including bereavement support if applicable-Appropriate and timely access to palliative care-Appropriate and timely referral to hospice care- Patient and/or caregiver experience of care from perspective of palliative care (symptom burden,



psychosocial and spiritual concerns) and/or hospice care, including end of life period if applicable. We note that to fill gaps in measurement in the domains of psychosocial and spiritual care, the field still needs significant additional research to elucidate the association of psychosocial and spiritual domains with outcomes important to patients. We need a much better understanding of how psychosocial and spiritual care impacts outcomes in order to develop appropriate measures in the areas of spirituality and psychosocial needs. Under Advanced Illness\* Care, we question the inclusion of “nutrition” as a high priority symptom. While there are a number of issues around nutritional support that have been identified in the literature, we do not see these as belonging under the concept of “symptoms.” Issues around nutritional support belong under the concepts of matching patient goals and overuse. For instance, the high rate of use of total parenteral nutrition in late stage cancers is common but is not associated with improved survival, is associated with increased risk of infection, sepsis and hospitalization, and routinely prevents patients from being at home. A measure about appropriate use of TPN would belong in the overuse category, not the high priority symptom category. Under “Affordability” we suggest that “Avoiding unnecessary end-of-life care” be renamed “avoiding end-of-life care inconsistent with patient values” Regarding patient and caregiver experience of care, we note that many of the current CAHPS surveys systematically miss patients who have died or are too ill to respond. Therefore, even when CAHPS includes questions relevant to advanced illness and palliative care, it provides little information on the actual performance of institutions in regard to these patients. A supplementary module to HCAHPS is needed in order to gather information on the experience of these sickest patients and their end of life experience. Models for such surveys are available (CARE, the Bereaved Family Survey, and the Family Experience of Hospice Care) and should be incorporated as supplementary modules into the HCAHPS family of surveys, especially for hospitals, LTCH, and nursing homes.

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### Children’s Hospital Association

#### Ellen Schwalenstocker

The Children’s Hospital Association appreciates the

specific mention of children in describing areas with insufficient coverage (p. 14). The Pediatric Quality Measurement Program (PQMP) Centers of Excellence established through the Children’s Health Insurance Program Reauthorization Act is the first national investment in the development of pediatric measures, and we are optimistic that the work coming out of the PQMP Centers as well as other initiatives will help to close this gap. The Association would be very happy to work with the National Quality Forum and the MAP in identifying and evaluating measures that are appropriate, meaningful and useful for infants, children and adolescents. With this in mind, we believe that some of the approaches for gap-filling (e.g., measure incubator) suggested in the report are promising and useful.

The synthesized list of measure gaps (Appendix F) is a very useful document, and we encourage the MAP and the NQF to continually monitor and adapt this list. In addition, we suggest that it would be helpful to expand some areas (e.g., person-centered communication, healthy living). Consideration should be given to the pediatric population throughout the gap areas, and we suggest that “person-centered” be expanded to “person/family-centered”. The Association respectfully suggests that the list of “child health conditions and risks” (Appendix D, p. 196) be revisited in terms of impact. Unlike in adult settings, condition-specific approaches are more limited in the pediatric population as relatively few patients may suffer from any single condition. We suggest that children with special health care needs and chronic and complex conditions be included as important priorities on this list.

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### Consumer-Purchaser Disclosure Project

#### Tanya Alters

We urge MAP to expand on this section of the report and provide either more granular detail on what the measurement gaps are, and/or provide a link to previous reports that describe the measure gaps. Those who may be reading this report as their first foray into MAP’s work will not have the actionable information that they may need to help NQF and MAP deliver on this initiative. In addition, we are concerned with the first sentence in this section that states “The first major recommendation derived from

the Gaps Report emphasizes using existing measures wisely.” We feel that the language that follows, regarding implementation gaps, is very relevant here yet it goes unstated. Using existing measures wisely won’t be productive if the measures we have are not up to the task. Later in this section there is a discussion of all the concerns raised by the MAP related to the challenges of filling measure gaps. However, the concern that was raised by several MAP members regarding the need for a better business case for measure development is not reflected here, and we ask that the final report include this concern.

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### **GlaxoSmithKline**

#### **Deborah Fritz**

GSK agrees that more existing measures be used and agrees with the gaps identified regarding outcome measures; populations; and specialty areas. In addition, GSK strongly recommends that MAP incorporate COPD, asthma and Comprehensive Medication Management (CMM) measures.

Chronic obstructive pulmonary disease (COPD) is the fifth most common reason for hospitalization of Americans over 65 and the third-leading cause of death. COPD is associated with increases in healthcare resource utilization and spending. GSK recommends including the following existing measures:

0091: COPD: spirometry evaluation (AMA-PCPI)

0102: COPD: inhaled bronchodilator therapy (AMA-PCPI)

0577: Use of spirometry testing in the assessment and diagnosis of COPD (NCQA)

1825: COPD - management of poorly controlled COPD (ActiveHealth Management)

0028: Tobacco Use Assessment and Tobacco Cessation Intervention

0577: Use of Spirometry Testing in the Assessment and Diagnosis of COPD

0549: Pharmacotherapy Management of COPD Exacerbation

New COPD measures should address the co-morbidities COPD patients usually present

including heart failure, pneumonia, osteoporosis, respiratory infection, myocardial infarction, angina, fractures and glaucoma, depression and/or anxiety and increased risk of diabetes among women with COPD.

GSK strongly recommends use of NQF#1800 “Asthma Medication Ratio (NCQA)” to identify patients whose asthma is not in control. The ratio measure is best measure of asthma control among the measures.

Comprehensive Medication Management (CMM) is essential to coordinated care and patient outcomes. CMM ensures each patient’s medications (prescription, nonprescription, alternative, traditional, vitamins, and nutritional supplements) are individually assessed to determine the medication is appropriate, effective for the medical condition, safe given the comorbidities and other medications being taken, and the patient is able and willing to take the medicine as intended. GSK recommends development and use of a comprehensive set of CMM measures to assure patients reach clinical goals of therapy, particularly patients with chronic diseases or at risk for readmission. GSK strongly supports the inclusion of PQRS measure #46, Medication Reconciliation as a part of CMM. GSK also recommends development of measures based on the guidelines of practice and documentation for CMM by the Patient-Centered Primary Care Collaborative (PCPCC).

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### **Greater New York Hospital Association**

#### **Lorraine Ryan**

Appropriate data stratification is important in protecting vulnerable populations. GNYHA is encouraged by MAP’s acknowledgment that adjustments to data through stratification are important in protecting vulnerable populations. GNYHA has strongly advocated for controlling for socioeconomic risk factors. In fact, in its comments to last year’s Pre-Rulemaking Report, GNYHA expressed deep concern that Medicare performance-based payment systems would increase health disparities by disproportionately cutting payments to hospitals and other providers primarily serving communities disadvantaged by poverty and cultural/linguistic diversity. GNYHA is pleased to see that MAP

recognizes this important issue and included it in its recommendations to HHS.

GNHYHA Recommendation: MAP should strengthen its language and support for inclusion of balancing measures; risk stratification related to race, gender, and socioeconomic status; or another appropriate methodology in hospital performance measurement programs, including the Hospital Readmission Reduction Program.

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### **Mindways Software, Inc.**

#### **Alan Brett**

Mindways believes that patients with osteoporosis or low bone mass who are at risk for fracture would greatly benefit from enhanced osteoporosis measures. These measures would lead to greater coordination of care and improved health outcomes while reducing cost. Mindways is pleased that MAP recognizes the need for bone mineral density testing, and prevention and treatment of osteoporosis in ambulatory settings as care gaps under the NQF priority Prevention and Treatment for the Leading Causes of Mortality.

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### **National Bone Health Alliance**

#### **Beatriz Duque Long**

NBHA believes that patients with osteoporosis or low bone mass and at risk for fracture would greatly benefit from enhanced osteoporosis measures that would lead to greater coordination of care and improved quality care and health outcomes while reducing cost. NBHA is pleased that MAP recognizes the need for evaluating bone density, and prevention and treatment of osteoporosis in ambulatory settings as care gaps under the NQF priority Prevention and Treatment for the Leading Causes of Mortality.

NQF has highlighted osteoporosis as one of the 20 medical conditions identified by the Centers for Medicare & Medicaid Services (CMS) that together impose “heavy health burdens on patients and account for over 95 percent of Medicare’s costs” and are currently challenged with important quality measurement gaps ([www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=26140](http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=26140); accessed August 13, 2012.) The MAP draft report once again highlights the heavy burden

osteoporosis and fractures represent for the Medicare population by listing hip and pelvic fracture (11) and osteoporosis (18) as high impact Medicare conditions.

In 2010, osteoporosis was the ninth ranked major illness among the top 5 percent highest cost Medicare beneficiaries (12 percent of all beneficiaries and 18 percent of high costs beneficiaries – ref: Gawande A. Slide referencing 2010 data from Centers for Medicare & Medicaid Services, presented at Care Innovations Summit, January 26, 2012, Renaissance Hotel, Washington, DC) and osteoporotic fractures are estimated to cost the Medicare system \$22 billion annually (ref: Burge R, et al. Incidence and economic burden of osteoporosis-related fractures in the United States, 2005–2025. *Journal of Bone and Mineral Research* 2007, 22: 465–475).

In 2012, CMS enhanced the prominence of osteoporosis quality measurement and reporting within the Physician Quality Reporting System (PQRS) by adding a measure group and composite measure, but more can be done to create incentives and opportunities that enhance the tracking and reporting of patient activities related to osteoporosis and fractures that improve post-fracture care. Additionally, the Joint Commission has recently developed evidence-based osteoporosis performance measures for both in-patient and out-patient populations that NQF and HHS could consider as an additional way to enhance post-fracture care.

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## PhRMA

### Jennifer Van Meter

PhRMA supports the recommendations outlined about measure gaps. We agree that while existing measures must be used wisely, progress on the next generation of measures must be made quickly. In order to do that, collaborations between stakeholders, including the pharmaceutical industry, must be stronger. For example, patient-reported outcomes measures are noted as an example of the next generation of measures. Research-based pharmaceutical companies employ patient-reported outcomes measures in clinical trials and thus have

extensive experience with these types of measures. This type of expertise should be tapped within a measure development collaboration. PhRMA appreciates the leadership of NQF in the quality arena. NQF's role as coordinator for filling measure gaps flows naturally from the work it already does. We support NQF in this role. In addition to the gaps identified by the MAP, we point out a number of others: Measures to evaluate multiple co-morbidities; weight management/ obesity, including counseling on multi-component interventions, including behavioral and pharmacological therapies; cognitive impairment/ dementia; Multiple sclerosis; Epilepsy; Depression, particularly in the areas of daily functioning and productivity, residual symptoms, side effects, and care coordination; Primary non-adherence to medications; Prescription abandonment; Outcome measures for many specialties as the value-based payment modifier program is implemented.

We also suggest development of a family of measures related to comprehensive medication management that could include measures about primary non-adherence, prescription abandonment, secondary adherence, medication safety, medication reconciliation, and other medication management activities.

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## Renal Physicians Association

### Robert Blaser

RPA believes the MAP should expand the list of measure gaps to include MEDREC, transition in care, inclusive of coordination of care, measures covering comorbid conditions (e.g., depression, CAH, HAI) and patient engagement metrics.

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## Takeda Pharmaceuticals

### Deborah Walter

Takeda Pharmaceuticals America, Inc. and Lundbeck LLC have undertaken significant work to identify all publically available measures in the field of depression, with a specific focus on major depressive disorder, and to monitor developments in the quality landscape for this condition. Through our assessment, we have identified measurement gaps around patient experience, daily functioning and productivity,

residual symptoms, side effects, and care coordination. We appreciate the efforts of measure developers to fill gaps in these areas but also recognize the limitations regarding implementation of measures in this space. Increased stakeholder collaboration would benefit measure developers as they seek to develop and refine meaningful measures that are also feasible to implement. Our companies understand the need to reduce data collection and reporting burdens, and appreciate the effort to minimize duplicative measure development through information sharing and harmonization. We support

MAP's emphasis on improved collaboration through partnerships between stakeholders who are focused on gaps and involved in the measure development process. We are similarly committed to advancing measure development, use, and other meaningful collaborations among stakeholders in this area. We will continue to monitor and support measure development around the NQF-identified gap areas in behavioral health and mental illness, particularly the development of varied measure types (e.g., outcome, composite) around care coordination and person/family-centered care.

## Section 4: Pre-Rulemaking Input on System Performance Measurement Programs

### American Academy of Physical Medicine and Rehabilitation

#### Elliot Roth

The American Academy of Physical Medicine & Rehabilitation (AAPM&R) supports MAP's recommendation that system-level measure sets align with the measures used for setting-specific performance measurement programs to leverage measurement data, decrease provider data collection burden, and align care delivery goals across programs. The Academy is in support of enhancing the Medicare Shared Savings Plan to include additional acute and post-acute care measures, and measures more relevant to patients with complex medical needs. To make the most impact, patient outcomes should be the focus of these system performance measures, as opposed to process measures. The AAPM&R also is in support of MAP's recommendation that from a program implementation perspective, longer time periods for calculating costs and cost-savings could strengthen the shared savings incentive programs.

### American Medical Group Association

#### Karen Ferguson

#### Quality Measurement and Improvement Activities

AMGA believes that quality measurement and improvement activities are essential in the provision of a patient-centered approach to measuring performance that can be assessed across settings,

and we agree that alignment to the extent possible will improve efficiency and reduce the burden to health care providers. Further, AMGA envisions that such activities would include preventive care and chronic disease management programs for targeted groups of patients; ongoing patient outreach programs to improve the health of those populations; participation in continuous learning, such as collaboratives, where medical groups can learn from one another; benchmarking activities; use of research such as applied data analytics to validate clinical processes and outcomes data to determine effectiveness; external reporting and transparent internal reporting on clinical outcomes, variability, and timely performance improvements; and the conduct of patient experience surveys.

#### Care Coordination

The high-performing health system will utilize a team-based approach that supports collaboration and communication among the patient, physician, and the licensed or certified medical professionals who are working at the top of their field to improve their patients' well-being. This would entail a single plan of care across health care settings and across health care providers who furnish care to the patient. Another important feature is shared decision-making, which is a true collaboration between the patient and the health care provider that empowers the patient in the decision-making process and provides the patient with objective information concerning (1) the risk or seriousness of their disease or condition

to be prevented or treated; (2) available treatment alternatives; and (3) the costs and benefits of available treatment alternatives.

#### Use of Information Technology and Evidence-Based Medicine

A high-performing health system will meaningfully use interoperable information technology, scientific evidence where it exists, and comparative analytics to aid in clinical decision-making and improve patient safety; help monitor patients and track preventive services; and aid in the prescribing of prescriptions drugs in order to improve safety.

**Compensation Practices That Promote the Above-Listed Objectives** The high-performing health system uses compensation structures that provide incentives to physicians and licensed and certified medical professionals to improve the health and outcomes of patient populations. Such practices could include patient experience surveys; and quality metrics such as chronic disease measures and compliance with prevention strategies within a patient population.

**Accountability** Ultimately, the high-performing health system will assume shared financial and regulatory responsibility and accountability for successfully managing the per-capita cost of health care, improving the overall patient experience, and improving the health of their respective populations.

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### American Nurses Association

#### Maureen Dailey

ANA applauds the MAP's consideration of measures of "systemness" related to cross cutting measures, such as patient-centered care, and measures to evaluate the care of populations requiring complex care within settings and in critical transitions. ANA also agrees that measurement burden should be minimized through efficient use of HIT across systems, and alignment of measures (e.g., definitions) whenever feasible to prevent stakeholder confusion. Robust care coordination measures are needed for primary care, particularly as they relate to ACOs and patient-centered health homes, in order to move beyond closing referral loops to addressing transitional care gaps. Aligning longitudinal measures and measures of avoidable care (e.g., emergent care) with shared accountability across care settings is needed to promote systems characterized by

patient-centered care coordination. ANA views the integration of patient-reported outcomes and patient-centered outcomes informed by PCORI as essential to assess healthcare systems. Patient-reported outcomes such as assessment and screening measures should be team-based with shared accountability and attribution to provider. Assessment and screening is a prime area for interprofessional teams to improve performance across systems through enabling practice to the top of the license, scope and competency for all team members. This will promote a system that reduces assessment and screening gaps and improves timely access to evidence-based, cost effective care. For example, depression screening and timely treatment is a major quality gap that must be closed to reduce care disparities and identify critical barriers to patient self-care, particularly in populations with multiple chronic conditions requiring complex care. ANA agrees with the MAP's suggestion to add acute and PAC/LTC measures to the MSSP. Given the program set has heavy emphasis on ambulatory measures, this will allow for better assessment of care gaps in the complex, vulnerable populations, such as the dual eligible. ANA also agrees that there should be a move beyond assessment and screening measures to include outcome measures, taking caution to include the right balance of structural, process, and outcome measures that will advance the NQS goals.

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### American Society for Bone and Mineral Research

#### Douglas Fesler

ASBMR supports performance measures that encourage post-fracture diagnosis, treatment and coordination of care because these are critical to ensure that individuals who suffer a fracture have the best opportunity to avoid a subsequent fracture and the complications that can lead to a diminished quality of life as well as increased morbidity, mortality and healthcare costs. ASBMR is pleased that the MAP draft report identifies two osteoporosis measures that are currently part of the Medicare Advantage 5 Star Quality Rating System for inclusion in the Medicare Shared Savings Program in support of measure alignment across federal programs: Osteoporosis Management in Women 67 or Older Who Had a Fracture and Osteoporosis Testing in Older Women. Making these osteoporosis measures

part of the MSSP would greatly enhance coordination of care for post-fracture patients as well as measure alignment across programs could encourage greater reporting on these measures.

ASBMR encourages both MAP and HHS to consider an additional NQF-endorsed measures more directly linked to care coordination during the rulemaking process: Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older. This measure addresses the need for follow up care for both men and women who fracture, as well as highlights the need for post-fracture care in patients starting by age 50, the age at which these fractures become signs of osteoporosis and not just accidents.

Fractures that occur in adults age 50 and above are often a sign of osteoporosis, yet nearly 80 percent of female Medicare beneficiaries who suffer a fracture do not currently receive appropriate follow-up care like bone density testing and/or treatment (ref: National Committee for Quality Assurance. NCQA 2011 benchmarks and thresholds, [www.ncqa.org/tabid/123/Default.aspx](http://www.ncqa.org/tabid/123/Default.aspx); accessed August 13, 2012.). Prior fracture is one of the biggest risk factors for future fracture, and given that up to 50 percent of osteoporosis-related repeat fractures in older adults can be prevented with appropriate treatment, the inclusion of measures that direct clinicians to perform and report on post-fracture care would ensure greater clinician awareness and appreciation for proactive patient management in the post-fracture care setting and improved health outcomes (Black DM, et al. Randomized trial of effect of alendronate on risk of fracture in women with existing vertebral fractures. Fracture Intervention Trial Research Group. Lancet 1996 Dec 7; 348 (9041), 1535-41).

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## America's Health Insurance Plans

### Carmella Bocchino

We are supportive of MAP's recommendation of system-level measurement for a truly patient-centric approach to measurement. We recommend that future measures in this area be closely aligned with the National Quality Strategy (NQS) goals of better care, healthy people and healthy communities, and affordable care. By leveraging these goals, measures can be developed and deployed that are

not limited to a point-of-care perspective, but are oriented toward longitudinal data collected across time and settings that promote patient-centered measurement. We are also supportive of alignment of the Medicare Shared Savings Program and Medicare Advantage Stars.

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## AmeriHealth Mercy Family of Companies

### Thomas James

AmeriHealth Mercy Family of Companies that the report recognizes the conflicting incentives through measurement of different quality metrics, which diverts energy and resources. For example there is discussion on the recommendations for alignment of MSSP (ACOs) and Medicare Advantage Stars. Such alignment of incentive metrics are very appropriate and should be done.

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## Center to Advance Palliative Care

### Emily Warner

The Center to Advance Palliative Care supports these measures. Italics shows suggested additional comments for further development:

0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment - expand measure beyond hospice patients

0647 Transition Record with Specified Elements Received by Discharged Patients - we particularly note with approval the inclusion of the Advance Care Plan as an element of the transition record

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

1625 Hospitalized Patients who Die an Expected Death with an ICD that has been deactivated

1626 Patients Admitted to ICU who Have Care Preferences Documented

1634 Hospice and Palliative Care: Pain Screening - expand measure beyond hospice patients

1637 Hospice and Palliative Care: Pain Assessment - expand measure beyond hospice patients

1638 Hospice and Palliative Care: Dyspnea Treatment - expand measure beyond hospice patients

1641 Hospice and Palliative Care: Treatment Preferences - expand measure beyond hospice and specialty palliative care patients

1626 Patients Admitted to ICU who Have Care Preferences Documented

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### **Genentech**

#### **Vanessa Reddy**

Genentech supports the MAP recommendation of measure O576 (Follow-up After Hospitalization for Mental Illness) for the use in the Medicare Shared Savings Program. This measure is highly relevant to the improvement of care coordination and patient health outcomes for patients with mental illness. The break in treatment due to a loss in follow-up after inpatient treatment has long been recognized as a significant issue in the care of patients with mental illness. Increased scrutiny and improved accountability for service providers will result in improvements for patient care and wellbeing, as well as benefits to patient families and the health care system.

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### **Mindways Software, Inc.**

#### **Alan Brett**

Mindways supports performance measures that encourage post-fracture bone mineral density testing, diagnosis, treatment and coordination of care because these are critical to ensure that individuals who suffer a fracture have the best opportunity to avoid a subsequent fracture and the complications that can lead to a diminished quality of life as well as increased morbidity, mortality and healthcare costs.

Mindways encourages both MAP and HHS to consider an additional NQF-endorsed measures more directly linked to care coordination during the rulemaking process: Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older. This measure addresses the need for follow up care for both men and women who fracture, as well as highlights the need for post-fracture care in patients starting by age 50, the age at which these fractures become signs of osteoporosis as fragility fractures and not simply accidents.

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### **National Bone Health Alliance**

#### **Beatriz Duque Long**

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## The Joint Commission

### Margaret VanAmringe

#### NQF Endorsement Across Programs

The Joint Commission appreciates the MAP's efforts to promote harmonization of measures across multiple programs and care settings. However, we believe that the MAP should not recommend a measure to DHHS for a setting beyond its NQF endorsement. It is not acceptable to expand the use of a measure to a new venue for which it has not received NQF endorsement without further evaluation, because each measure has been specified and tested for a particular setting, and thus its validity and reliability may not translate to use in an alternate setting. Alignment is, however, a very important goal, especially across setting using a similar metric. And, as discussed at the MAP, attention needs to be paid to assure alignment even within the same care setting. For example, it is not reasonable to apply a hospital measure differently across programs; subjecting hospitals to inconsistent rules, weighting, or performance benchmarks that can also cause confusion to the public viewing such results. "Topped Out" Measures It is important to consider the issue of potential measure retirement (and the criteria for such retirement) in the context of a broad, more comprehensive future vision for performance measurement. We do not believe that a topped out measure in and of itself is a sufficient criterion for retirement for all programs. Excellent (accountability) measures should not automatically be retired because they are topped out. Rather, the

measure should remain available for use in at least some fashion. This is important because there is a risk of degradation of performance for those highly scientific measures that we know are related to improved patient outcomes. We certainly should not remove them altogether from the national portfolio and/or replace them with measures less likely to bring about positive patient care improvements. There is a definite lack of experience as to the consequences of retiring excellent measures and the potential for resultant unintended consequences.

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### The Joint Commission

#### Margaret VanAmringe

Currently there is a paucity of research as to the consequences of retiring excellent measures. Therefore, we would recommend before removing any measures, other than for scientific reasons and/or clear patient safety issues, that a demonstration project be undertaken to ascertain the impact of measure removal and the ability for organizations

to sustain improvement over time for measures that are not part of a mandatory reporting program. In addition, the demonstration project could address the concept of potentially cycling measures in and out, but not retiring them. Through the goals of meaningful use, quality data derived directly from the clinical care documentation, and interoperability should make it increasingly easy for ongoing data extraction. From a global quality measurement perspective, the continued monitoring would allow the ability to 'reactivate' a measure if desired for public reporting.

Because the primary aim of the public reporting program is to stimulate improvement that results in consistent excellence, eliminating measures on which hospitals have achieved high levels of performance sends the wrong message about improvement. The basis for the proposed exclusion of "topped-out" measures lies in the belief that their use is statistically insignificant in the differentiation of hospital performance scores, yet it appears that the assumption being made is.

## Section 5: Pre-Rulemaking Input on Clinician Performance Measurement Programs

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### American Academy of Dermatology

#### Daniel Siegel

Melanoma: Coordination of Care (M238)

Biopsy Follow-up (M1103)

Both of these measures were recommended by the MAP for phased removal from future CMS programs, as their respective NQF endorsement was removed in 2012. The AAD encourages the MAP to reconsider their call for removing these measures, as dermatologists have limited quality measures to report to the various reporting programs, such as the Physician Quality Reporting System (PQRS). It is important for all eligible professionals (EPs) to have the opportunity to report successfully, as programs such as PQRS and the Value Based Payment Modifier (VBPM) transition into a penalty phase. Approximately 850, 1,200, and 1,350 AAD member dermatologists reported on at least one of these two measures through the Academy's PQRS registry in 2010, 2011, and 2012, respectively.

Regarding M1103 in particular, it would be beneficial to continue the collection of data on this measure through the PQRS program. Longer term data would aid in the assessment of trends and the subsequent development of a more robust quality improvement effort.

Based on the loss of NQF endorsement for these two measures, the AAD has continued to work to develop additional measures, including M2591 and M2845 listed below. If the MAP maintains that M238 and M1103 be phased out of the federal reporting programs, the AAD urges the NQF to not do so until 2016, so that the AAD can work to develop additional measures to be submitted for possible inclusion in future reporting programs.

The AAD appreciates the opportunity to provide our comments. Please contact Alison Shippy, Senior Manager, Quality at (202) 712-2610 or AShippy@AAD.org if you require clarification on any of the above points or would like more information.

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## American Academy of Dermatology

### Daniel Siegel

Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier (M2951)

Cardiovascular Disease Risk Factor Assessment for Psoriasis Patients (M2845)

These two measures were not recommended for inclusion in the 2014 PQRS program. The AAD encourages the MAP to reconsider their decision to not support these measures, as dermatologists have limited quality measures to report to the various reporting programs. Additionally, based on various literature reviews and discussions among Psoriasis experts within the AAD, these two measures reflect important gaps in practice and knowledge within dermatology that should be evaluated and addressed. In response to M2951, the MAP notes that the measure is “not ready for implementation, and should be submitted for and receive NQF endorsement. This measure should be expanded to address tuberculosis prevention for anyone on a biological immune response modifier; it should not be limited to individuals with psoriasis and psoriatic arthritis.” While widespread tuberculosis prevention is of course important, this rationale is confusing. NQF recently endorsed a similar measure for a limited patient population. NQF Measure #0408, “HIV/AIDS: Tuberculosis (TB) Screening” had its endorsement renewed on January 7, 2013. This recent renewal stands in opposition to the MAP’s call for an expanded patient population. Psoriasis affects approximately 7.5 million Americans and this measure has the potential to positively impact those patients being treated on biological immune response modifiers by monitoring that their TB prevention is managed appropriately. In response to M2845, the MAP notes that the “measure does not adequately address any current needs of the program and that cardiovascular risk should be more broadly assessed and not limited to one condition.” Again, while overarching cardiovascular management is critical, there has been a knowledge gap noted among dermatologists who are unaware of the increased cardiovascular risks associated with psoriasis patients. Reporting of this measure in a federal program, like PQRS, presents an opportunity

to examine that gap and address improvement in practice.

The AAD appreciates the opportunity to provide our comments. Please contact Alison Shippy, Senior Manager, Quality at (202) 712-2610 or AShippy@AAD.org if you require clarification on any of the above points or would like more information.

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## American Academy of Dermatology

### Daniel Siegel

Melanoma Reporting (M2905)

This measure, submitted by the College of American Pathologists (CAP), was not recommended for inclusion in future CMS programs. The AAD urges NQF to consider this measure for inclusion, as very few dermatopathologists have measures that apply to their practices. It is imperative for all eligible professionals (EPs) to have the opportunity to report successfully, as programs such as PQRS and the VBPM transition into a penalty phase.

The AAD appreciates the opportunity to provide our comments. Please contact Alison Shippy, Senior Manager, Quality at (202) 712-2610 or AShippy@AAD.org if you require clarification on any of the above points or would like more information.

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## American Academy of Neurology

### Christopher Bever, MD

The American Academy of Neurology (AAN) is a national medical specialty society representing more than 25,000 neurologists and neuroscience professionals. The AAN is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system such as epilepsy, Parkinson’s disease, dementia, stroke, migraine, multiple sclerosis, and traumatic brain injury.

The AAN is committed to improving care of persons with neurological illness through formal quality improvement programs, has developed over two-hundred sets of evidence-based practice recommendations over the past twenty years, and has developed over fifty quality measures in the past five years. The AAN has participated in the American

Medical Association convened Physician Consortium for Performance Improvement®(PCPI) since its inception and has partnered with the PCPI to develop quality measures and has independently developed other measures. The AAN is a long standing member of the National Quality Forum (NQF).

The AAN agrees with the new NQF criteria and believes it is necessary to have standardized criteria for measure development. Our concern is the retrospective application of the new criteria to measures that were developed when no such criteria were established.

As early as 2006, the AAN recognized the need for physicians to develop clinical quality measures based on the evidence. As is widely known, for many specialty conditions there is a lack of high-quality evidence on patient outcomes. Yet, the AAN developed epilepsy, dementia and Parkinson's disease measures to help its members assess and improve the care of neurologic patients.

Until new measures for epilepsy, Parkinson's disease and dementia can be developed, we recommend that the current Physician Quality Reporting System (PQRS) neurology-specific measures are retained in the program so that neurologists can choose specialty-specific measures.

In addition to the critical importance of these measures for neurologists to participate in PQRS, these measures are needed for overall quality assessment and maintenance of certification or licensure. Without them, there are very few measures neurologists can utilize to participate in this program.

If CMS were to eliminate these measures from the PQRS in future program years, it could severely impact neurologists' ability to report on quality measures and improve the quality of care their patients receive for neurologic conditions. Furthermore, the AAN has developed additional measure sets which have yet to be presented to the NQF for consideration and have already been submitted to CMS for possible inclusion in the PQRS. These include measures for distal symmetric polyneuropathy, amyotrophic lateral sclerosis, and additional measures for epilepsy and Parkinson's disease. If the only requirement for inclusion in the PQRS is that measures must be NQF endorsed

without allowing for exceptions, this will preclude physicians treating neurologic conditions from participating in a program for which they are subject to payment penalties. The AAN strongly urges the Measures Application Partnership (MAP) to recommend the three epilepsy, six Parkinson's disease and nine dementia measures for continued use in PQRS and in other CMS programs. The AAN also urges the MAP to consider the recommendation of the five distal symmetric polyneuropathy measures and nine Amyotrophic Lateral Sclerosis (ALS) measures for inclusion in the PQRS program. Thank you for the opportunity to present our comments and concerns regarding the MAP recommendations for inclusion of these measures in current CMS programs. We appreciate your review of these comments. Epilepsy, Parkinson's disease and dementia are conditions that cause significant morbidity, mortality and are associated with considerable resource use. The AAN feels strongly that the continued implementation of these measures in the CMS Physician Quality Reporting System and in other reporting and quality initiatives will markedly improve care for patients suffering from these debilitating conditions.

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## American Academy of Neurology

### Bruce Sigsbee

We are writing to make you aware of the recent NQF Neurology Phase II project which reviewed several AAN developed measures which are currently included in the Physician Quality Reporting System (PQRS). We agree with the new NQF criteria and thank them for providing some explicit guidance. However, it is unfair to retrospectively apply the new criteria to measures that were developed when no such criteria were established. Until new measures in these conditions can be developed, we recommend that the current PQRS neurology-specific measures are retained in the program so that neurologists can choose some specialty-specific measures. Neurology is a specialty that deals with different neurological chronic diseases that are often unrelated to each other. Unlike diabetes, asthma or coronary artery disease, neurological conditions often need different assessment tools to evaluate the functional state of a patient. In addition to the critical importance of these measures for neurologists to

participate in PQRS, these measures are needed for overall quality assessment and maintenance of certification or licensure. Without them, there are very few measures neurologists can utilize to participate in this program. Epilepsy is a common and widely recognized neurologic condition, but it is often poorly understood, misdiagnosed and improperly treated. Epilepsy is surprisingly common; approximately 2 million Americans are living with the chronic condition<sup>1</sup>. The deficits in quality of life due to epilepsy and its treatment are comparable to conditions such as diabetes, heart disease and depression. The epilepsy treatment gap is defined as the proportion of people with epilepsy who require treatment, but do not receive it. There are racial, ethnic and socioeconomic disparities in access to treatment. A lack of specialty care may lead to delayed recognition of seizures and inadequate treatment. Thus, there is a large disparity between care that should be delivered and the care that is actually delivered. Parkinson's disease is a chronic condition that affects more than 500,000 Americans<sup>2</sup> and is associated with significant effects on health utilization economics and health related quality of life (HRQOL)<sup>3</sup>.

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### American Academy of Neurology

#### Bruce Sigsbee

Five of the six measures developed by AAN pertain to non-motor symptoms. Non-motor symptoms are often strongly associated with quality of life. Clinicians who treat Parkinson's disease will recognize that non-motor manifestations are equally important to patient well-being and functioning. These non-motor manifestations include anxiety, depression, cognitive impairment, fatigue, pain, psychosis and sleep disorders. These non-motor symptoms are readily detectable on clinical interview and specifically measured and captured on HRQOL instruments. Several recent studies confirm that HRQOL is inversely proportional to Parkinson's disease severity and a wide range of HRQOL dimensions are affected, including bodily comfort, emotional well-being, self-image, communication, among other factors<sup>4</sup>.

The total cost (economic impact) to care for patients with epilepsy and Parkinson's disease is \$15.5 billion

and \$10.8 billion<sup>5</sup>, respectively. Their economic impact on the US healthcare system is not negligible, which is why it is so important to keep these measures sets in PQRS. These measures also meet or exceed the standards set by PQRS for measurement sets.

Dementia is a chronic condition that poses a major and growing threat to the public's health, affecting approximately 5%–8% of individuals over age 65 years, 15%–20% of individuals over age 75 years, and 25%–50% of individuals over age 85 years.<sup>6</sup> Currently, an estimated 5.3 million Americans of all ages have Alzheimer's disease – the most common form of dementia.<sup>7</sup> Medicare and Medicaid cover about 70 percent of the costs of care which are projected to increase from \$200 billion in 2012 to \$1.1 trillion in 2050 (in 2012 dollars).<sup>8</sup>

The care for individuals with dementia is multidimensional and clinical practice guidelines indicate the need for a comprehensive approach to management. Unfortunately, a number of studies have shown variability in adherence to recommended practices for the multiple elements of the assessment and management of patients with dementia.<sup>9,10,11</sup> In response to this variability, the Department of Health and Human Services (HHS) established a National Plan to Address Alzheimer's Disease, and identified high-quality dementia care guidelines and measures across settings as a key strategy. The plan indicates that measures are needed that can track whether recommended care is being provided and suggests that these measures should be based on guidelines tailored to the stages of the disease; and they should address the physical, cognitive, emotional, and behavioral symptoms of Alzheimer's disease in the myriad care settings in which care is delivered.

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### American Academy of Neurology

#### Bruce Sigsbee

The AAN understands that the Secretary of HHS has the authority to specify use of measures by CMS that have not been endorsed by NQF if the measures 1) have a high impact on healthcare and supports CMS and HHS priorities for improved quality and efficiency of care; 2) address gaps in the PQRS measure set; 3) impact chronic conditions; 4) are applicable across different care settings;

5) reflect the services furnished to beneficiaries by a particular specialty. The epilepsy, Parkinson's disease and dementia measures address all areas listed above. The goal of these measures is to improve patient care by ensuring that physicians are asking the requisite questions to better manage the care of these patients. Currently, these are the only measures in the PQRS that address epilepsy, Parkinson's disease and dementia. If these measures are removed, it will be difficult, if not impossible, to determine whether physicians are performing these critical tasks. Including these measures in PQRS will help gather more data to better demonstrate how the current standard of care is addressing the needs of these patients and how it can be improved. If CMS were to eliminate these measures from the PQRS in future program years, it could severely impact neurologists' ability to report on quality measures and improve the quality of care their patients receive for neurologic conditions. Furthermore, the AAN has developed additional measure sets which have yet to be presented to the NQF for consideration and have already been submitted to CMS for possible inclusion in the PQRS. These include measures for distal symmetric polyneuropathy, amyotrophic lateral sclerosis, and additional measures for epilepsy and Parkinson's disease. If the only requirement for inclusion in the PQRS is that measures must be NQF endorsed without allowing for exceptions, this will preclude physicians treating neurologic conditions from participating in a program for which they are subject to payment penalties. We strongly urge CMS to retain the three epilepsy, six Parkinson's disease and nine dementia measures for continued use in PQRS and in other CMS programs. The AAN has requested the NQF Neurology Phase II Steering committee reconsider the measures that were not recommended for endorsement in the Draft Steering Committee Report. The Steering Committee met for a two hour conference call on December 13, 2012 for continued discussion and re-voting on the measures. The AAN awaits the final report from the Steering Committee, review by the NQF Consensus Standards Advisory Committee, approval from the NQF membership and approval by the NQF Board of Directors regarding endorsement or non-endorsement of the epilepsy, Parkinson's disease and dementia measures. Thank you for the opportunity to

present our comments and concerns regarding the NQF endorsement decisions for these measures. We appreciate your review of these comments. Epilepsy, Parkinson's disease and dementia are conditions that cause significant morbidity, mortality and are associated with considerable resource use. The AAN feels strongly that the continued implementation of these measures in the CMS Physician Quality Reporting System and in other reporting and quality initiatives will markedly improve care for patients suffering from these debilitating conditions. Should you have questions or require further information, please contact Daneen Grooms, AAN's Manager of Regulatory Affairs, by email at [dgrooms@aan.com](mailto:dgrooms@aan.com) or by phone at (202) 525-2018.

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### **American Academy of Ophthalmology**

#### **William Rich, MD**

The American Academy of Ophthalmology (Academy) supports inclusion of measure NQF 1741: Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)<sup>®</sup> Surgical Care Survey in the Physician Quality Reporting System (PQRS). The Agency for Healthcare Research and Quality's (AHRQ) CAHPS Consortium developed the survey in partnership with the American College Surgeons and a coalition of surgical specialty societies to assess surgical patients' experiences before, during, and after surgical procedures to identify opportunities to improve quality of care, surgical outcomes, public reporting, and patient experience. The survey was developed using the same methodology and scientific rigor applied when developing all CAHPS surveys. Ophthalmology was one of nine specialties that participated in the field testing of the measure. We agree that NQF 1741 serves to fill several gaps in the PQRS measure set including patient experience and measures of surgical care.

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### **American Academy of Ophthalmology**

#### **William Rich, MD**

Comment on M2292 Glaucoma Screening and M2490 Ophthalmologic Exam The American Academy of Ophthalmology agrees with MAP's decision not to support M2292: Glaucoma Screening in Older Adults and M2490 Ophthalmologic Exam for inclusion

in the PQRS program. We do not believe these measures are specified or tested for physician-level implementation.

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### **American Academy of Ophthalmology**

#### **William Rich, MD**

Comment on M2473 and M2474

The Academy disagrees with the reasoning behind the MAP's decision not to support M2473 Education of patient about symptoms of choroidal neovascularization necessitating early return for examination and M2474 Education of patient about the role of good glucose control in slowing progression of diabetic retinopathy. While there is value in more general measures that can be reported by multiple specialties, we continue to believe that physicians will find the most value in measures that pertain to their specific patient populations. Measures must be relevant and actionable if measurement is to promote improvement in the quality of care. The MAP itself states that it seeks to encourage clinician participation in PQRS and other quality reporting programs by identifying measures that are considered clinically relevant for all clinician specialties. Moreover, if the PQRS program is to continue to serve as the basis for the value-based modifier, condition specific measures are needed to benchmark clinicians adequately against their appropriate clinical peers.

However, we agree with the MAP's decision not to support these measures. The Academy has ceased development of these measures to focus our measure development efforts on electronically-specified measures.

Comment on M1103 and M238

The Academy opposes MAP's decision to withhold support for M1103 Biopsy follow-up and M238 Melanoma: Coordination of Care. M1103 and M238 fill a gap within the PQRS program and should be retained. Oculoplastic surgeons currently have very few measures in the PQRS program that apply to their patient population. Most are unable to report on general ophthalmology measures, because they do not practice comprehensive ophthalmology. However, some oculoplastic surgeons perform sufficient biopsies and see sufficient melanoma cases to report

on M1103 and M238. As the PQRS program moves to the penalty phase, it is critically important that all physicians have measures that apply to their patient population so that they can avoid the PQRS penalty.

We also note that M1103 has only been a part of the PQRS program for one year. Data collection for the 2012 PQRS program is still underway, therefore CMS does not yet have sufficient data to evaluate the measure. We recommend that M1103 continue as a PQRS measure to allow more time to assess the measure and its use by physicians.

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### **American Academy of Ophthalmology**

#### **William Rich, MD**

Comments on Episode Groupers in the Value-Based Modifier

The Academy agrees with the MAP that the episode groupers are not yet ready for implementation and we have serious concerns with including untested groupers in the value-based modifier. Historically, the Academy has encountered problems with the methodology of episode groupers used by commercial insurance plans. For example, attribution and risk adjustment methods are often not sophisticated enough to distinguish between generalists and specialists, and episodes of care are not always defined appropriately. It is also not clear to us how CMS would apply episode groupers in the value based modifier when groupers do not address conditions managed by every Medicare physician. We urge the NQF and CMS to use caution and thoroughly evaluate any episode groupers before including groupers in the value based modifier.

Comments on Cost Measures for the Value-Based Modifier

The Academy has several concerns with the MAP's support for the direction of a total per capita cost measures currently being used in the value-based modifier. We strongly agree with the MAP that this measure is not ready for implementation. CMS included the per capita cost measures in the last several rounds of Quality and Resource Use Reports distributed to Medicare physicians. Our experience was that physicians did not find this information to be informative or actionable because it included costs that are not attributable to the individual physician.

For example, a retina specialist managing the care of a patient with age-related macular degeneration primarily sees the patient in the office to provide treatment. Any inpatient hospital costs associated with that patient's care are most likely to be unrelated to care provided by the ophthalmologist, yet they are included in the per capita cost measure and would be included in that individual physician's value-based modifier. The Academy does not believe that per capita costs represent an accurate picture of the physician or physician group's role in the cost of patient care. The cost measures proposed for the value based modifier will not be actionable by individual physicians or single specialty physician groups. We believe that physicians will be more interested in actionable resource use measures that compare their treatment patterns to the treatment patterns of their peers. The cost measures proposed for the value based modifier are simply too global to be actionable by most physicians.

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### **American Academy of Physical Medicine and Rehabilitation**

#### **Elliot Roth**

The American Academy of Physical Medicine & Rehabilitation's (AAPM&R) members are challenged to identify endorsed measure sets that are applicable to the practice of physiatry. Many of the current endorsed measures are process measures that are specific to narrow diagnostic categories. Psychiatrists treat patients across care continuums, typically with complex co-morbidities, after a life changing diagnosis such as stroke or brain or spinal cord injury, and focus on a variety of interventions to improve the patient functional status, such as exercise, pharmacologic agents, or procedures. Most of the patients treated by psychiatrists fall into the exempted category for the presently endorsed measure sets. AAPM&R applauds MAP's recommendation with the goal of alignment in identifying a set of measures that all clinicians report across programs, regardless of specialty. We support the focus on patient experience and engagement measures, and also encourage consistent or complementary measures for coordination of care, promotion of population health, and removal of health disparities. We believe that increasing the proportion of cross-cutting, patient-centered measures, as compared

to narrowly-defined process measures; will increase physician participation in PQRS reporting. However, this can only occur if the reports can easily be produced from the EHR and if the measure attributes are embedded in the patient care delivery processes, not with an additional administrative burden on the clinician, whose time is already reduced for the provision of direct patient care services.

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### **American Association of Neurological Surgeons**

#### **Koryn Rubin**

##### Physician Quality Reporting Program

As PQRS moves from a rewards-based program to one that assess penalties for non-compliance, it is incumbent on the MAP to ensure that measures which are recommended/endorsed have been tested and developed in the care setting in which they were intended. For example, a measure that was developed for the inpatient setting may not be appropriate for use in the ambulatory setting or applied across programs. Measure 1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)Neurosurgery is concerned with this measure because it was developed for the inpatient setting. The measure is also currently undergoing revisions and without access to the full measure specifications, we recommend against CMS moving forward with the measure. We are also concerned how CMS will ascertain—using administrative data—whether or not a readmission was planned, part of a patient's treatment process, or unplanned. Not all readmissions mean a failure of appropriate care has occurred. Risk adjustment must also be considered, but not before the problems with utilizing administrative data are resolved. Value Based Payment Modifier CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys): Neurosurgery does not believe physicians should be measured on the outcomes of a CAHPS survey and are not supportive of the MAP's endorsement recommendation. Implementation of CAHPS in a practice is costly and time consuming. To be implemented correctly, it requires training of staff and workflow redesign. The surveys are very lengthy and CMS has not been clear on possible repercussions if a physician's patients do not fill out the survey. Total Per Capita Cost Measure: Without



access to the full measure specifications, we recommend against CMS moving forward with the measure, especially since a penalty will be associated with the measure. We are also concerned with CMS measuring all physicians the same, regardless of specialty. Spending will differ based on a physician's specialty (and even within specialty, if they are sub-specialized), as well as the physician's patient case mix. This measure may lead to cherry picking if it is not appropriately risk-adjusted. Risk adjustment methodology is a key component in attempting to determine a physician's spending per patient. Without robust data, a lack of measure specifications and finalized program requirements, neurosurgery cannot support inclusion of this measure.

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### **American Board of Medical Specialties**

#### **Tom Granatir**

On behalf of the American Board of Medical Specialties, I appreciate this opportunity to submit comments on the Measures Application Partnership's draft pre-rulemaking report. Because the certifying boards are concerned primarily with the assessment and certification of individual physicians, our comments focus exclusively on physician quality reporting and the incentive and accountability programs associated with physician quality. Let me begin by commending staff for guiding the MAP through the dense thicket of measures and frameworks at every level of care. We understand the difficulties and the statutory constraints and hope our comments will lead to useful discussions at future meetings.

Focus less on measures and reporting, more on the learning and improvement system we want to create

Of necessity, last year MAP's work focused almost exclusively on the measures themselves, leaving little time to discuss how the use of measures might differ for incentive and accountability applications. More recently MAP, led by the Clinician Workgroup, has begun to differentiate criteria for use in the two different applications. The criteria and recommended priorities for the different applications seem sensible and can help steer the conversation toward a more clearly articulated theory of the case for using incentives on the one hand, and public reporting on the other to make care better for patients. I think

we would all agree that measurement and reporting will not make care better unless they are linked to the knowledge, practices, feedback, and systems thinking that make improvement possible. MAP has the opportunity – and, we believe, the authority – to make broader recommendations to CMS about its measurement and improvement strategy. We urge the MAP to consider what sorts of behaviors these incentive and accountability programs are intended to produce; and to make sure that the measures adopted are backed by a logic model linked to those desirable behaviors. It would be useful for CMS to have a long-term strategy for capacity building and infrastructure development so that when implemented these programs actually achieve what they are intended to achieve. Might the MAP be able to identify phases of development – engagement through registries to begin, followed by the use of measures in an improvement cycle, before imposing penalties to which few have the capacity to respond? These steps do not have to be created de novo. There are existing registry models to draw on, and the MOC certification process to build on. The broad spectrum of interests represented on the MAP will each bring useful perspectives on how this system can be effectively and efficiently built.

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### **American Board of Medical Specialties**

#### **Tom Granatir**

##### **Align with ABMS Maintenance of Certification**

The MAP report calls on CMS to align with ABMS Maintenance of Certification. We agree. This alignment might mean simply assuring that the measures recommended for use in ABMS MOC programs can also be used to satisfy federal quality programs. CMS has expressed its desire to assure that this sort of alignment takes place, and several of the ABMS member boards have submitted measures for use in PQRS or adopted PQRS measures for use in their MOC programs. Rewards for clinicians, perhaps unlike those for organizations and institutions, should be linked not to events but to practices, specifically to the kinds of practices and behaviors that underlie the six "competencies" that are foundational to medical education and to ABMS Maintenance of Certification. We noted previously that the measures used in PQRS generally assess patient care and procedural skill,

only one of the six competencies that form the basis for good medical practice. The other competencies involve interpersonal communication, medical knowledge (including diagnostic acumen), system-based practice, professionalism, and lifelong learning and improvement. These competency domains are the framework for graduate medical education, and for certification and continuing education throughout a physician's lifetime of practice. Physicians are encouraged continuously to develop their mastery of each of the domains. By embracing a competency-based framework for understanding physician performance, we must recognize that the standard statistical approaches to performance measurement will not be sufficient; they cannot capture all the domains. As we have recommended in previous notes to the Committee, we would welcome a discussion of other methods that may be necessary fully to capture excellence in physician performance. ABMS Boards have a unique role to play in prioritizing measures for each of the specialties and subspecialties. The Boards are set up to determine, just as they do for the knowledge exam, exactly what domains of performance are most important to each specialty and subspecialty. As NQF proceeds to take a more active role in filling the "measure gaps," we would urge the NQF to view the Boards as strategic partners in measure prioritization by specialty.

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### American Board of Medical Specialties

#### Tom Granatir

Acknowledge the tension between parsimony and relevance

The report suggests a goal to create a common set of measures for all physicians regardless of specialty in the name of "parsimony." This will be an elusive goal. If measurement is going to lead to any kind of meaningful improvement it has to be relevant to the care that physicians actually provide. A small set of measures common to all physicians could make the program largely irrelevant, unlikely to produce the quality improvements that justify its implementation.

We think it would be preferable to develop a core set of measures for each major specialty or at least for each major practice context. ABMS recognizes 24 major specialty boards representing nearly 150 subspecialties. Assuming a "parsimonious" data set

for each specialty includes one measure group at the specialty level and one measure group at the subspecialty level, even these many parsimonious measure sets will not be specific enough to capture what is most important to patients or to clinicians.

Alternatively, MAP might recommend a measure set describing each of five major contexts for physician practices, including, for example, primary care physicians (internal medicine, family medicine, and pediatrics, where relevant); hospital-based physicians (anesthesiologists, radiologists, pathologists, nuclear medicine physicians, and emergency physicians); surgeons (general, plastic, thoracic, and colorectal); other surgical specialties (OB/GYN, urology, ophthalmology); and ambulatory specialties (like dermatology and allergy and immunology).

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### American Board of Medical Specialties

#### Tom Granatir

"Patient experience" will differ for different contexts of care

MAP has suggested focusing reporting on patient experience, including functional and long-term outcomes of care, and proposed the use of CG-CAHPS and Surgical CAHPS as standard instruments for all physicians. We would recommend two issues for discussion by the MAP. First, although CG-CAHPS has become the standard for physician office practices, and some of our Boards have been piloting its use in Maintenance of Certification for several years, questions have been raised about the standard's suitability for certain physicians, particularly in hospital-based specialties – anesthesiology, diagnostic radiology, emergency medicine, nuclear medicine, and pathology. Second, several boards find that some customization by specialty or by condition may produce more useful, actionable, and meaningful information for patients. The American Board of Internal Medicine, for example, has developed condition-specific surveys that capture both encounter experience plus interim clinical and functional outcomes. Feedback from patients and physicians suggests that this may be the most useful and motivating information for practice improvement. We encourage MAP to identify a workgroup to look specifically at the measurement

and survey issues associated with patient experience of care.

#### Stronger coordination to fill measure gaps

We support the idea that the National Quality Forum should begin to serve a coaching or facilitation role in measure development. NQF has developed an expertise in measurement that needs to be widely shared at the front end of measure development to assure that the lengthy and time-consuming process of measure development yields measures that will be fit for use.

#### Change “Support Direction” to Support with Testing

The MAP assigns measures one of three designations: support, support direction, and not support. “We suggest that when designated as “support direction,” such measures be tested for use. We suggest further that while they are being tested, physicians would be credited for reporting and providing feedback on the measures without their being used in either of the applications. In this way CMS can begin to create the feedback loops essential to the “learning system” envisioned by the MAP strategy adopted last summer.

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### American Board of Radiology

#### Gary J. Becker

On the spreadsheet of measures (attached) used by the MAP Clinician Workgroup at its December meeting, the measures of interest are referred to as “Radiation Dose Optimization” measures. These measures, M1882, M1883, M1888, M2442 and M2443, as designated in the MAP Clinician Program list/spreadsheets, are labeled as either HIT or Imaging. We would like to suggest that the categorization of these measures may be more accurate or descriptive as safety and/or care coordination. In the course of the PCPI development process, the measures were appropriately re-named, “Optimization of Patient Exposure to Ionizing Radiation (OPEIR)”, and included under that heading in the 2013 Physician Fee Schedule Final Rule, (Federal Register, Vol. 77, No. 222/Friday, November 16, 2012 Rules and Regulations, Table 95, Individual Quality Measures for the Physician Quality Reporting System Proposed to be Available for Reporting via Claims, Registry, EHR, or GRPO Web Interface Beginning in 2013 or 2014,

pp. 69260-69261) (attached). A very brief description of each of the five measures is also attached.

As the OPEIR moniker suggests, image quality is directly related to the magnitude of exposure to ionizing radiation. In general, lower exposures result in decreased image quality; higher exposures, superior image quality. However, in the best interests of patients, a key question that radiologists and other medical imagers must always ask is, “How little exposure can we utilize and still derive the necessary diagnostic information?” This question has been brought to the forefront in response to a national priority to reduce ionizing radiation exposures to the US population in general, and in the medical community, to patients in particular.

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### American Board of Radiology

#### Gary J. Becker

Importantly, the OPEIR measures were developed as part of a pilot collaboration between ABR/ABMS, the American College of Radiology (ACR), and AMA/PCPI. Early in the process, the ABR was asked to choose a measure topic, based upon evidence of demonstrable quality/safety gaps and greatest importance from the standpoint of significance. From the outset, optimizing patient exposure to ionizing radiation was seen as the most important high impact area offering a significant opportunity to improve population health. Work by the National Council on Radiation Protection and measurements (NCRP), the National Cancer Institute’s (NCI’s) Radiation Epidemiology Branch, the ACR, and the American College of Emergency Physicians (ACEP) provided the evidentiary basis for the measures that were ultimately developed in the pilot. Specific desired outcomes of the use of these measures (and several others developed in the same collaboration) include: 1) reduce patient harm, 2) reduce excessive radiation risk and exposures, 3) reduce procedural complications, 4) reduce morbidity in patients undergoing imaging, 5) reduce unnecessary or duplicate imaging studies (and the associated cost and radiation exposure), 6) encourage recording and reporting of radiation dose information, 7) enhance awareness of cumulative radiation exposure, and 8) encourage appropriate utilization of ionizing radiation and nonionizing radiation. Since the five

OPEIR measures address improvement in patient safety and population health, as well as lower cost, they do indeed encompass all aspects of the National Quality Strategy's "triple aim". In addition, the Physician Fee Schedule Final Rule has two of them classified as patient safety measures and three as care coordination ones. The ABR is extremely proud to have co-developed these measures as part of the pilot collaboration with PCPI, and we plan to feature them in our 2013 and 2014 MOC program as preferred measures. As soon as they become available for use in PQRS reporting, diplomates will have the opportunity to fulfill their MOC Part IV requirements while simultaneously meeting their PQRS reporting requirements and MOC:PQRS incentive requirements by employing these measures accordingly, thereby satisfying the principle of parsimony.

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#### **American Board of Radiology**

##### **Gary J. Becker**

In summary, the ABR views implementation of the five OPEIR measures under consideration as a vital step toward improved patient safety, quality of care, and care coordination in medical imaging, as well as reduced waste, duplication, and cost. The ABR will feature the use of these measures in its MOC program in 2013 and 2014 as a preferred method of satisfying MOC Part IV (Practice Quality Improvement) requirements. Furthermore, as soon as diplomates are able to use these measures to satisfy PQRS reporting requirements and the associated MOC:PQRS incentive requirements, alignment between the ABR MOC and CMS programs will have been achieved. Parsimony in the measures development enterprise will also have been accomplished. Therefore, we strongly urge the MAP Coordinating Committee to recommend to CMS the inclusion of these five OPEIR measures in its PQRS program as well as potentially in the Physician Value Based Modifier and Physician Compare. Thank you very much for your consideration.

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#### **American College of Cardiology**

##### **Eileen Hagan**

The American College of Cardiology commends the MAP on this important deliverable and

offers the following comments on the MAP's clinician performance measurement program recommendations.

#### **Attribution for Accountability**

Both the NQF and the MAP need to do more to accommodate the discrete nature of health plan and clinician programs and individual measures within the programs. As these programs move from pay-for-reporting to pay-for-performance, it is critical to apply the appropriate level of accountability. Harmonizing system-level population-based measures with clinician-level patient-based measures proves to be challenging; clinician-level measures must allow for the capture of patient-level interventions and exclusions.

For example, per the measure descriptions below, NQF #18-- HTN: Controlling High Blood Pressure is more appropriate for a health plan/system level of accountability while M1430—HTN Blood Pressure Control is more appropriate for a clinician/group level of accountability. Applying #18 to the clinician level could result in clinicians refusing to care for difficult-to-control hypertensive patients. In addition, there is the danger of overtreatment when using the population level (health plan) measure at the individual physician level. It is a point we have emphasized and there is a literature developing on the subject including a paper out of the Veterans Administration last year (attached). Our concern centers primarily on what is best for our patients and the need to systematically assess the clinical impact of various applications of performance measures with respect to the balance of their benefits and harms (unintended adverse consequences). This is particularly important in the use of physician level measures in programs that include significant provider incentives.

We appreciate that CMS has finalized the M1430 measure for use in PQRS and Meaningful Use; we plan to resubmit the measure for NQF endorsement during the next call for CV measures. Please note that the measure endorsement was not 'removed'; the measure was not endorsed due to lack of testing and the appearance of overlap with NQF #18. We respectfully request the MAP to reconsider its lack of support for this measure and support its use in clinician-level programs pending NQF endorsement.

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**American College of Cardiology****Eileen Hagan**

MAP Guiding Principles ACC agrees that potential unintended consequences related to use of a measure should be identified and addressed prior to implementing the measure in a payment adjustment program. ACC disagrees with the principle that measures for use in the Value-Based Payment Modifier (VBPM) should have been reported in a national program, such as PQRS, for a year. We believe that a measure needs more than one year of experience in the PQRS given the 2-year lag in publishing PQRS program results—2010 results were published in April 2012. ACC recommends that the MAP perform an evaluation of measure uptake (frequency of reporting—overall and by specialty) and performance rates among providers who participate continuously in the measure to further inform the MAP in its ongoing efforts to identify measures for all clinician specialties that are considered clinically relevant.

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**American College of Cardiology****Eileen Hagan**

The American College of Cardiology commends the MAP on this important deliverable and offers the following comments on the MAP's clinician performance measurement program recommendations.

Measure: M1033: CAD: Symptom Management

MAP Recommendation: Support and Submit for NQF endorsement

ACC Response: ACC supports inclusion in PQRS and MU: This PCPI-developed measure will be resubmitted during next NQF CV cycle

Measure: M1430: HTN: BP Control

MAP Recommendation: Phase Removal from PQRS and MU-EP due to NQF endorsement removed

ACC Response: ACC does not support phased removal from PQRS and MU. MAP should SUPPORT this important PCPI-developed outcome measure pending NQF endorsement during its next CV measure cycle.

Measure: M2876 Episode Grouper: AMI

M2879 Episode Grouper: CABG

M2880 Episode Grouper: PCI

M2882 Episode Grouper: CAD

M2884 Episode Grouper: CHF

MAP Recommendation: Support Direction: Not ready for implementation; should be submitted for and receive NQF endorsement

ACC Response: ACC agrees that groupers are not ready for implementation in VBPM

Measure: M2147 Total per Capita Cost Measure

M2148 Condition-specific per capita cost measures for COPD, diabetes, HF, and CAD

MAP Recommendation: Support Direction: Not ready for implementation; should be submitted for and receive NQF endorsement

ACC Response: ACC agrees that these cost measures are not ready for implementation in VBPM

As you know, the ACC is committed to proactively working with the MAP, the NQF, the PCPI, and the CMS to achieve our shared goals of improvement, transparency, and value in health care. We look forward to our continued engagement in the MAP process.

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**American College of Chest Physicians****Jeff Maitland**

Measure ID - 2920 - Percutaneous Central Line Placement 2: Central line- associated bloodstream infection (CLABSI) (2 of 3: Measures Group Percutaneous Central Line Placement) Approve with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC expressed its desire for harmonization between this measure and Measure 3035.

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**American College of Radiology****Judy Burleson**

Because it will be necessary in 2013 to quickly engage our members who have not yet participated in the Physician Quality Reporting System (as

with physicians overall, approximately 80% of our members) so that they will not be penalized in 2015, we urge the MAP to balance this need with availability of quality measures that require greater achievement in quality improvement activities. We hope that the MAP will ensure the PQRS includes measures that are a good entry point for physicians, by making greater use of the “phased removal” category as well as supporting measures more readily that have not yet undergone National Quality Forum (NQF) endorsement; particularly measures that have already been finalized by the Centers for Medicare and Medicaid Services (CMS) for inclusion in PQRS. Specifically, if CMS has finalized measures that the MAP is considering, the MAP should ensure that they have or review more specific information about finalized measures in order to make the best recommendation. For example, the MAP considered eight measures from the ABMS/ABR/ACR/AMA PCPI Optimization of Patient Exposure to Ionizing Radiation (OPEIR) measure set (M1882, M1883, M1886, M1887, M1888, M2442, M2443, M2444). Five of these measures have been finalized for CY2014 PQRS (M1882, M1883, M1888, M2442, M2443). Initial recommendations documented by both the MAP Clinician Workgroup and the MAP Coordinating Committee indicated either “do not support” (M1883) or other inconsistencies in categorization of these measures.

Recognizing this, the ACR as well as the American Board of Radiology, provided more detailed information to both the Clinician Workgroup and the Coordinating Committee so that they would have a better basis with which to make a recommendation to CMS. Specifically, the information provided included measure descriptions as well as the following:

“Measure M1883, Utilization of a Standardized Nomenclature was meant to enable and be paired with M2443, Reporting to a Dose Index Registry (MAP supported direction of M2443 in the MAP 2012 report). M1883 is a measure that is substantially more than a practice standard (as indicated by the MAP report). There is no standard lexicon implemented across the board for naming CT exam procedures. In fact, a report generated from data in the ACR Dose Index Registry for 6 months in 2012, 18,272 distinct study descriptions mapped to 120 standardized

procedure names. One standard exam name, “CT ABDOMEN WITH IV CONTRAST” was associated with at least 230 distinct study descriptions. To make like comparisons of sites reporting dose index data to a registry, it is necessary to use a specific CT exam name. M1883 serves to standardize the exam names by requiring exam name mapping.”

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## American College of Radiology

### Judy Burleson

Again we recognize the magnitude of the MAP tasking, however we do not feel the information was given due consideration. We urge the MAP to support M1883. Additionally, we understand that if the MAP does not include a measure in its report that was submitted for consideration, that by lack of specific comment, the recommendation is to stay “as is”, or to submit for NQF endorsement. This is confusing. We would like clarification for measures M1882, M1883, M2442, and M2443, which have all been finalized by CMS for PQRS inclusion. The MAP 2012 conclusion on each of these measures was “do not support.” Is the MAP staying with their recommendation in 2012 or recommending that the measures be submitted for NQF endorsement? Does CMS understand this? We urge the MAP to clearly state whether they “support direction,” if that is the case, in addition to “submit for NQF endorsement”. In terms of the MAP considering measures that are designed and validated for use in a certain health care setting (such as the hospital outpatient level), the MAP should not assume that they are appropriate for a different setting. For example, the MAP considered 0513, Thorax CT: Use of Contrast Material, for PQRS. The measure is currently in use in the CMS Hospital Outpatient Quality Reporting program. The measure was not specifically designed or tested for physician level use for PQRS. There likely would be attribution or risk adjustment issues to implement this in PQRS. However, such a measure may be used successfully in a different implementation at the physician level, without attributing the results of the measure to the individual physician (radiologist) who may not have entire control on the outcome of the measure. For example, in a Maintenance of Certification Part IV project, an individual physician or physician group may achieve quality improvement such as what the Thorax CT measure attempts, We recommend

the MAP consult with measure developer for the particular measure that the MAP is considering for use in alternative settings or levels of evaluation.

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### **American College of Rheumatology**

**Ken Saag, Jinoos Yazdany, Mark Robbins**

The ACR is strongly committed to the delivery of evidence-based and personalized quality care for patients with rheumatic disease. We recognize that, when properly implemented and utilized, quality measurement and improvement programs can improve healthcare quality and safety, simplify delivery, empower patients and significantly reduce the cost of care. The ACR supports the goals for quality improvement; however, we also recognize that criteria for quality measurement and performance rating programs must be carefully considered and operationalized to appropriately account for practice settings, specialties, and patient populations within the health care system. Several diseases that rheumatologists treat are part of the National Priorities Partnership priority conditions, including rheumatoid arthritis, osteoporosis and osteoarthritis. These are also areas where significant measure gaps exist.

The rheumatology set of measures that are currently NQF endorsed do not, from the perspective of the rheumatology provider community, represent a comprehensive set of measures that encompass quality care for a rheumatology patient. The ACR has been actively working over the last several years to update its clinical practice guidelines in several of the disease areas that rheumatologists treat and develop a relevant and meaningful set of quality measures in those areas with a plan to submit to the NQF for endorsement with the musculoskeletal call for measures in the third quarter of this year. However, because of the timing of the call for endorsement cycle, the measures that are most relevant and valuable to rheumatologists in terms of managing the care of their patients are not currently NQF endorsed.

The ACR believes it is extremely important for rheumatology providers to be able to participate in national quality reporting programs with measures that are within a rheumatologist's scope of practice and meaningful to the care of their patients. Given

the current environment where the rheumatology measures that are most relevant, have validity and importance within the rheumatology community and have traditionally been in programs such as PQRS are not yet NQF endorsed, the ACR strongly supports the inclusion of the current rheumatology PQRS RA measure set in the PQRS program. In addition, the ACR would eventually like to see measures that are applicable and relevant to rheumatologists in other quality reporting programs.

We note that, within the MAP recommendations and report for measures to be included in Federal quality reporting programs, the rheumatology measures listed were requested to be submitted for NQF endorsement. We would request that the NQF await measures that we are developing and validating and hope the rheumatology provider community will not be penalized for not yet having a strong set of NQF endorsed measures since the reason is primarily due to timing of the call for measures.

The ACR very much appreciates the opportunity to provide comments to and work with the NQF Measure Applications Partnership Coordinating Committee to ensure that quality programs under HHS continue to consider measures appropriate for the rheumatic disease patient population. We are also eager to explore additional ways to collaborate and provide input into this important process going forward. The ACR has experts and infrastructure both on the clinical rheumatology side as well as on the quality measure side, and are strongly committed to developing the best possible set of measures for rheumatology patients. If we can be of assistance to you in any way, please contact Rachel Myslinski, ACR vice president, quality, registries and health informatics at [rmyslinski@rheumatology.org](mailto:rmyslinski@rheumatology.org) or (404) 633-3777.

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### **American College of Surgeons**

**David B. Hoyt**

Clinician Workgroup's Guiding Principles

ACS generally supports the MAP's Clinician Workgroup's Guiding Principles. We believe that it is important for the national quality improvement enterprise that PQRS be broadly inclusive of measures to encourage physician participation and

to act as a test bed to find measures which drive improvement in practice. Specifically, we support the following statement from MAP Pre-Rulemaking Report: Measures that are not NQF-endorsed may be included if the measure supports alignment (e.g., outcome measures also used in MOC programs), is an outcome measure for a topic not already addressed by an outcome measure included in the program, or is clinically relevant to specialties that do not currently have clinically relevant measures. To be recommended by MAP for PQRS, measures that are not NQF-endorsed must be fully specified. Some measures that are not NQF-endorsed may not yet be fully tested, and PQRS can serve as a vehicle for gaining access to data for testing and provide implementation experience with these measures. We would also like to note our concern that the Clinician Workgroup's review of the clinician measures—led by the guiding principles—may not have analyzed the measures with the appropriate level of detail. Unlike the Hospital Workgroup which reviewed each measure individually, the Clinician Workgroup more broadly used the guiding principles to determine their recommendations. This may have resulted in missing subtleties in the measure specifications. We recommend that the Centers for Medicaid and Medicare Services (CMS) consider this in their internal review of the MAP recommendations for clinician-level measures.

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### American College of Surgeons

#### David B. Hoyt

##### PQRS

ACS supports the MAP's conclusion and rationale to "support the direction" of the ACS surgical Measure Groups. The measures include:

- Appendectomy 1-4;
- AV Fistula 1-5;
- Cholecystectomy 1-4;
- Colectomy 1-6;
- Colonoscopy 1-4;
- Esophagogastroduodenoscopy (EGD) 1-2;
- Hemorrhoidectomy 1-4;
- Inguinal Hernia 1-3;
- Mastectomy +/- Lymphadenectomy or SLNB 1-4;

- Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SNLB 1-4;
- Skin/Soft Tissue Lesion Excision 1-4;
- Thyroidectomy 1-5;
- Inguinal Hernia 1-3;
- Ventral Hernia 1-5.

The American Board of Surgery (ABS) has endorsed these measures because they deemed these procedures and outcomes to be the most important to measure for individual surgeons. Likewise, they are some of the most common procedures performed in the U.S. Inclusion of these measures also follows the Clinician Workgroup's Guiding Principles which supports alignment with MOC programs and registries, as the ABS will base their MOC on these Measure Groups. These measures will function as a way for surgeons to learn their strengths and identify areas for improvement which will promote life-long learning and enhancement of patient quality of care.

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### American College of Surgeons

#### David B. Hoyt

MAP did not support the direction of several ACS surgical Measure Groups. These measures include: - Bariatric Lap Band Procedure 1-3; - Bariatric Laparoscopic or Open Roux-en Gastric Bypass 1-6; - Bariatric Sleeve Gastrectomy 1-6; and - Varicose Veins 1-3. It is inconsistent that the MAP "supported direction" of the ACS surgical Measure Groups listed in the previous section and did not support direction for these ACS surgical Measure Groups. The ABS has endorsed these measures because they deemed these procedures and outcomes to be the most important to measure for individual surgeons. They are also some of the most common procedures performed in the U.S. Inclusion of these measures follows the Clinician Workgroup's Guiding Principles which supports alignment with MOC programs and registries. The MAP report states that "bariatric surgery is of low importance to this (PQRS) program." However, we would like to share some important information that may not have been recognized during the evaluation of the bariatric procedures. Indeed, the Medicare population is specifically an at-risk population for obesity and its consequences. Eligibility for Medicare benefits include



age >65 and disability including end-stage renal disease (ESRD). Numerous studies have also detailed the impact of obesity leading to disability. In a 2008 Obesity Review article, Neovius and colleagues found that patients with a BMI>35 had a three-fold risk of being disabled.<sup>2</sup> The same article highlighted the strong impact of bariatric surgery upon potential reversal of disability with a doubling of return to work for obese disabled patients who had surgical treatment for their obesity. Flegal in a 2010 JAMA article found a 12.1 percent incidence of BMI>35 in the population age >60.<sup>3</sup> Obesity has also been found to lead to increased waiting times for ESRD patients awaiting transplant leading to weight-related disparities in care for these Medicare patients in need. In point of fact, Medicare beneficiaries include age >65, disabled, have ESRD, or beneficiaries who have dual eligibility for both Medicare and Medicaid. The overall Medicare population aged <65 is conservatively at least 17 percent of the overall Medicare population.<sup>5</sup> Furthermore, the disabled Medicare population age <65 is disproportionately at risk for being or becoming obese with significantly more comorbidities than the average bariatric population or, in general, they would not have been categorized as disabled. Similarly, ESRD patients may be disenfranchised from kidney transplantation because of their weight, as referenced earlier. Finally, the Medicare SSI (disability) population represents a very high-risk group who would benefit from bariatric surgery. Coverage of the bariatric surgery could lower the total cost of management of the high risk Medicare patient (such as those with obesity hypoventilation syndrome, chronic congestive heart failure (CHF), re- or post-transplant patients), while providing a more effective procedure, especially for Type 2 Diabetes Mellitus, than the gastric band, also covered by CMS.

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### American College of Surgeons

#### David B. Hoyt

In addition, another of the Clinician Workgroup's principles is to ensure that measures are included that are "clinically relevant to specialties that do not currently have clinically relevant measures." The inclusion of these measures would ensure that bariatric surgeons have measures included in PQRS and are able to participate in the program.

For these reasons, the quality of care being delivered to this population should be measured. In conclusion, we disagree that bariatric surgery was thought to be of "low importance" to the PQRS program, and we recommend that the MAP support the direction of these measures.

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### American College of Surgeons

#### David B. Hoyt

##### Surgical Site Infection (SSI) Measures

ACS would like to clarify the rationale supporting individual surgical site infection (SSI) measures within each proposed surgical Measure Group. We included an SSI component in each of the following surgical measure groups: -Appendectomy 4, - AV Fistula 5, - Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 3, - Bariatric Sleeve Gastrectomy 5, - Cholecystectomy 4, - Colectomy 6, - Mastectomy +/- Lymphadenectomy or SLNB 4, - Partial Mastectomy or Breast Biopsy/Lumpectomy +/-Lymphadenectomy or SLNB- Skin/Soft Tissue Lesion Excision 4, - Varicose Veins 3, and - Ventral Hernia 5. While the MAP supported the direction of including SSI measures within each measure group, it also commented that they have previously recommended the measure entitled ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753) "be expanded to address SSI's for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred."

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### American College of Surgeons

#### David B. Hoyt

ACS agrees that for other reasons there is value in including a broad SSI measure for surgery generally—particularly to track SSI in procedures that are not part of the surgeries specified for the measures submitted as part of these Measure Groups. However, we believe it is important to recognize that these measures are part of Measure Groups directed at tracking the quality of specific common and important procedures, given these are what the ABS has endorsed as the important information for tracking quality of care for general surgeons. Several procedure-specific outcomes are examined to have a more comprehensive snapshot of the success

of the procedure. Likewise, they are some of the most common procedures performed in the U.S. Inclusion of these measures also follows the Clinician Workgroup's Guiding Principles which supports alignment with MOC programs and registries.

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### American College of Surgeons

#### David B. Hoyt

In response to the NQF's "additional finding" response, if NQF #0753 were to be specified for clinician-level measurement and include multiple procedures, the information would not be as meaningful for surgeons or to the ABS for MOC. A broader measure may not be as actionable for quality improvement compared to a procedure-specific Measure Group. For example, it is important to know if a surgeon has higher odds of an SSI compared to the average surgeon for a given procedure. This rationale was similarly applied to the ACSCDC measure (NQF #0753) which was endorsed for colectomy and hysterectomy. For the reasons outlined, we recommend the MAP to consider deleting the "additional findings" of the SSI measures which recommends broader measures.

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### American College of Surgeons

#### David B. Hoyt

Unplanned Hospital Readmission within 30 Days of Principal Procedure Measures

ACS would like to clarify the rationale supporting the ACS Unplanned Hospital Readmission within 30 Days of Principal Procedure measures. These measures were included in the following Measure Groups:- Appendectomy 3;- AV Fistula 4;- Bariatric Lap Band Procedure 3;- Bariatric Laparoscopic or Open Roux-en Y Gastric 4;- Bariatric Sleeve Gastrectomy 4;- Cholecystectomy 3;- Colectomy 5;- Colonoscopy 3;- Hemorrhoidectomy 4;- Inguinal Hernia 3;- Mastectomy +/- Lymphadenectomy or SLNB 3;- Partial Mastectomy or Breast Biopsy/Lumpectomy +/-Lymphadenectomy or SNLB 3;- Skin/Soft Tissue Lesion Excision 3;- Thyroidectomy 5;- Ventral Hernia 4

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### American College of Surgeons

#### David B. Hoyt

The MAP supported the direction of these measures but commended that "broader readmission measures are preferred." It is important to recognize that these measures are part of the ACS surgical Measure Groups. Several procedure-specific outcomes are examined to have a more comprehensive snapshot of the success of the procedure. Additionally, the ABS has endorsed these measures because they deemed these procedures and outcomes to be the most important to measure for individual surgeons. Likewise, they are some of the most common procedures performed in the U.S. Inclusion of these measures follows the Clinician Workgroup's Guiding Principles which supports alignment with MOC programs and registries.

In response to NQF's "additional findings" which recommend a broader readmission measure, it is important to note that in order to be more meaningful for quality improvement purposes, surgeons need to know readmission rates by procedure. A broader measure may not be as actionable for individual surgeons to improve quality and safety compared to a procedure specific measure group. Therefore, we recommend the MAP to consider deleting the "additional findings" of the ACS readmission measures which recommends the preference of broader measures.

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### American College of Surgeons

#### David B. Hoyt

Percutaneous Central Line Placement

NQF did not support the direction of the Percutaneous Central Line Placement (M2919, M2920, M2921) measure group, including the central line-associated bloodstream infection (CLABSI) measure. NQF stated that the "measure does not adequately address any current needs of the program," and that the "NQF-endorsed CLABSI should be explored for use at the individual clinician level of analysis." However, this measure group addresses the National Quality Strategy priorities, and is a high-impact condition that is one of the most common procedures performed by surgeons in the U.S. The ABS has endorsed this Measure Group and

the included measures because they deemed these procedures and outcomes to be the most important to measure for individual surgeons. Inclusion of these measures follows the Clinician Workgroup's Guiding Principles which supports alignment with MOC programs and registries. Therefore, we recommend the MAP support the direction of this measure group, including analysis at the clinician level and delete the "additional findings" which recommends specifying the current NQF-endorsed CLABSI measure for use at the individual clinician level of analysis.

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### **American College of Surgeons**

#### **David B. Hoyt**

Patient-Centered Surgical Risk Assessment Measure

NQF's MAP did not support the measure entitled Patient-Centered Surgical Risk Assessment: the percent of patients who underwent non-emergency major surgery who received preoperative risk assessment for procedure-specific postoperative complications using a data-based patient-specific risk calculator and who had a personal discussion of these risks with a surgeon (M2916). This may be one of the most important measures to include in PQRS. The report did not provide rationale behind MAP's decision. ACS believes that measuring risk assessment and communication between surgeons and patients is critical to ensure informed consent and shared decision-making. The Patient-Centered Surgical Risk Assessment "risk calculator" provides a personalized, empirically-based estimate of a patient's risk of post-operative complications based on their demographics, comorbidities, and indication for the operation. Evidence suggests that sharing numeric estimates of patient-specific risk will engage patients, improve informed consent, and may enhance patient trust in providers.<sup>6</sup> This measure is at the core of patient-centered surgical care. To this end, we strongly recommend that MAP support this measure because it aligns with both the "patient and family engagement" and "communication and care coordination" priorities of the National Quality Strategy.

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### **American College of Surgeons**

#### **David B. Hoyt**

Physician Compare

MAP stated that Clinician and Group CAHPS (CG-CAHPS), "while not finalized for use in any federal clinician measurement program, is an NQF endorsed patient experience measure that MAP recommends for incorporation into all clinician programs. MAP viewed this measure as a high priority that should be implemented quickly." ACS wants to stress that the CG-CAHPS is not equally meaningful to surgical patients, and therefore the CAHPS Surgical Care Survey (S-CAHPS) should also be recommended for inclusion on Physician Compare after a year of being reported in PQRS. If CG-CAHPS is the sole patient experience of care measure, CMS runs the risk of applying an inappropriate patient experience of care survey to surgical practice groups.

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### **American College of Surgeons**

#### **David B. Hoyt**

S-CAHPS has been tested by the same standards as the CG-CAHPS, is NQF endorsed, follows the same collection mechanism as the CG-CAHPS, and is just as accurate. S-CAHPS expands on the CG-CAHPS by focusing on aspects of surgical quality which are important from the patient's perspective and for which the patient is the best source of information. The survey asks patients to provide feedback on surgical care, surgeons, their staff, and anesthesia care. It assesses patients' experiences with surgical care in both the inpatient and outpatient settings by asking respondents about their experience before, during, and after surgery. If S-CAHPS is included as an option to be reported on Physician Compare, physicians could then select the patient experience of care survey that is most appropriate to their group practice and patients could receive information which better reflects the care provided by a surgical group.

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### **American Medical Association**

#### **James L. Madara**

Balancing Physician Quality Reporting System (PQRS) Program Objectives

Beginning in 2015, the law requires that physicians

who do not successfully participate in the PQRS will be penalized. In implementing this provision, CMS has established 2013 as the performance year on which 2015 penalties will be based. As a result, PQRS participation will exponentially increase and the program will experience an influx of hundreds of thousands of physicians and other eligible professionals. The need to quickly engage eligible professionals in the PQRS in 2013 to avoid a penalty could be at odds with the goal of quality measurement and improvement activities that foster standardization and better outcomes. The AMA urges the MAP to balance these goals of helping physicians and other health care professionals successfully engage in the PQRS, while also helping the program and its participants achieve quality improvement that results in better outcomes. In this light, we urge that the MAP ensure the PQRS contains measures that allow a good entry point to the program for physicians and other eligible professionals who have not previously participated in the program. Specifically, it would be wise to make more use of the “phased removal” category, and maintain those measures in the PQRS for another two or three years, while other more outcome-focused measures are developed. Further, the MAP should recommend inclusion of certain measures (as indicated in the attachment), even if they are not yet National Quality Forum (NQF) endorsed, to maximize the number of physicians who are able to participate in the PQRS. For example, the MAP recommendation to not support a number of bariatric measures was based on the rationale that bariatric surgery “is of low importance for this program.” Yet, this may leave physicians who primarily provide bariatric surgery without an opportunity to participate in the PQRS. A flexible approach is critical to ensuring that relevant measures are available to as many physicians as possible as many new physicians begin participating in the PQRS.

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### American Medical Association

#### James L. Madara

##### Categorization of Specific Measures

The MAP pre-rulemaking report categorizes specific measures and provides the MAP’s conclusions and rationale for how each measure should or should not

be used in a federal program. The AMA applauds the MAP for revising many measure titles to accurately reflect the measure’s purpose. With regard to specific measures, the AMA has the following comments:

- The MAP should not assume that measures designed and validated for use in a certain health care setting (such as at the health plan level) are appropriate for use in other settings (such as at the individual physician or small group level). For example, the AMA-convened Physician Consortium for Performance Improvement (PCPI) Care Transitions Measures (NQF IDs: 0646, 0647, 0648 and 0649) have been reviewed by the MAP for consideration in a physician level program (PQRS) and a facility level program, the Long Term Care Hospital Quality Reporting Program. These measures are intended to be implemented at the facility level only. They are not appropriate for individual physician level measurement. Therefore, the AMA does not support these measures being considered for inclusion in the PQRS. The AMA does, however, support the inclusion of measures 0646, 0647, and 0648 in the Long Term Care Hospital Quality Reporting Program. There are numerous reasons why measurement varies across health care settings. These include, but are not limited to: methodological problems with attribution and/or risk adjustment at various levels of attribution; measures have not completed testing and therefore have not been eligible to receive full NQF endorsement; funding is not available to help evolve a measure concept by adding specifications; or there is no solid evidence base available that justifies the development and use of a measure within a particular health care setting. To better explore measure application across settings, the AMA recommends that the MAP consult with measure developers for the particular measures the MAP is considering for use in alternative settings or levels of evaluation.

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### American Medical Association

#### James L. Madara

- The AMA urges the MAP workgroups to exercise flexibility in their deliberations and recommendations concerning the use of measures in government programs. This is especially needed

given that measure review and endorsement can take several or more years. In the meantime, as this review and endorsement process is occurring, the PQRS could prove to be a training ground for measures until a final decision is made concerning endorsement. This will also allow broader participation in the PQRS, especially for subspecialty physicians for whom relevant measures are not currently available in the PQRS. For example, the MAP did not recommend three new measures for inclusion in the 2014 PQRS, as developed and submitted by the College of American Pathologists (CAP). These include measures M2899, M2900, and M2905. CAP developed the two lung cancer measures (M2899, M2900) directly in response to a request from the National Quality Forum (NQF) Cancer Care Committee in March 2012 that CAP develop these measures. In addition, CAP developed the melanoma measure (M2905) for use by dermatopathologists who currently have no applicable measures in the PQRS and thus have no way to participate in the program. Because of the multiple year NQF measure review cycle, these measures have not yet had a chance to undergo NQF review and endorsement. The earliest opportunity for review of these new measures will be 2015. In the meantime, these measures could be used in the PQRS and other federal programs. Although the MAP did not offer an explanation for its decision to not support these three measures, the AMA urges the MAP to reconsider and support these measures, as this would provide needed flexibility and allow for broader participation in the PQRS.

The AMA also urges the MAP to reconsider its recommendations concerning other measures in the MAP report. We have attached a chart with our specific comments highlighting the need for reconsideration of various measures in the MAP report.

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### **American Nurses Association**

#### **Maureen Dailey**

ANA is concerned that the clinician measures continue to have significant care coordination gaps including the lack of team-based care coordination measures with shared accountability and attribution.

It is essential to meet the goals of the NQS three-part aim, including prevention and safety goals, that the best mix of clinicians with the right staffing provide comprehensive, coordinated, timely patient-centered care. This cannot occur without a clearer understanding of the role and contribution of all team members. As per the IOM Future of Nursing Report, practicing to the top of the license is important to achieve clinical quality goals, including patient safety, at lower cost. Team-based interprofessional care coordination is essential in primary care models to achieve national goals for prevention of avoidable hospitalization. This is particularly true for high-risk populations with multiple chronic conditions, such as subgroups of the dual eligible populations who experience care disparities, and those with advanced illness requiring improved access to patient-centered palliative and hospice care.

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### **American Optometric Association**

#### **Kara Webb**

The MAP has called for the incorporation of CG CAHPS into all clinician quality reporting programs. The MAP also noted that this recommendation should be implemented quickly. While patient experience data is important, the AOA believes that practitioners and beneficiaries alike must be educated regarding the use of CG CAHPS. Rather than quickly incorporate CG CAHPS into all programs, the AOA recommends that education efforts regarding CG CAHPS be initiated and rolled out methodically. This is especially important if the results of the CG CAHPS will be made public. The AOA continues to have concerns regarding the feasibility of creating a core set of measures that can be reported, regardless of a practitioner's specialty. Over the past several years, there have repeatedly been calls for a consistent measure set to be created but few steps have been made towards this goal. The MAP's recent identification of possible focus areas for core measures is helpful. Developing consistent patient experience, coordination of care, population health and health disparities measures for all practitioners is far more attainable than attempting to identify measures related to specific health conditions that could be reported by all practitioners. The MAP has recommended that only measures that are meaningful to consumers should

be made available on physician compare. The AOA is concerned that the measures data that is publically shared could have the potential to confuse rather than assist consumers if it is overwhelming or is not provided within sufficient context. The AOA believes that the MAP should communicate these additional concerns to HHS. The AOA concurs with the MAP recommendation that measures should have been reported in a national program, such as PQRS, prior to being included in the VBPM. The AOA supports the MAP's recommendation to CMS to make the clinician measures under consideration available earlier in the year. This would allow for greater analysis of the measures presented. The MAP has suggested that clinical panels could be convened to review the measures prior the convening of the MAP Clinician Workgroup. The AOA believes this could be very helpful.

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### **American Psychiatric Institute for Research and Education**

#### **Robert Plovnick**

NQF #1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

Unplanned readmission is an important consideration for quality improvement and healthcare efficiency, and the American Psychiatric Association supports the need to measure this aspect of care. Patients with primary psychiatric illness are likely to experience unplanned readmissions for a variety of factors, some pertaining to the hospitalization which could potentially be modified, others related to the course of illness and post-discharge conditions and services over which the hospital will have far less control. Measure #1789 excludes patients with primary psychiatric disease with the rationale that "patients admitted for psychiatric treatment are typically cared for in separate psychiatric or rehabilitation centers which are not comparable to acute care hospitals." While we agree that psychiatric patients should be excluded from this measure due to technical considerations, we note that a significant number of patients are treated within acute care hospitals for primary psychiatric illness. Further, psychiatric illness, whether primary or secondary, is prevalent, particularly in the dual eligible population. Excluding this population limits the reach of the measure. We

therefore suggest unplanned readmissions in the population of patients with psychiatric illness be prioritized for further study and the development of quality improvement resources.

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### **American Society for Bone and Mineral Research**

#### **Douglas Fesler**

ASBMR supports performance measures that encourage clinician evaluation of risk factors for osteoporosis and fracture, focusing first on those risk factors most likely to lead to osteoporosis and fracture. ASBMR concurs with the MAP draft report in supporting the direction of the osteoporosis composite measure. As HHS considers the individual osteoporosis measures that make up the composite measure, and the composite measure itself, ASBMR believes that priority should be placed on those performance measures that will most directly affect health outcomes and enhance coordination of care.

Osteoporosis diagnosis and treatment are critical first steps for both post-fracture patients and those at risk, followed by adequate calcium and vitamin D intake, and then by weight bearing exercise, fall prevention and decreased alcohol consumption. Clinician monitoring of all risk factors for osteoporosis and fractures is ideal, but focusing on post-fracture diagnosis and treatment will yield improved health outcomes in the short term and allow clinicians to focus reporting and quality improvement activities on the urgent need for post-fracture care and preventive activities targeted to those most at risk for osteoporosis and fracture. Additionally, consistency between performance measurers is important and ASBMR encourages the use of the more widely applicable phrase "bone mineral density (BMD) test" here as it is used in the other measures related to osteoporosis, rather than the more narrow description of "dual-emission X-ray absorptiometry (DXA) scan" which may preclude the use of other valid methods.

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### **American Society for Clinical Pathology**

#### **Jeff Jacobs**

The American Society for Clinical Pathology has reviewed the report, and in particular, the measures applicable to pathology (Lung Cancer Reporting

((1)biopsy/cytology specimens and (2) resection specimens) and (3) Melanoma Reporting) and wishes to state its full and unconditional support for these measures. These measure involved significant expenditure of time and other resources, involving expert review, other organization inputs and commitments.

These three measures were developed by pathology as a concerted effort to improve quality diagnostics and patient care. If adopted, they will help improve the patient care experience.

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### **American Society of Cytopathology**

#### **Andrew Renshaw**

On behalf of the American Society of Cytopathology, I wish to provide the support of College of American Pathologists (CAP) pathology measures.

In August 2012, the CAP submitted three new pathology measures to CMS for the 2014 PQRS in the hopes of increasing opportunities for pathologists to participate in the PQRS. The ASC asks that the MAP please change its recommendations and support the three new pathology measures submitted by the CAP (Measures M2899 Lung Cancer Reporting (biopsy/cytology specimens), M2900 Lung Cancer Reporting (resection specimens), and M2905 Melanoma Reporting.) The CAP developed these measures directly in response to a request from the National Quality Forum Cancer Care Committee during its March 2012 meeting.

The ASC strongly supports the CAP and ask that the MAP reconsider including the pathology measures that were submitted in August 2012. The American Society of Cytopathology (ASC) is the largest medical society solely devoted to recognizing cellular abnormalities in order to benefit patients.

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### **American Speech-Language-Hearing Association**

#### **Lisa Satterfield**

The Audiology Quality Consortium (AQC) represents 10 audiology organizations and works as the measure owners for NQF measure numbers: M287, M288, and M289. The AQC agrees with the MAP and recommends removal of M287, Referral for Otologic Evaluation for Patients with Congenital

or Traumatic Deformity of the Ear, as the measure does not engage clinician participation and is minimally relevant to Medicare beneficiaries. We are requesting full retirement of the measure in 2014 and will not be seeking NQF endorsement. It was our understanding that M288 and M289 were recommended for retirement by the MAP in 2012, and were subsequently removed by CMS for reporting. The AQC requests that, consistent with 2012 recommendations, the MAP ensures M288 and M289 not be put forward as measures for reporting in 2014, as educational efforts have focused on those measurements as retired for 2013. The AQC requests that as measures are submitted for consideration by NQF and the MAP, the AQC be consulted on those measures that are broadly inclusive and have potential for audiologists to report.

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### **American Speech-Language-Hearing Association**

#### **Lisa Satterfield**

Comments: NQF Measures M308 through M315, Functional Communication Measures

The American Speech-Language-Hearing Association (ASHA) is the organization representing speech-language pathology and the measure owners for NQF measure numbers M308 through M315. These measures are recommended for phased removal by the MAP.

The recommendation for phased removal of all of the measures is surprising given recent conversations with CMS that encouraged us to continue use of the measures. When we recognized that the NQF endorsed measures did not align with new program specifications and NQF endorsement would be removed, we determined it was in the best interest of the program and our members to resign. However, Dr. Dan Green expressed his concern over this action, and per this communication exchange, we agreed to continue use of the measures in order to ensure our members had appropriate measures for participating in PQRS. Measures M308 through M315 are the only clinically applicable speech pathology measures at this time. Speech-language pathologists participate in PQRS only through registry and are not familiar with the claims-based medication management measure that was edited to include therapy CPT codes in late 2012 for 2013. Therefore, considerable

education is necessary to move forward with use of that or other claims-based measures.

We are concerned that movement toward cross-discipline measures will dilute the validity of the performance improvement outcomes as they are not directly relevant to the clinical services provided, and therefore; the cross-disciplinary measures may not adequately serve the intended function of helping to inform patients of the quality of a given provider's services. Without the M308 through M315, there would be no PQRS measures specific to the practice of a speech-language pathologist.

However, ASHA is generally supportive of the transition of the current PQRS measures to multi-purpose measurement data to reduce clinician reporting burden and to align with other federal programs. In the 2013 final rule, CMS used the same Functional Communication Measures that are currently represented in NQF measure numbers M308-M315 as a template for creating claims-based functional outcome reporting G-codes. In 2013, all SLPs providing therapy services to Medicare Part B beneficiaries are required to include the G-codes on the claim in designated reporting intervals that represent patient function, severity, and progress throughout the treatment plan. ASHA would like to suggest that if these same measures were to be retained in PQRS, perhaps a more-streamlined process could be established wherein the therapy services reporting in the claims data could inform both programs, reduce reporting burden for the clinician, and significantly increase the data available for PQRS. ASHA supports the phased removal of the PQRS measures if alignment with the therapy services functional outcomes reporting is a reality.

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### **America's Health Insurance Plans**

#### **Carmella Bocchino**

We are supportive of the measures in the clinician performance measurement programs, however, measures such as #0076 Optimal Vascular Care Composite require a combination of claims and chart-based data, and not all end-users will have access to both data sources, particularly in those communities with limited electronic data infrastructure capabilities. There also needs to be development of measures for specialty care.

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### **AmeriHealth Mercy Family of Companies**

#### **Thomas James**

AmeriHealth Mercy Family of Companies agrees with alignment of federal programs around incentives. However there is discussion that it would be an improvement if there were a limited set of measures on which all physician specialties could be measured. This hope for simplification fails to recognize why there are multiple specialties. The relationship of what an office-based dermatologist, an operating orthopedic surgeon, and a community center-based psychiatrist does is fairly far apart. Finally, Measures which follow NQF principles in development but are not NQF certified should be allowed in the pre-rule making process.

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### **AMGEN Inc.**

#### **Sharon Isonaka**

Amgen supports performance measures that encourage post-fracture diagnosis, treatment, and coordination of care because these are critical for ensuring that individuals who suffer a fracture have the best opportunity to avoid a subsequent fracture and the complications, which can lead to a diminished quality of life as well as increased healthcare costs. Both Measure 1110/NQF #0053 and NQF #0037, along with several other NQF-endorsed osteoporosis measures that are currently part of CMS' Physician Quality Reporting System (PQRS), would greatly enhance coordination of care, and benefit fracture patients by ensuring that fracture patients are tested for osteoporosis and prescribed pharmacologic therapy, if appropriate. Amgen also supports performance measures that encourage comprehensive clinician evaluation and monitoring of patient risk factors for osteoporosis and fracture. Furthermore, Amgen believes that clinician attention toward post-fracture identification, diagnosis and treatment is particularly well-placed, as these patients continue to be amongst the most chronically at-risk for on-going problems related to their osteoporotic condition, as well as the associated, additional healthcare costs that these patients represent to the federal healthcare system. Once NQF endorsed, widespread and careful utilization of the Osteoporosis Composite Measure 2700 should help the community to better address the needs



of this patient population, and highlight areas for necessary improvement.

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### **Association for Molecular Pathology**

#### **Mary Steele Williams**

The Association for Molecular Pathology (AMP) is an international medical and professional association representing approximately 2,000 physicians, doctoral scientists, and medical technologists who perform or are involved with laboratory testing based on knowledge derived from molecular biology, genetics and genomics. Membership includes professionals from the government, academic medicine and the in vitro diagnostics industry.

The College of American Pathologists (CAP) submitted three new pathology measures to CMS in August 2012 for the 2014 PQRS in the hopes of increasing opportunities for pathologists to participate in the PQRS. AMP asks that the MAP please change its recommendations and support the three new pathology measures (Measures M2899 Lung Cancer Reporting (biopsy/cytology specimens), M2900 Lung Cancer Reporting (resection specimens), and M2905 Melanoma Reporting.)

Many pathologists currently cannot participate in CMS quality programs because there are no applicable measures. AMP is aware of CAP's proposals and believes there is ample justification for inclusion of these measures and that they offer significant contributions to quality improvement for lung cancer and melanoma patients. If the MAP has specific concerns regarding CAP's proposals, we respectfully request that the MAP work with CAP to address them.

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### **Association of American Medical Colleges**

#### **Jennifer Faerberg**

The AAMC appreciates the development of the principles for hospital and physician measures. However, the principles are buried in an appendix at the end of the report and therefore lose their effectiveness. As these principles are fundamental in the consideration of measures perhaps further work should be done to incorporate these principles into the measure selection criteria and therefore ensure they are applied consistently.

The AAMC supports the staged approach referenced in both principle documents as it relates to measures being used in performance-based payment programs. While it is a requirement for hospital measures not to be included in VBP until they have been reported on Hospital Compare for one year, the same should hold true as referenced in the principles, for the physicians where no measure should be included in the VM program prior to being included in PQRS.

The AAMC supports the use of hospital measures only for hospital-based physicians.

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### **Association of Pathology Chairs**

#### **Ann Thor**

The Association of Pathology Chairs strongly supports the three new pathology-specific performance measures developed and submitted by the College of American Pathologists (CAP) for inclusion in the 2014 Physician Quality Reporting System (PQRS). These three measures, pertaining to complete reporting of lung cancer biopsy specimens, lung cancer resection specimens, and cutaneous melanoma specimens, are important determinants of the quality of pathology results in support of effective patient management. They were carefully developed by a panel of experts, and field-tested by subspecialist pathologists, to ensure that they reflect the latest classification and staging guidelines for these potentially devastating diseases and hold pathologists accountable for including this vital information in their reports. Two of the measures were developed in direct response to a request by the National Quality Forum Cancer Care Committee that the CAP develop such performance measures for pathologists. The Measures Application Partnership (MAP) did not recommend inclusion of any of these measures to CMS. We strongly encourage reconsideration by the MAP to support inclusion of these three important measures in the 2014 PQRS.

Proposed New Measure #1 – Lung cancer reporting (biopsy/cytology specimens) Pathology reports based on biopsy and/or cytology specimens with a diagnosis of non small cell lung cancer classified into specific histologic type or classified as NSCLC-NOS with an explanation included in the pathology report

Proposed New Measure #2 – Lung cancer reporting (resection specimens) Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non small cell lung cancer, histologic type

Proposed New Measure #3 – Melanoma reporting Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate

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### Center to Advance Palliative Care

#### Diane Meier

The Center to Advance Palliative Care supports these measures. Italics shows suggested additional comments for further development:

0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment - expand measure beyond hospice patients

0647 Transition Record with Specified Elements Received by Discharged Patients – we particularly note with approval the inclusion of the Advance Care Plan as an element of the transition record

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

1625 Hospitalized Patients who Die an Expected Death with an ICD that has been deactivated

1626 Patients Admitted to ICU who Have Care Preferences Documented

1634 Hospice and Palliative Care: Pain Screening - expand measure beyond hospice patients

1637 Hospice and Palliative Care: Pain Assessment - expand measure beyond hospice patients

1638 Hospice and Palliative Care: Dyspnea Treatment - expand measure beyond hospice patients

1641 Hospice and Palliative Care: Treatment Preferences - expand measure beyond hospice and specialty palliative care patients

1626 Patients Admitted to ICU who Have Care Preferences Documented

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### Children’s Hospital Association

#### Ellen Schwalenstocker

The Children’s Hospital Association supports the need to monitor for unintended consequences to vulnerable patients noted under VBPM. We believe it is premature to state that “broader readmissions measures” are preferred (e.g., p. 69). There is not yet sufficient experience with readmission measures, particularly in pediatric populations, to support this statement. It is unclear from reading the report how measures 1789, 1170 (p. 48) and M2580 relate to one another. The report states that measure 1789 is supported by the MAP for PQRS. The MAP supports the direction of M1170 but notes that it needs to be specified and tested for use at the individual clinician level of analysis. Can it be assumed that 1789 has been tested at this level? MAP also supports the direction of M2580, which is another all-cause readmission measure.

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### College of American Pathologists

#### Fay Shamanski

Many pathologists currently cannot participate in CMS quality programs because there are no applicable measures. The College submitted three new pathology measures to CMS in August 2012 for the 2014 PQRS in the hopes of increasing opportunities for pathologists to participate in the PQRS. The College asks that the MAP please reverse its recommendations and support the three new pathology measures (Measures M2899 Lung Cancer Reporting (biopsy/cytology specimens), M2900 Lung Cancer Reporting (resection specimens), and M2905 Melanoma Reporting.) The College developed these measures directly in response to a request from the National Quality Forum Cancer Care Committee during its March meeting that CAP develop such measures. In addition the melanoma measures (M2905) will allow dermatopathologists who currently have no applicable measures in the PQRS to participate. The College submitted these measures to cognitive testing in collaboration with other stakeholders including with American College of Surgeons and the American Academy of Dermatology.

The MAP did not provide any specific reasons for its recommendations to not support the pathology

measures, so we cannot address any specific concerns. However, we ask the MAP to consider the following justification for inclusion of these measures. The lung cancer measures are based on guidelines developed by the International Association for the Study of Lung Cancer, American Thoracic Society, and European Respiratory Society<sup>i</sup> and the TNM staging system of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC)<sup>ii</sup>. As noted in the guidelines, the purpose of pathologic evaluation is to precisely classify the histologic type of lung cancer and to determine all staging parameters including tumor size, the extent of invasion (pleural and bronchial), adequacy of surgical margins, and presence or absence of lymph node metastasis and is critical for subsequent therapeutic decisions. At the March NQF Cancer Care Committee meeting, the importance of staging measures was confirmed; and the notion of separating non-small cell lung cancer (NSCLC) into squamous cell (SCC) and adeno-carcinoma (AC) was advocated. This is now critical and not uniformly applied.<sup>iii</sup> This distinction is important because there are now targeted therapies, e.g. EGFR antagonists and Avastin, for AC that either do not work for SCC or can be lethal (e.g. pulmonary hemorrhage in SCC treated with bevacizumab). Furthermore, the inclusion of cytologic specimens is imperative. Most diagnoses are now made on such specimens because it is less invasive and most patients present with locally advanced or metastatic disease.

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### College of American Pathologists

#### Fay Shamanski

Recent research and the publication of new guidelines<sup>iv</sup> on melanoma indicate newer tumor characteristics for more precise staging with implications for treatment outcomes. CAP believes there is a gap in reporting of these new characteristics in melanoma pathology reports and justification for inclusion of the melanoma measure in the PQRS.

The College believes the MAP did not fully appreciate the significance of the measures or their contribution to quality improvement for lung cancer and melanoma patients and requests that MAP reconsider these measures. The College intends to bring these

measures to the NQF for endorsement at the earliest opportunity and reminds the MAP that the NQF just completed its review of cancer measures (during which these measures were requested), and based on the current schedule will not call for cancer measures again for several years. Please don't hesitate to contact Fay Shamanski, CAP Assistant Director, Economic and Regulatory Affairs at [fshaman@cap.org](mailto:fshaman@cap.org) if you have any questions on these comments.

i Travis WD, Brambilla E, Noguchi M, et al. International Association for the Study of Lung Cancer/American Thoracic Society/European Respiratory Society International Multidisciplinary Classification of Lung Adenocarcinoma. *Journal of Thoracic Oncology* 2011;6:244-285.

ii The NCCN. Non-Small Cell Lung Cancer: Clinical Practice Guidelines in Oncology. [http://www.nccn.org/professionals/physician\\_gls/pdf/nscl.pdf](http://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf). Updated April 11, 2012. Accessed May 9, 2012. To view the most recent and complete version of the guideline, go online to [www.nccn.org](http://www.nccn.org).

iii Arch Path 137:32, 2013

iv The NCCN. Melanoma: Clinical Practice Guidelines in Oncology. [http://www.nccn.org/professionals/physician\\_gls/pdf/melanoma.pdf](http://www.nccn.org/professionals/physician_gls/pdf/melanoma.pdf). Updated December 1, 2011. Accessed May 9, 2012. To view the most recent and complete version of the guideline, go online to [www.nccn.org](http://www.nccn.org).

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### Consumer-Purchaser Disclosure Project

#### Tanya Alters

Under "Key Issues" we are concerned over the statement that "An overarching goal for all federal clinician performance measurement programs is engaging clinician participation in meaningful quality reporting." For consumers and purchasers, the overarching goal is better performance, which means getting more meaningful measures into the program. The language here needs to show that balance. In addition, these programs will not be voluntary for much longer, and soon there will be penalties that will drive greater participation. Thus, we want to promote having the best measures available for use. Later in this section it says that MAP aims to reduce clinician reporting burden. We would like to note that the use of the word "burden" occurs 15 times in this

document, the first being on p. 6. We recommend MAP use a more neutral term to describe this issue, such as “improving data collection efficiencies.” As an alternative, MAP could also use the word “burden” to describe the problem that patients face when they don’t have the information they need to identify high and low performing providers. Note that these comments also relate to the language in the report regarding the PQRS.

In the Physician Compare language, we applaud and support MAP’s continued support of the use of the CAHPS survey for reporting on patient experience at the provider level.

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### Consumer-Purchaser Disclosure Project

#### Tanya Alteras

In the section on Meaningful Use, we urge that the final report clarify, in regard to the following statement – “specifically, the workgroup recommends including endorsed measures that have eMeasure specifications available” – that having eMeasure specs does not equate with a measure being meaningful. This point was raised at the Coordinating Committee meeting but it is not reflected here. In addition, in the second bullet listed below that language, we suggest adding language about the importance of leveraging health IT capabilities to collect longitudinal data in an effort to create more meaningful measures.

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#### Eisai, Inc.

##### Charles Hampsey

Eisai agrees with the MAP’s recommendation not to support Measure 2944 (Surgical Therapy Referral Consideration for Intractable Epilepsy) for adoption in federal quality programs.

The measure targets “Patients with disabling complex partial seizures, with or without secondary generalized seizures, who have failed appropriate trials of first-line antiepileptic drugs [who] should be considered for referral to an epilepsy surgery center, although criteria for failure of drug treatment have not been definitely established.”[1] With over 40 epilepsy syndromes, multiple seizure types, and over 20 medications used to treat epilepsy, the measure steward acknowledges it can be “unclear which

medication should be tried first based on efficacy or toxicity.”[2] Prescribing decisions are not always clear cut, and clinicians must consider multiple factors.

We applaud the intent 2944 which is to assess whether these patients have been considered for referral to a higher level of care on a regular basis (every 3 years)[3] but failure of a first-line therapy does not necessarily imply the epilepsy is intractable or drug resistant. Criteria for failure of antiepileptic drug therapy can vary, but the International League Against Epilepsy (ILAE) guidelines suggest that failure occurs when at least two well-chosen and tolerated drugs have not worked.[4] Quality measures must be clearly defined and easily applied and that is not the case with 2944. Eisai recommends that a future measure include an evaluation by an epileptologist for definitive diagnosis and to rule out nonepileptic seizures.[5]

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[1]American Academy of Neurology (ANN). Epilepsy physician performance measurement set. August 10, 2009. Page 29. <http://www.aan.com/globals/axon/assets/9079.pdf>.

[2]ANN. Epilepsy physician performance measurement set. Pages 9 and 26.

[3]Fountain NB, Van Ness PC, Swain-Eng R, Tonn S, Bever CT. Quality improvement in neurology: AAN epilepsy quality measures. American Academy of Neurology special article. January 4, 2011. Page 97. <http://www.aan.com/globals/axon/assets/8092.pdf>

[4]Kwan P, Arzimanoglou A, Berg AT, Brodie MJ, Hauser WA, Mathern G, Moshé SL, Perucca E, Wiebe S, French J. Definition of drug resistant epilepsy. Consensus proposal by the ad hoc Task Force of the ILAE Commission on Therapeutic Strategies. *Epilepsia*. doi: 10.1111/j.1528-1167.2009.02397. [http://www.ilae.org/visitors/Documents/Epigraph\\_Definitionofdrugresistantepilepsy.pdf](http://www.ilae.org/visitors/Documents/Epigraph_Definitionofdrugresistantepilepsy.pdf).

[5]Gates, JR. Nonepileptic Seizures: Classification, Coexistence with Epilepsy, Diagnosis, Therapeutic Approaches, and Consensus. *Epilepsy & Behavior* 3, 28–33 (2002). doi:10.1006/ebeh.2001.0310, available online at <http://www.idealibrary.com>.

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## Genentech

### Vanessa Reddy

Genentech supports the MAP recommendation for including measure 1879 (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) for use in the Physician Quality Reporting System. For the future, we recommend that there be a provision to add new medications and treatment delivery technologies beyond antipsychotics that address existing unmet treatment needs and demonstrate appropriate efficacy, as they become available. While the current therapies alleviate much of the positive symptoms of schizophrenia, they have demonstrated little to no effect on the negative and/or cognitive symptoms of the disease, which have a significant impact on patient functionality and health-related quality of life. It would be beneficial to monitor the most inclusive list of medications used in the treatment of schizophrenia.

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## Heart Rhythm Society

### Laura Blum

The Heart Rhythm Society (HRS) appreciates the opportunity to comment on the Measures Application Partnership (MAP) Pre-Rulemaking Draft Report. HRS appreciates MAP's decision to support the direction of the performance measure, "HRS-3 Implantable Cardioverter-Defibrillator (ICD) Complications Rate," for the Physician Quality Reporting System. However, we are writing to express our concern that this measure is one of the six HRS-developed measures for consideration for PQRS that was supported by the MAP.

We remind MAP about the other important outcomes measures we have developed and encourage it to consider these measures during future review processes. These measures include:

#### Atrial Fibrillation

HRS-1: Complications of Catheter Ablation Treatment for Atrial Fibrillation

HRS-2: Failure to Achieve Adequate Heart Rate Control for Patients with Atrial Fibrillation

HRS-12: Cardiac Tamponade Following Atrial Fibrillation Ablation

#### Prevention of Sudden Cardiac Arrest

HRS-4: In-person Evaluation Following Implantation of a Cardiovascular Implantable Electronic Device

HRS-9: Infection within 180 days of Device Implantation, Replacement, or Revision

It is important to keep in mind that although there are an abundance of performance measures for cardiovascular care, few measures apply to heart rhythm care. As such, we were disappointed that during its review process, the MAP Clinician Workgroup did not discuss these measures.

The Society's Atrial Fibrillation (AF) measures (HRS-1, HRS-2, and HRS-12), in particular, address critically important clinical patient outcomes and fill a gap area. HRS's AF measures aim to reduce the burden of this condition. Similarly, "HRS 4: In-person Evaluation Following Implantation of a CIED" fulfills a high-priority gap under the National Quality Strategy by promoting effective communication and coordination of care. HRS-4 holds the implanting physician responsible for ensuring that the initial 2 to 12 week post-implantation evaluation occurs—whether with the implanting physician or through coordination with the patient's primary cardiologist. This targets a substantial performance gap that currently exists in short-term follow-up. HRS urges MAP and the Department of Health and Human Services (HHS) to create "upstream" opportunities for measure stewards to provide contextual details (e.g., testing status, harmonization effort, NQF submission status) about measures under consideration which can inform MAP's review. Additionally, likely due to the high volume of measures under consideration, the Clinician Workgroup glossed over the Society's AF measures. HRS recommends that HHS provide more time for NQF and MAP to review measures under consideration. HRS also recommends that the NQF evaluates MAP's measure review process with the goal of ensuring its consistent application.

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## Medical Imaging & Technology Alliance

### Gail Rodriguez

#### NQF-Endorsed Measures

The 2013 draft report includes four NQF-endorsed measures on diagnostic imaging and one on

radiation therapy: Repeat Imaging Studies (NQF 0312, MAP ID 2238), Appropriate Imaging for Acute Back Pain (NQF 0315, MAP ID 2960), Thorax CT: Use of Contrast Material (NQF 0513, MAP ID 2256), Ultrasound Guidance for Internal Jugular Venous Catheter Placement (NQF 0666, MAP ID 2952), and External Beam Radiotherapy for Bone Metastases (NQF 1822, MAP ID 2866). We support the inclusion of these measures. Of these measures, NQF 0666 has time-limited NQF-endorsement. If NQF endorsement is withdrawn, we believe CMS should remove the measure.

#### Measures Without NQF Endorsement

In addition to the above stated measures, CMS proposes diagnostic imaging measures which do not have NQF endorsement. Of these, MAP notes five diagnostic imaging measures are not ready for implementation and should be submitted for and receive NQF endorsement: Equipment Evaluation for Pediatric CT Imaging Protocols (MAP ID 1886), Adult Sinusitis: Appropriate Diagnostic Testing for Chronic Sinusitis (underuse) (MAP ID 2417), Adult Sinusitis: Computerized Tomography for Acute Sinusitis (overuse) (MAP ID 2418), Adult Sinusitis: More than 1 Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (overuse) (MAP ID 2419), Adult Sinusitis: Plain Film Radiography for Acute Sinusitis (overuse) (MAP ID 2421). We agree that these measures should be considered by and receive NQF endorsement prior to use. In addition, MAP supports the direction of Radiation Dose Optimization Appropriateness: Follow-up CT Imaging for Incidental Pulmonary Nodules According to Recommended Guidelines (MAP ID 2444), but also notes that it is not ready for implementation and should be submitted for and receive NQF endorsement. We agree with this assessment and support the NQF endorsement process in evaluating this measure prior to use by CMS.

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### Medical Imaging & Technology Alliance

#### Gail Rodriguez

MAP recommends that measures that have lost NQF endorsement be phased out. We agree with this proposal and support the removal of Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports (MAP ID 109). In addition,

MAP proposes the phased removal of Radiation Dose Optimization: Utilization of a Standardized Nomenclature for CT Imaging Description (MAP ID 1883), which never received NQF endorsement. We also support the removal of this measure. MAP notes that Magnetic Resonance Imaging/Computed Tomography Scan (MRI/CT Scan) Results (MAP ID 1383) no longer has NQF endorsement. We support the removal of this measure as well.

Finally, MAP does not support Static Ultrasound with Elective Internal Jugular Vein Cannulation (MAP ID 2535), which has not been NQF endorsed. We encourage NQF to assess this measure and CMS to include it upon NQF-endorsement.

MITA appreciates this opportunity to comment on the 2013 draft report. We would be pleased

to answer any questions you might have about these comments.

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### Mindways Software, Inc.

#### Alan Brett

Mindways supports performance measures that encourage evaluation of risk factors for osteoporosis and fragility fracture, focusing first on those risk factors most likely to lead to osteoporosis and consequent fracture.

Osteoporosis diagnosis and treatment are a critical first step for both post-fracture patients and those at risk, followed by adequate calcium and vitamin D intake, and then by weight bearing exercise, fall prevention and decreased alcohol consumption. Clinician monitoring of all risk factors for osteoporosis and fractures is ideal, but focusing on post-fracture bone mineral density testing, diagnosis and treatment will yield improved health outcomes in the short term and allow clinicians to focus reporting and quality improvement activities on the urgent need for post-fracture care and preventive activities targeted to those most at risk for osteoporosis and fracture. Additionally, consistency between performance measurers is important and Mindways would encourage the use of the more widely applicable phrase “bone mineral density (BMD) test” here as it is used in the other measures related to osteoporosis, rather than the more narrow description of “dual-emission X-ray absorptiometry

(DXA) scan” which may preclude the use of other valid methods.

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### **National Bone Health Alliance**

#### **Beatriz Duque Long**

NBHA supports performance measures that encourage clinician evaluation of risk factors for osteoporosis and fracture, focusing first on those risk factors most likely to lead to osteoporosis and fracture. NBHA concurs with the MAP draft report in supporting the direction of the osteoporosis composite measure. As HHS considers the individual osteoporosis measures that make up the composite measure, and the composite measure itself, NBHA believes that priority should be placed on those performance measures that will most directly affect health outcomes and enhance coordination of care.

Osteoporosis diagnosis and treatment are a critical first step for both post-fracture patients and those at risk, followed by adequate calcium and vitamin D intake, and then by weight bearing exercise, fall prevention and decreased alcohol consumption. Clinician monitoring of all risk factors for osteoporosis and fractures is ideal, but focusing on post-fracture diagnosis and treatment will yield improved health outcomes in the short term and allow clinicians to focus reporting and quality improvement activities on the urgent need for post-fracture care and preventive activities targeted to those most at risk for osteoporosis and fracture. Additionally, consistency between performance measurers is important and NBHA would encourage the use of the more widely applicable phrase “bone mineral density (BMD) test” here as it is used in the other measures related to osteoporosis, rather than the more narrow description of “dual-emission X-ray absorptiometry (DXA) scan” which may preclude the use of other valid methods.

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### **National Coalition for Hospice and Palliative Care**

#### **Timothy Quill**

The National Coalition for Hospice and Palliative Care supports these measures. Italics shows suggested additional comments for further development

0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial

Assessment - expand measure beyond hospice patients

0647 Transition Record with Specified Elements Received by Discharged Patients - we particularly note with approval the inclusion of the Advance Care Plan as an element of the transition record

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

1625 Hospitalized Patients who Die an Expected Death with an ICD that has been deactivated

1626 Patients Admitted to ICU who Have Care Preferences Documented

1634 Hospice and Palliative Care: Pain Screening - expand measure beyond hospice patients

1637 Hospice and Palliative Care: Pain Assessment - expand measure beyond hospice patients  
1638 Hospice and Palliative Care: Dyspnea Treatment - expand measure beyond hospice patients

1641 Hospice and Palliative Care: Treatment Preferences - expand measure beyond hospice and specialty palliative care patients

1626 Patients Admitted to ICU who Have Care Preferences Documented

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### **National Osteoporosis Foundation**

#### **Beatriz Duque Long**

NOF supports performance measures that encourage clinician evaluation of risk factors for osteoporosis and fracture, focusing first on those risk factors most likely to lead to osteoporosis and fracture. NOF concurs with the MAP draft report in supporting the direction of the osteoporosis composite measure. As HHS considers the individual osteoporosis measures that make up the composite measure, and the composite measure itself, NOF believes that priority should be placed on those performance measures that will most directly affect health outcomes and enhance coordination of care.

Osteoporosis diagnosis and treatment are a critical first step for both post-fracture patients and those at risk, followed by adequate calcium and vitamin D intake, and then by weight bearing exercise, fall prevention and decreased alcohol

consumption. Clinician monitoring of all risk factors for osteoporosis and fractures is ideal, but focusing on post-fracture diagnosis and treatment will yield improved health outcomes in the short term and allow clinicians to focus reporting and quality improvement activities on the urgent need for post-fracture care and preventive activities targeted to those most at risk for osteoporosis and fracture. Additionally, consistency between performance measures is important and NOF would encourage the use of the more widely applicable phrase “bone mineral density (BMD) test” here as it is used in the other measures related to osteoporosis, rather than the more narrow description of “dual-emission X-ray absorptiometry (DXA) scan” which may preclude the use of other valid methods.

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### Renal Physicians Association

#### Robert Blaser

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease. RPA is pleased to strongly support the following measures included in the MAP List of Measures Under Consideration: Measure 2523 - Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy Comment: Comment: RPA strongly supports the inclusion of this measure in PQRS as it meets the National Quality Strategy priorities of clinical quality of care, safety and efficiency and cost reduction. ACE inhibitors and ARBs are recommended as preferred agents for diabetic kidney disease and non-diabetic kidney diseases with proteinuria. In these diseases, they lower blood pressure, reduce proteinuria, slow the progression of kidney disease, and likely reduce CVD risk by mechanisms in addition to lowering blood pressure. In these types of CKD, ACE inhibitors and ARBs are recommended even in the absence of hypertension. ACE inhibitors and ARBs may also be used alone or in combination to reduce proteinuria in patients with or without hypertension. This measure is consistent with the new KDIGO CPG for CKD.

Measure 2525 - Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis access is a catheter at the time maintenance hemodialysis is initiated Comment: RPA strongly supports the inclusion of this measure in PQRS as it meets the National Quality Strategy priorities of clinical quality of care, safety and efficiency and cost reduction. Among vascular access modalities, catheters have the highest rates of infectious complications, thrombosis, risk of permanent central venous stenosis or occlusion. Patients receiving catheters have greater mortality risk than patients dialyzed with fistulae.

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### Renal Physicians Association

#### Robert Blaser

Measure 2527 - Adult Kidney Disease: Referral to Nephrologist

RPA strongly supports the inclusion of this measure in PQRS as it meets the National Quality Strategy priorities of clinical quality of care, safety and care coordination. Nephrology care for individuals with severe chronic kidney disease (CKD) has potential health benefits including: treatment of kidney disease complications (e.g., outcome hypertension, anemia, metabolic abnormalities), attenuation of disease progression, informed modality choice and coordinated initiation of renal replacement therapy, timely placement of vascular access, and arrangements for kidney transplantation, if appropriate. Among patients beginning ESRD therapy in 2008, 43.7% had not seen a nephrologist prior to initiation of therapy. Of those with no nephrologist care prior to initiating therapy, 89% initiated with a catheter and only 2.6% had a fistula, the preferred vascular access modality. It also reflects disparities in care: 47% of African American patients receive no nephrologist care before beginning ESRD therapy, compared to 41% of white patients<sup>1</sup>. In 2008, 57 percent of new ESRD patients had received some pre-ESRD nephrology care; just 25 percent received care for more than twelve months. In a study comparing referral patterns of primary care physicians for CKD, results show that women, minorities, elderly patients, and those with non-private insurance (i.e., Medicare and Medicaid) are at risk for late or non-referral to a nephrologist for CKD. With respect to the elderly, female gender and a



higher burden of comorbidity predict non-referral.

Measure 2522 - Adult Kidney Disease: Catheter Use for greater than or equal to 90 Days

RPA strongly supports the inclusion of this measure in PQRS as it meets the National Quality Strategy priorities of clinical quality of care, safety and efficiency and cost reduction. Among vascular access modalities, catheters have the highest rates of infectious complications, thrombosis, risk of permanent central venous stenosis or occlusion. Patients receiving catheters and grafts have greater mortality risk than patients dialyzed with fistulae. Long-term catheter use without appropriate adjustments in treatment duration can compromise dialysis adequacy. Compromise of dialysis adequacy is associated with increased morbidity and mortality. Long-term catheter access is associated with a risk for central venous stenosis development, which can preclude the establishment of a permanent vascular access for HD. Data suggest that a change from non-cuffed to long-term cuffed catheters, and the reduction in catheter placement rates, may reflect longer duration of catheter use and longer exposure to potential infections<sup>29</sup>. The infection rate for long-term cuffed catheters is one episode per 252 catheter days, and their use is associated with lower blood flows, less hemodialysis, and an increased risk of sepsis, endocarditis, and metastatic infections.

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### Renal Physicians Association

#### Robert Blaser

Measure 2524 - Adult Kidney Disease: Arteriovenous Fistula Rate RPA strongly supports the inclusion of this measure in PQRS as it meets the National Quality Strategy priorities of clinical quality of care, safety and efficiency and cost reduction. Among vascular access modalities for hemodialysis patients, the use of arteriovenous fistulas (AVFs) has been consistently associated with lower rates of complications (e.g., infection, stenosis, thrombosis, aneurysm, and limb ischemia), morbidity and mortality.

Measure 2526 - Adult Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level <10g/dL RPA strongly supports the inclusion of this measure in PQRS as it meets the National Quality Strategy priorities of clinical quality of

care and safety. Additionally, RPA believes that in order to assess Hgb management that there needs to be measures probing both the upper end and lower ends of the Hgb distribution curve. Further, NQF has endorsed Measure 1667(Pediatric) ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL was recommended for endorsement by this committee. RPA does not believe that a person's anemia treatment should change once they turn 18 years old. In addition, pediatric nephrologists often continue to see patients until they are 21 years old. Therefore, since the pediatric Hgb < 10 measure is recommended for endorsement, capturing patients that suffer from anemia, these patients and other adults with anemia should also be captured.

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### Renal Physicians Association

#### Robert Blaser

Measure 2528 - Adult Kidney Disease: Transplant Referral

RPA strongly supports the inclusion of this measure in PQRS as it meets the National Quality Strategy priorities of clinical quality of care, safety, care coordination and efficiency and cost reduction. Kidney transplantation offers lower rates of all cause, cardiovascular and infectious hospital admissions and better long-term survival than hemodialysis in ESRD patients. In 2007, Adjusted one-year survival with a functioning transplant is 91% for recipients of first-time, deceased donor transplants and 96% for recipients of first time, living donor transplants. Transplant patients require less hospitalization. Hospital days per patient year for transplant, hemodialysis and peritoneal dialysis patients are 12.8%, 13.3% and 5.9%, respectively. Further, racial and ethnic disparities in referral rates continue to persist.

Measure 2530 - Adult Kidney Disease: Adequacy of Volume Management

RPA strongly supports the inclusion of this measure in PQRS as it meets the National Quality Strategy priorities of clinical quality of care and safety. Management of hypertension in dialysis patients includes the management of fluid status. Poor extracellular volume control may exacerbate hypertension and so it is important to optimize ultrafiltration, volume status and dry weight to

control blood pressure in an effort to improve patient outcomes.

As always, the RPA appreciates the scope of MAP's efforts in the area of quality improvement, and we look forward to future collaboration whenever possible.

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## Renal Physicians Association

### Ruben L. Velez

Measure 2523 - Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy Comment:

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## Society of Hospital Medicine

### Shaun Frost

The Physician Quality Reporting System Program

As noted above, hospital medicine is not yet recognized as a medical specialty by CMS with its own unique Medicare identifier. Thus the majority of performance measures currently included in the different physician-level CMS programs were developed and implemented for primary care General Internal Medicine and may lack relevance for hospitalists.

SHM would like to encourage the consideration of the following measures for inclusion in the applicable physician-level programs including the PQRS:

- Measure 728 Adherence to Chronic Medications
- Measure 2962 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- Measure 2961 Timely Transmission of Transition Record
- Measure 2963 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
- Measure 1035 Atrial Fibrillation/Atrial Flutter Assessment of Thromboembolic Risk Factors
- Measure 2501 Patients Admitted to ICU Who Have Care Preferences Documented
- Measure 2152 Stroke and Stroke Rehab: TPA Considered Measure 2432 Stroke and Stroke Rehab: Lipid Management
- Measure 2433 Stroke and Stroke Rehab: TPA Administered
- Measure 2486 Asthma: Assessment of Asthma Risk – Emergency Department to Inpatient Setting

- Measure 2487 Asthma: Asthma Discharge Plan – Emergency Department to Inpatient Setting
- Measure 2579 30-Day Post Discharge Visit
- Measure 187 Coronary Artery Disease: ACE/ARB Therapy for Patients with CAD and DM and/or LVSD
- Measure 107 HF-6: Heart Failure Beta-blocker Therapy for LVSD
- Measure 1110 Osteoporosis Management in Women >= 67 Who Had a Fracture
- Measure 2964 Reconciled Medication List Received by Discharged Patients
- Measure 2952 Ultrasound Guidance for Internal Jugular Central Venous Catheter Placement
- Measure 2919 Percutaneous Central Line Placement 1. Iatrogenic Injury to Adjacent Organ/Structure

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## Society of Hospital Medicine

### Shaun Frost

- Measure 2920 Percutaneous Central Line Placement 2: Central line-associated bloodstream infections SHM is aware that assigning physician-level attribution for accountability for performance measures is challenging. We are familiar with the evolving CMS attribution methodology from the QRURs with attribution categorization of physicians as directing, influencing or contributing to care. We have previously offered comment to CMS about the deficiency of this methodology for attributing care to with hospitalized patients where a multidisciplinary team of physicians, nurses and ancillary services is involved. Additionally, hospitalists are identified as general internal medicine physicians for the purposes of CMS attribution. The role of a hospitalist as the leader of an acute care team is distinctly different than a general internist working in the outpatient setting. We recommend and encourage that the following measures should receive careful review of the attribution methodology and the reporting specifications before inclusion in an accountability program such as the PQRS or Physician Value-Based Modifier Program:
- Measure 2881 Hospital Wide All Cause Unplanned Readmissions.
- Measure 2987 Acute Composite: Acute Composite (1 of 3): Bacterial pneumonia Acute Composite (2 of

- 3): UTI Acute Composite (3 of 3): Dehydration
- Measure 2991 Chronic Composite (See 2 individual measures AND 1 composite measure consisting of 4 additional individual measures below [Total of 7 measures] to define Chronic Composite)
- Measure 2580 All Cause Readmissions
- Measure 2878 Episode Grouper: Pneumonia
- Measure 2879 Episode Grouper: Coronary Artery Bypass Graft (CABG)
- Measure 2880 Episode Grouper: Percutaneous Coronary Intervention (PCI)
- Measure 2882 Episode Grouper: Coronary Artery Disease
- Measure 2884 Episode Grouper: Congestive heart Failure
- Measure 2885 Episode Grouper: Chronic Obstructive Pulmonary Disease
- Measure 2887 Episode Grouper: Asthma
- Measure 1170 ACO 8 Risk-Standardized, all Condition Readmission

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## Society of Hospital Medicine

### Shaun Frost

Physician Compare, Physician Feedback, Value-Based Payment Modifier Program

SHM supports the following measures for consideration for inclusion on the Physician Compare web site and the Physician Feedback and Value-based Modifier Programs:

- Measure 1164 How well your doctors communicate.
- Measures 187 and 303 Percent of patients with CAD and LVEF<40% prescribed ACEI or ARB, and percent of patients with ischemic vascular disease with documented use of asa or other anti-thrombotic.
- Measure 1135 – Persistent Use of beta-blockers for 6 months post discharge AMI. SHM supports the concept of this measure. However, the difficulty for hospitalists will be that this measure is attributed to a group of physicians identified under single TIN. For hospitalists working within private primary care or multi-disciplinary groups, this is not an issue. For national hospital medicine groups or hospital-based groups, there will not be the ability to document

180-day course of therapy, leaving the majority of hospitalist physicians unable to report.

- Measures 296 and 1891 - measurement of lipids with LDL <100 documented or plan of care to achieve such result in all patients with either CAD or ischemic vascular disease, including use of a statin.
- Measure 107 - Beta-blocker therapy for LVSD <40% patients prescribed a beta-blocker either within a 12-month period in outpatient setting or at hospital discharge.
- Measure 1160 - Drug-Disease interactions in the Elderly. As noted in measure 1135, this measure will be assigned to group of physicians under the same TIN. Again, it may affect some hospitalists who are part of a private group but miss national and hospital based hospital medicine groups.

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### **Takeda Pharmaceuticals**

#### **Deborah Walter**

NQF 0711 “Depression Remission at Six Months”: We agree with the inclusion of this outcome measure in the Physician Quality Reporting System (PQRS) to assess remission in patients. This measure includes the use of the PHQ-9, a standardized tool that aids providers in monitoring patients’ depression. Consistent use of such a tool also promotes provider and patient contact. By evaluating a patient’s remission status at six months, this measure promotes providers’ continued monitoring of the patient’s response to treatment.

M2504 PCPI: “[DRAFT] Adult MDD: Follow Up Assessment of Depression”: We disagree with MAP’s decision not to support this measure’s inclusion in PQRS. We understand that MAP wants to avoid duplicative efforts; there is a significant gap in care coordination across the depression care continuum. This measure assesses the documentation of a patient’s response to treatment (at least 3X in the first 90 days), including a systematic assessment of symptoms, side effects, adherence, and functional status. It also assesses documentation of treatment plan review/ alteration. Patient response to an antidepressant is unpredictable due to individual metabolic profile, potential for poor patient compliance, intrinsic phenotypic heterogeneity of the depressive syndrome, etc. Follow-up with patients is considered proper standard of care. Use of this

measure can help ensure steps are taken to monitor treatment emergent signs and symptoms, including worsening of depression. We strongly support this measure concept for improving follow-up care for patients with depression.

M2505 PCPI: “[DRAFT] Adult MDD: Continuation of Antidepressant Medications”: We disagree with MAP’s decision not to support the inclusion of this measure in PQRS. This measure assesses patients who were continued on antidepressants for 16 wks following initial status change to remission & allows for use of many different validated tools based on the DSM-IV-TR criteria to identify remission. The American Psychiatric Association’s guideline recommends that if a patient is treated successfully with antidepressants in the acute phase, he/she should be continued on antidepressants for 4-9 months to reduce the risk of relapse. Similarly, the VA/ DoD’s guideline suggests that patients remain on the same dose for an additional 6-12 months. As MDD patients often have other comorbidities that may inhibit full or continued remission, it is important to maintain patients on medications beyond initial remission. While a drug holiday may eventually be appropriate based on patient preference and physician assessment, use of this measure can help ensure patients receive a period of continued treatment in the four months following remission, when the majority of relapses occur. We support this measure for NQF endorsement and inclusion in PQRS.

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### **The Joint Commission**

#### **Margaret VanAmringe**

Support for the Perinatal Measures

The Joint Commission appreciates and supports the MAP’s recommendation to include three of The Joint Commission’s perinatal measures in several CMS reporting programs. The Joint Commission’s perinatal set is important because it supports the widely held belief among policymakers and health professionals that there should be a standard set of quality measures focused on perinatal care.

Elective Delivery (PC-01) recommended for inclusion in the Hospital Value-Based Purchasing Program: This measure was recommended by the MAP last

year and adopted for inclusion in the Hospital Inpatient Quality Reporting Program for FY 2015. The measure was also adopted for the Medicare and Medicaid Electronic Health Record Incentive Program as a clinical quality measure for Eligible Hospitals and Critical Access Hospitals for Stage 2 of Meaningful Use. Preterm births are a rapidly escalating public health problem that can have significant consequences for families, and we believe that this early elective delivery measure aligns well with the National Quality Strategy's three-part aim of better health care for individuals, better health for populations, and lower costs for health care.

Cesarean Section (PC-02) was recommended for inclusion in the Hospital Inpatient Quality Reporting Program: This measure seeks to focus attention on the most variable portion of the Cesarean Section (CS) epidemic -- Cesarean Section in nulliparous women. This population segment accounts for the large majority of the variable portion of the CS rate, and is the area most affected by subjectivity.

Breast Milk Feeding (PC-05) was recommended for inclusion in the Hospital Inpatient Quality Reporting Program: This measure has also been adopted for the Medicare and Medicaid Electronic Health Record Incentive Program as a clinical quality measure for Eligible Hospitals and Critical Access Hospitals for Stage 2 of Meaningful Use. Exclusive breast milk feeding for the first 6 months of neonatal life has long been the expressed goal of organizations such as the World Health Organization, the Department of Health and Human Services, the American Academy of Pediatrics, and American College of Obstetricians and Gynecologists.

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### Tri-Society (Gastroenterology)

#### Ronald Vender, Loren Laine, Thomas Deas

As CMS' quality programs move from an incentive to penalty phase and as CMS begins to incorporate Physician Quality Reporting System (PQRS) measures in other quality reporting programs, we believe it is critical for CMS to increase the number of meaningful, endoscopy-related measures for reporting by gastroenterologists. Incorporation of meaningful gastroenterology (GI) specific measures into CMS quality programs will allow for meaningful assessment of high-performing gastroenterologists

who provide value for their patients.

In 2013, gastroenterologists are still struggling with compliance and identifying performance metrics that are relevant to their scope of practice. According to the 2010 PQRS and ERx Experience Report published by CMS in April 2012, 11,959 gastroenterologists were eligible to participate in the PQRS program in 2010; however, only 2,612 (21.8%) participated. We speculate that the lack of endoscopic measure contributes to a low PQRS participation rate by gastroenterologists.

During CMS' "call for 2014 PQRS measures," our societies requested that CMS accept our jointly developed "colorectal cancer screening" measures group for inclusion in PQRS beginning in 2014.

Colonoscopy is a high-volume service performed predominately by gastroenterologists. NQF has identified colorectal cancer as a high-impact condition, making development of meaningful colonoscopy measures paramount to our societies. Colonoscopy is considered to be the most effective screening option for colorectal cancer. Our organizations recommended that CMS create a colorectal cancer screening measures group consisting of the following measures, of which NQF measures #659 and #658 are already included in the PQRS program.

- Endoscopy and Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (PQRS Measure #185; NQF Measure #659)
- Endoscopy and Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (PQRS Measure #320; NQF Measure #658)
- Screening Colonoscopy Adenoma Detection Rate (Recently developed by the AGA, ASGE and ACG Quality Improvement Task Force)
- Colonoscopy Quality Composite (Recently developed by the AGA, ASGE and ACG Quality Improvement Task Force)

The addition of the Adenoma Detection Rate (ADR) and Colonoscopy Quality Composite measures to the group creates an appropriate mix of measure types that meets the priorities of the National Quality Strategy, MAP Measure Selection Criteria and the Clinician Workgroup Principles in developing a quality measure sets.

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**Tri-Society (Gastroenterology)****Ronald Vender, Loren Laine, Thomas Deas**

## Colonoscopy Adenoma Detection Rate Measure

We are disappointed with the Clinician Workgroup's recommendation of "Do Not Support" for the proposed ADR measure for 2014 PQRS, as well as the lack of supporting rationale. This ADR measure is a true outcome measure directly linked to reduced mortality from colorectal cancer.<sup>1</sup> This measure was developed through a consensus expert panel of gastroenterologists representing the GI societies. Additionally, the developers sought further harmonization by providing a public comment period for their members and other measure stakeholders in order to further refine the ADR measure specifications to meet the needs of all colonoscopy providers.

One of the goals of the NQF is to endorse measures that are truly associated with better outcomes for patients; the ADR measure is consistent with that goal. This measure pertains to a high-impact condition, promotes alignment across quality programs, helps to prevent a leading cause of mortality and morbidity, upholds equitable access and treatment for health disparities, and does not increase clinical reporting burden. This measure is currently being captured in and readily reported out of the two GI registries: GI Quality Improvement Consortium, Ltd. Registry (GIQuIC) – the non-profit collaboration of ACG and ASGE, and the AGA Digestive Health Outcomes Registry.

The detection of neoplastic lesions is the primary goal of the most colonoscopic examinations.<sup>2</sup> The removal of adenomatous polyps during a screening colonoscopy is associated with a lower risk of subsequent colorectal cancer incidence and mortality. Higher adenoma detection rates (> 20% in a mixed gender population) are associated with significant protection against incident colorectal cancer in the five years following screening colonoscopy. Up to 30% of colorectal cancers arise from serrated neoplasms including sessile serrated polyps, sessile serrated adenomas and traditional serrated adenomas.<sup>3</sup>

The adenoma detection rate is the best-established neoplasia-related quality indicator and is defined as

the proportion of patients undergoing colonoscopy in which an adenoma, colorectal cancer precursor or colorectal cancer is found.<sup>4</sup>

1 Zauber, AG, Winawer, SJ, O'Brien, MJ, et al. Colonoscopic Polypectomy and Long-Term Prevention of Colorectal-

Cancer Deaths. *N Engl J Med* 2012;366: 687-696.

2 Rex DK, Petrini JL, Baron TH, et al. Quality Indicators for Colonoscopy. *Am J Gastroenterol* 2006;101:873-885

3 Rex DK, Ahnen DJ, Baron JA, Batts KP, Burke CA, Burt RW, Goldblum JR, et al. Serrated lesions of the colorectum:

Review and recommendations from an expert panel. *Am J Gastroenterology* 2012; advance online publication, 19

June 2012; doi: 10.1038/ajg.2012.161.PMID: 22710576

4 Church J. Adenoma detection rate and the quality of colonoscopy: the sword has two edges. *Dis Colon Rectum*

2008;51:520-3.

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**Tri-Society (Gastroenterology)****Ronald Vender, Loren Laine, Thomas Deas**

This measure calculates a physician's adenoma detection rate by examining the number of patients 50 years of age or older for which the physician reported that at least one adenoma or other neoplasm was detected during a screening colonoscopy.

Studies show that high adenoma detection rates are associated with a significant reduction in colorectal cancer risk. Yet, virtually all studies on this subject have found marked variation in polyp detection rates among physicians. Currently, there are no measures in PQRS that address the quality outcome of the colonoscopy, only the appropriate follow-up and use of surveillance colonoscopy.

There is a strong interaction between the quality with which the colon is cleared of neoplasia and the effectiveness of the recommended intervals for surveillance. We believe that CMS quality programs must not only address the potential overuse of

colonoscopy, but also the quality of the technical aspects of the procedure.

We also believe that this ADR measure may not have been supported because NQF did not endorse a previously-submitted ADR measure. It is important to emphasize that the specifications for the ADR measure submitted for inclusion in 2014 PQRS has changed significantly from the ADR measure submitted for 2013 PQRS consideration. In instances where the same or similar measure is proposed for NQF endorsement or inclusion in CMS quality programs, we believe that the MAP should request historical information from NQF to explain to the Workgroup why a previously-submitted measure was rejected and information from the measure developer on why the same or similar measure is being resubmitted. In fact, NQF needs to make easily accessible to the MAP and developers the transcripts and reasons for the previous rejection to help measure developers know how to respond when proposing a similar measure.

Our societies will be submitting the ADR measure to the NQF Gastrointestinal/Genitourinary Steering Committee for NQF endorsement consideration during the next measure submission process.

Given the GI societies' efforts to develop a measure that has strong published evidence proving that saves lives and decreases frequent surveillance resulting in reduced costs, we request that the MAP reconsider its proposed decision of "Do Not Support" for the ADR measure or provide rationale for its current decision.

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### **Tri-Society (Gastroenterology)**

**Ronald Vender, Loren Laine, Thomas Deas**

Colonoscopy Quality Composite Measure

We are pleased with the MAP's recommendation to support the direction of the Colonoscopy Composite Measure submitted to CMS by ACG, AGA and ASGE for inclusion in the 2014 PQRS. Proper colonoscopy documentation and recommendations help to ensure a quality colonoscopy and can diminish risks to patients and improve continuity of care. Additionally, we believe that adherence to this measure will result in a reduction of duplicative or unnecessary tests, resulting in a cost-savings to the Medicare program.

This measure, as recommended, includes two components:

1. Assessment of bowel preparation – Poor bowel preparation is a major impediment to the effectiveness of colonoscopy because; it affects the ability to detect polyps and influences the timing of repeat examinations.
2. Cecal intubation/depth of intubation with photodocumentation – Studies have shown that physicians do not routinely document the depth of insertion in the colonoscopy report. Quality evaluation of the colon consists of intubation of the entire colon – from the rectum to the cecum. Knowing the depth of insertion can inform physicians of whether a radiographic procedure or repeat colonoscopy is necessary. However, the lack of comprehensive

documentation can lead to unnecessary or repeat tests.

Successful reporting of this measure would require the documentation bowel preparation and cecal intubation for patients who undergo a colonoscopy.

When the workgroup briefly discussed this measure during its meeting, it seemed unaware of a similar Colonoscopy Quality Index measure recently considered by the NQF Gastrointestinal/Genitourinary Steering Committee. This measure was approved to move to Stage 2 of the new NQF measure endorsement process being piloted pending harmonization with other stakeholders. The GI societies have been contacted by the developer of this measure to seek harmonization among the two measures.

Our societies believe that knowing where a proposed measure is in the NQF process is critical to the review process of the workgroups and the MAP's mission to perform with integrity and transparency. Recognition that the workgroup has assessed measures and measure concepts currently in the NQF pipeline would increase the confidence of measure developers and of CMS in the workgroup's recommendations. We strongly recommend that the specialty-specific steering committees that review measure concepts for NQF be given a role in the MAP process in future years to ensure that the workgroups have access to all relevant information



pertaining to specialty-specific measures advancing through the NQF endorsement process.

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### **Tri-Society (Gastroenterology)**

#### **Ronald Vender, Loren Laine, Thomas Deas**

Other GI-Related Measures under Consideration by MAP

During the MAP process, our societies learned of several measures submitted by the American College of Surgeons (ACS) that are directly related to the scope of practice for gastroenterology. The Clinician Workgroup supported the direction of the ACS measures, which are components of the measures included in the Colonoscopy Quality Composite measure. Unaware of these measure submissions to CMS, the GI societies plan to seek harmonization with ACS on their proposed and any future GI measures.

In the future, the MAP should be more directive with developers relative to harmonization when similar measures have been submitted such as those submitted by the GI societies and ACS. While the workgroup supported the direction of these measures, there was no encouragement of harmonization between the developers. During the meeting, the Workgroup discussed the need for a measure incubator tool so that developers could start to collaborate on measure development and reduce the number of duplicative measures submitted. We support the development of this tool.

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### **Tri-Society (Gastroenterology)**

#### **Ronald Vender, Loren Laine, Thomas Deas**

MAP Decision Categories and Rationale

This year, the MAP developed a more extensive process to evaluate measures for inclusion in Medicare quality programs. We believe that the MAP's current review and decision structure still lacks transparency and rigor. For example, under the PQRS measures for consideration, the Colonoscopy Quality Composite measure received a "Support Direction." The MAP concluded in its rationale that the measure was not ready for implementation and should be submitted for and receive NQF endorsement. Under additional findings, the MAP stated that the composite measure is preferred over

the individual measures submitted by the ACS. There was no additional feedback to CMS or developers on why the measure was not ready for implementation. In contrast, the Adenoma Detection Rate measure received a "Do Not Support." No rationale or additional findings for this decision were provided. We are very disappointed that no additional feedback was provided on this determination. In fact, it begs the question if the MAP even recognized that the ADR measure submitted for 2014 PQRS consideration was different from the measure submitted for 2013 PQRS. During the Clinician Workgroup meeting, Workgroup members expressed concern with the adequacy of the decision categories and proposed a "Conditional Support" category be added to the decision structure. We strongly support this recommendation. In future years, the decision structure and feedback process must be improved for developers to be confident of the MAP's decision-making process for inclusion of measures in CMS quality programs.

#### Clinician Workgroup Recommendations on CMS Quality Programs

To stimulate broad clinician participation, HHS asked the MAP to consider a colossal number of measures – 731 measures—for inclusion in federal clinician performance measurement programs. We believe that this was a herculean task given to the Clinician Workgroup. The Clinician Workgroup seemed overwhelmed with the sheer number of measures it needed to evaluate for provider-related quality programs. During the meeting and in the report, the Workgroup expressed a need for a more feasible and thoughtful review process that includes experts familiar with the specialty measures under consideration. In the report, the Workgroup recommended Clinical Panels. We support the use of Clinical Panels to provide objectivity to the process and streamline the Clinician Workgroup review process. These Clinical Panels should include experts from the specialty in which measures are being considered.

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### Tri-Society (Gastroenterology)

**Ronald Vender, Loren Laine, Thomas Deas**

Core Measures for All Clinicians

The Clinician Workgroup developed Guiding Principles for Applying Measures to Clinical Programs. These principles are intended to complement program-specific statutory and regulatory requirements and the MAP Measure Selection Criteria. The Workgroup expressed a need for a core set of measures that all clinicians, regardless of specialty

and setting, can report across all programs. The Workgroup believes the core set should focus on patient experience and engagement, patient-reported outcomes, other outcomes and care coordination, appropriate care, and population health. These measures should support parsimony

and alignment; the same measures should serve multiple programs where possible. The measures should be tested at the appropriate level of analysis.

We are not convinced that a core set of measures can capture the quality of subspecialists in a meaningful way. Core measures only capture part of the picture, however, they can be reasonable to implement after consultation with specialty providers on how these measures should be geared for particular populations of patients. In a procedure-dominant field, such as gastroenterology, a program needs to know if the procedure being provided is of high quality even if the patient expressed satisfaction with their care.

We believe more subspecialty measures need to be made available for reporting before CMS focuses on a set of core measures that can be used for all physicians and across all settings.

## Section 6: Pre-Rulemaking Input on Hospital Performance Measurement Programs

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### Alliance of Dedicated Cancer Centers

**R. Donald Leedy**

The ADCC comprises the eleven cancer centers that have a singular focus on cancer. The ADCC institutions are dedicated to advancing the nation's understanding of the causes, prevention, diagnosis, and treatment of cancer; providing innovative cancer therapies and the best possible care to patients; and, disseminating this knowledge to the community at large. The ADCC's members also collaborate to improve quality of care and outcomes for cancer patients. Because of our focused attention on cancer care only, Congress has twice protected the ADCC institutions from the shortfalls of a prospective payment system (PPS). While a PPS may be appropriate for most acute care hospitals, such a system is inappropriate for dedicated cancer centers that have a singular focus on one disease – cancer. PPSs assume that an array of services and diseases will be provided and treated at such hospitals. Such a system is based on the law of averages (i.e., hospitals typically treat a wide array of conditions/diseases with varying acuity levels, where payments for some services offset payment for other services); also, PPSs typically have a significant lag time before

new services and treatments may be integrated into payment rates.

Likewise, in the Patient Protection and Affordable Care Act of 2010 (ACA), Congress mandated that a separate reporting program be created for the ADCC institutions rather than applying an existing quality reporting program for PPS hospitals (e.g., the Inpatient Quality Reporting or IQR Program). Clearly, Congress recognized the unique nature of four institutions and of cancer treatment, which is primarily delivered in an outpatient setting, and the need for measures that account for the complex condition of cancer patients. Thus, measures adopted for our mandatory reporting program, the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, must be relevant and appropriate for our patients and must establish distinctions between providers of cancer care. Our singular focus and unique payment status provide an important perspective on the recommendations included in this report for the PCHQR Program. We trust that the MAP will give due consideration to our comments since this program applies exclusively to the dedicated cancer centers.

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## Alliance of Dedicated Cancer Centers

### R. Donald Leedy

We appreciate the MAP's position that the measures in the PCHQR Program should be aligned with the measures in the IQR and Outpatient Quality Reporting (OQR) Programs. However, as noted in our comment letter to the 2012 MAP Pre-Rulemaking Report, we recognize the need to avoid the unilateral application of measures from these programs to the PCHQR. The need for measure alignment is clear, but it is crucial that the aligned measures are relevant to cancer care to ensure that patients are appropriately informed about the quality of care in our centers and to prevent inappropriate diversion of scarce hospital resources from cancer-specific performance improvement and outcomes measurement. As an example, an IQR measure that specifies immunization would not be appropriate for immuno-suppressed cancer patients, since they are unable to mount an immune response. Such a measure applied to the dedicated cancer centers would have the unintended consequence of unnecessary and wasteful resource consumption.

Furthermore, we support MAP's position in placing a high priority on measures of patient and/or caregiver experience and patient-reported outcomes. Our cancer centers place a high value on patient and caregiver quality of life and well-being during and after cancer treatment, and the ADCC supports including in the PCHQR a National Quality Forum (NQF)-endorsed, cancer-specific patient experience survey, which accommodates changing patient and caregiver needs across the continuum of care. Thus, we are following closely the development of the CAHPS for Cancer Care Survey (Cancer CAHPS), the first disease-specific Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey that is being developed and tested with support from the National Cancer Institute (NCI) and the Agency for Healthcare Research and Quality (AHRQ). Several ADCC institutions are considering serving as pilot sites for future testing of the Cancer CAHPS survey in 2013; however, no pilots have been conducted to date at the PPS-exempt cancer hospitals.

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## Alliance of Dedicated Cancer Centers

### R. Donald Leedy

0166—Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Position: Consistent with the MAP's position, the ADCC supports the direction of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). However, we do not consider it the most appropriate survey for our patient population.

Rationale: The HCAHPS survey is widely used by PPS hospitals, whose care delivery primarily is inpatient-based. Conversely, the vast majority of cancer care delivered at the ADCC centers is outpatient-based. Thus, adopting the HCAHPS survey for the PCHQR would yield a patient experience assessment that is not representative of our cancer care. Moreover, its adoption for the PCHQR may lead to imprecise comparisons between our hospitals, particularly given the large variation in bed size (and associated inpatient volume). A survey that focuses on care in the ambulatory setting, where volume differences will not have as great an impact, would not be encumbered by these measurement issues. Finally, the ADCC is concerned that adoption of the HCAHPS survey—coupled with adoption of a cancer-specific patient experience survey, which is likely to occur in a year or two—will constitute an unintentional federal mandate to burden patients of PPS-exempt cancer centers by over-surveying.

Specific Considerations: As noted above, the ADCC supports including in the PCHQR an NQF-endorsed, cancer-specific patient experience survey that accommodates changing patient and caregiver needs across the continuum of care. Cancer patients represent a distinct subset of patients requiring long-term treatment plans for a single diagnosis (3-6 months or more) across a variety of providers and outpatient/inpatient settings that are not always integrated or coordinated. Variations in diagnosis and treatment across time, location, and providers present confounding factors to measuring and validating patient and caregiver experience with care. Thus, the instruments for measuring consumer experience require substantial validation to ensure their appropriateness and utility in the cancer population and to demonstrate a positive correlation

between quality outcomes and patient experience.<sup>1</sup> To our knowledge, the HCAHPS survey has not been tested specifically in a specialty population, such as cancer. Therefore, further testing would be required to ensure its appropriateness for the cancer population before it is used for reimbursement purposes under the PCHQR.

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### Alliance of Dedicated Cancer Centers

#### R. Donald Leedy

As the MAP is aware and as noted above, the Cancer CAHPS is the first disease-specific CAHPS patient experience survey and is being developed and tested with support from NCI and AHRQ. Research and development of this survey, which contains elements applicable to inpatient and outpatient cancer care, began in late 2009. The results from an initial pilot study at six sites are expected to be made public by February 1, 2013, and additional, broader testing is needed before the survey is finalized. It is anticipated that the additional testing may be completed as early as within one year. The ADCC welcomes the opportunity to evaluate the Cancer CAHPS for its applicability for our patients. Furthermore, we are considering potential piloting and implementation of the Cancer CAHPS survey within our cancer centers. However, until the Cancer CAHPS has been validated through beta testing in a broader array of cancer care settings, including PPS-exempt and non-exempt cancer centers, and has been vetted through the NQF endorsement process, the ADCC is reticent to support the adoption of any patient experience survey for the PCHQR.

Of note, four ADCC institutions are utilizing the HCAHPS survey to support internal performance improvement activities for our inpatient units. However, should the Cancer CAHPS (or a similar cancer-specific patient experience survey that is applicable to inpatient and outpatient cancer care) be validated for use in our hospitals, our leadership will give serious consideration to discontinuing the use of the HCAHPS to avoid over-surveying our patients, which has been associated with survey fatigue, leading to smaller response rates and decreased validity of survey results. Thus, if the HCAHPS is adopted for the PCHQR, we urge The Centers for Medicare and Medicaid Services (CMS)

to make this a temporary adoption until a cancer specific patient experience survey is validated and endorsed by the NQF. This position is of particular importance to ensure that the surveys applied to our patients are sensitive to the nuances of cancer care and that our patients are not overburdened by receiving multiple surveys for the same episode of care.

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### Alliance of Dedicated Cancer Centers

#### R. Donald Leedy

Surgical Care Improvement Project (SCIP) Measures—  
General Surgery

- 0218—Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time
- 0284—Surgery patients on beta blocker therapy prior to admission who received a beta blocker during the perioperative period
- 0452—Surgery Patients with Perioperative Temperature Management
- 0453—Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero
- 0527—Prophylactic antibiotic received within 1 hour prior to surgical incision
- 0528—Prophylactic antibiotic selection for surgical patients
- 0529—Prophylactic antibiotics discontinued within 24 hours after surgery end time

Position: In general, the ADCC supports the MAP's recommendation to adopt these Surgical Care Improvement Project (SCIP) measures for the PCHQR.

Rationale: The development of post-operative complications, including venous thromboembolisms (VTE) and surgical site infections (SSI), in a patient with cancer can lead to a life-threatening event, especially in those who are immunocompromised. Avoidance of these post-operative complications clearly leads to decreased morbidity and mortality, and the SCIP process measures (listed above) reduce the risk of these complications in surgical patients.

Specific Considerations: We appreciate CMS'

approach in applying selected SCIP measures for our program, rather than unilaterally applying all SCIP measures, which may or may not be appropriate for our centers. We urge CMS to exercise due caution in developing implementation guidelines for adopting these measures for the PCHQR. To our knowledge, these measures have not been formally tested in a specialty population, such as cancer. Thus, despite high compliance rates under these measures, our patients may experience higher infection rates unrelated to infection prevention protocols. Serious consideration must be given to relevant patient comparison groups, subsets and stratifications (e.g., by cancer type) and to appropriate exclusions where the recommended therapy is clinically inappropriate for our patients. Additionally, the required portion of population coverage for these measures is unclear. Consistent with their use in the IQR, we would expect that a patient sample would suffice. We trust that CMS will consider carefully these concerns in its rulemaking process.

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## Alliance of Dedicated Cancer Centers

### R. Donald Leedy

Surgical Care Improvement Project (SCIP) Measures—  
Cardiac Surgery

- 0300—Cardiac Surgery Patients With Controlled Postoperative Blood Glucose

Position: The ADCC does not support the MAP's recommendation to adopt this measure for the PCHQR.

Rationale: Our centers rarely, if ever, perform the cardiac procedures included in this measure. In the rare event that one of our centers performs one of these cardiac procedures, the volume would be too low to provide a valid comparison. Such a measure applied to the dedicated cancer centers would have the unintended consequence of unnecessary and wasteful resource consumption. Moreover, this measure has not been validated for the cancer population.

Specific Considerations: Post-operative blood glucose maintenance is important for all patients. However, this measure is intended for and has been tested in cardiac surgery patients only, not in the cancer population. Thus, additional testing and

vetting would be required to apply this measure to our surgical population.

### 0380—Multiple Myeloma – Treatment with Bisphosphonates

Position: The ADCC supports the MAP's recommendation to adopt this measure for the PCHQR, subject to the modifications outlined below. However, we urge CMS to consider delaying adoption of this measure until development and testing of a new, broader measure is complete.

Rationale: Bisphosphonates are the standard of care for preventing bone deterioration in multiple myeloma patients. However, bisphosphonates may be clinically inappropriate for some patients with multiple myeloma, and long-term use has demonstrated serious side effects in certain patients. Furthermore, we are concerned that the adoption of this measure essentially would lock our clinicians into one standard of care when emerging studies suggest that Denosumab, an osteoclast inhibitor, may provide equivalent if not superior bone protection in these patients.

Specific Considerations: Multiple myeloma is a serious disease, but it represents a small proportion of newly diagnosed cancer patients. We recommend that CMS utilize a similar, broader measure, such as the measure currently under development by CMS contractors, which addresses use of bisphosphonates and osteoclast inhibitors in patients with multiple myeloma as well as breast, prostate, and non-small cell lung cancers. This measure may be available for reporting as early as 2015. Thus, we recommend that CMS delay consideration of adopting NQF measure #0380 for the PCHQR until the broader measure has been fully tested, since switching to a new, broader measure within one year would prevent meaningful comparisons of data over time and would likely cause confusion in the minds of patients, for whom the quality reporting is intended. Additionally, it would not be resource-efficient for CMS, its contractors, or the ADCC institutions.

If adopted, we recommend that CMS work with the measure developer to apply exclusions that allow physicians to utilize other clinically appropriate therapies in patients where bisphosphonates were unsuccessful in preventing bone deterioration or where bisphosphonates are contraindicated.

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## Alliance of Dedicated Cancer Centers

### R. Donald Leedy

0382—Oncology: Radiation Dose Limits to Normal Tissues

Position: The ADCC supports the MAP's recommendation to adopt this measure for the PCHQR, with the exclusion described below.

Rationale: This is a reasonable measure to adopt and reflects the standard of care.

Specific Considerations: If adopted, we recommend that CMS work with the measure developer to apply the following exclusion to the measure: "Patients with metastatic disease treated for palliation." According to the NQF measure specifications, the measure would include patients with metastatic lung or pancreatic cancer receiving treatment for a metastatic site (e.g., bone or brain metastases) with 3D conformal radiation therapy for palliation. Dose limits to normal tissues may not always be applicable for such cases.

#### Pain Management Measures

0383—Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)

0384—Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)

Position: In general, the ADCC supports the MAP's recommendation to adopt these measures for the PCHQR, with the modifications outlined below.

Rationale: Frequently, cancer patients experience pain as a consequence of disease progression and as a side effect of treatment. Effective pain management for these patients is essential to maintaining or improving their quality of life during treatment and, in particular, at the end of life.

Specific Considerations: These measures reflect good concepts, but are hard to capture as written and, in certain cases, are too vague. Additionally, they seem insufficient to accommodate changes in level of pain across the continuum of care. For example, as pain intensifies along with progression of disease, a patient may require revisions to his or her plan of care for pain, but this nuance is not reflected in

the specification for NQF measure #0383. Also of note, producing these indicators likely will require manual chart review for our cancer centers. Based on our high patient volumes, we recommend that, if implemented, CMS adopt a sampling approach rather than 100% population coverage.

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## Alliance of Dedicated Cancer Centers

### R. Donald Leedy

Additionally, NQF measure #0383 would be improved by changing the title to "documented plan of appropriate/adequate care to address pain" and by modifying the numerator statement. As described in the NQF measure specifications, the numerator would suggest that patients with a pain intensity score of 1 or more should have a documented plan of care for pain. While we agree that all reported pain should be evaluated for potential treatment, patients with a pain score of 1 or 2 on a 10-point scale or with pain unrelated to cancer disease or treatment (e.g., an unrelated headache) do not require intervention in most circumstances, and the absence of documentation may lead to non-compliance in reporting this measure. Thus, we recommend that the numerator be revised to: "Patient visits that included a documented plan of care to address pain reported as moderate or severe—3 or more on a 10-point scale."

For NQF measures #0383 and #0384, the interpretation of the denominator statement ("All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain") is too narrow in certain cases. For example, it does not measure appropriately the denominator in cases where patients are not candidates for chemotherapy or radiation therapy or where patients have completed chemotherapy and/or radiation therapy and are not in remission. We recommend that CMS work with the measure developer to revise the denominator statements for both measures to read: "All visits for patients, regardless of age, with a diagnosis of cancer seen in an oncology clinic who report having pain."

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## Alliance of Dedicated Cancer Centers

### R. Donald Leedy

0389—Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patient

Position: The ADCC supports the MAP’s recommendation to adopt this measure for the PCHQR.

Rationale: It is well-known that the overuse of advanced imaging leads to considerable cost waste in the healthcare system. Therefore, appropriate and efficient use of advanced imaging has clear benefits for patients and the public at large.

Specific Considerations: If adopted, we recommend that CMS work with the measure developer to clarify what is meant by “low risk” (e.g., low risk of metastasis) and to provide additional specifications categorize patients as “low risk.” Additionally, we recommend that the measure be revised to incorporate a literature-based time frame for the numerator (i.e., patients who did not have a bone scan performed within X days of diagnosis). Furthermore, we recommend that the measure steward consider revising the measure to address overuse of abdominal computed tomography (CT) in addition to bone scan.

0390—Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Position: In general, the ADCC supports the MAP’s recommendation to adopt this measure for the PCHQR, subject to the considerations described below.

Rationale: Hormonal therapy is the standard of care for prostate patients at high risk for recurrence.

Specific Considerations: This measure recommends a standard of care that exceeds the recommendations in the original study, but there is a strong basis for expansion based on the current literature. For example, there is compelling data to support the use of neoadjuvant and concurrent androgen deprivation therapy (ADT), rather than adjuvant ADT alone. If adopted, we recommend that CMS work with the measure developer to provide additional specifications to categorize patients as “high risk for recurrence.” For example, we question the use of prostate-specific antigen (PSA) testing for defining

“high risk for recurrence” since the major studies on which this measure is based used tumor size and nodal status to assess this risk.<sup>5</sup> Additionally, we recommend that the measure be revised to incorporate a literature-based time frame for the numerator (i.e., patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin releasing hormone] agonist or antagonist) within X days of diagnosis).

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## Alliance of Dedicated Cancer Centers

### R. Donald Leedy

0753—American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

Position: The ADCC supports the MAP’s recommendation to adopt this measure for the PCHQR.

Rationale: The development of a surgical site infection in a patient with cancer can lead to a life threatening event, especially in those who are immunocompromised. Avoidance of these infections clearly leads to decreased morbidity and mortality.

Specific Considerations: We urge CMS to exercise due caution in developing implementation guidelines for adopting this measure for the PCHQR. Serious consideration must be given to relevant patient comparison groups, subsets, and stratifications, particularly for patients with a suppressed immune response. Additionally, the required portion of population coverage for these measures is unclear as well as the proposed reporting mechanism. Consistent with their implementation of the SCIP measures in the IQR, we expect that a patient sample would suffice.

Likewise, our centers are open to reporting this measure through the Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN), through which we are currently reporting other infection rates. We trust that CMS will consider carefully these concerns in its rulemaking process.

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## Alliance of Dedicated Cancer Centers

### R. Donald Leedy

#### M1643—Medicare Spending Per Beneficiary

**Position:** The ADCC does not support adopting the PPS Medicare Spending per Beneficiary (MSPB) measure for the PCHQR.

**Rationale:** In general, the ADCC supports the establishment of an efficiency measure that takes into account the special nature of cancer care and the dedicated cancer centers; however, we do not believe that the MSPB measure, as applied to PPS hospitals, is able to serve such a function. After a preliminary review of the MSPB measure designed for PPS hospitals, it is clear that substantial testing and adjustments are needed before any consideration is given to applying this measure to the ADCC.

**Specific Considerations:** We appreciate that the PPS MSPB measure is designed to capture pre-surgical testing and inefficiencies related to complications or readmissions, but the measure would not capture our efforts to minimize admissions. The ADCC institutions have been at the forefront of developing many of the advances that have allowed cancer care to be provided in the outpatient setting, which benefits patients and is more cost-effective than inpatient care.

Moreover, the PPS MSPB “episode” does not appropriately reflect the way that cancer care is delivered. For example, patients often receive necessary treatment (e.g., neoadjuvant chemotherapy) that is unrelated to the admission in the three days prior to admission and in the 30 days after discharge. Such spending should not be captured in the MSPB calculation. Of note, CMS recognizes this distinction in care by establishing a 72-hour hospital preadmission rule for PPS hospitals and a 24-hour rule for the dedicated cancer centers.

We also note that in the calculation of the MSPB measure for PPS hospitals, CMS price standardized, risk-adjusted, and excluded other payments that recognize the extraordinary nature of care provided in some hospitals (i.e., disproportionate share hospital payments and indirect medical education) in order to avoid distortions when comparing efficiencies across hospitals. Similarly, we trust that payments made to dedicated cancer centers will not

be included in any MSPB measure to avoid similar distortions. Furthermore, due to our advances in outpatient treatment, the inpatients that we serve have a higher acuity and severity of illness than in PPS hospitals. Therefore, appropriate risk-adjustment is vital.

Lastly, should a similar measure ever apply to the ADCC institutions, the median hospital standard to which we are compared should not be that of a PPS hospital. Our singular focus on cancer compared to a PPS hospital's treatment of a variety of conditions would produce an inaccurate picture of efficiency.

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## Alliance of Dedicated Cancer Centers

### R. Donald Leedy

#### M3035—Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)

**Position:** Due to the lack of measure specifications available for this measure and the potential overlap with NQF measure #0139 National Healthcare Safety Network (NHSN) Central line associated Bloodstream Infection (CLABSI) Outcome Measure, which is currently part of the PCHQR, we cannot provide meaningful input on the MAP's recommendation for this measure. We request that the measure developer provide specifications for the measure so that we may provide substantive comments on its adoption for the PCHQR.

**Rationale:** The ADCC supports the adoption of a revised CDC CLABSI measure, which excludes blood stream infections unrelated to central line placement and which utilizes for comparison appropriate inpatient units for the cancer population. If measure #M3035 incorporates these revisions, then we likely would support its adoption, pending review of the measure specifications.

**Specific Considerations:** CMS adopted NQF measure #0139 for the PCHQR for FY2014 reimbursement. It is unclear if the proposed measure is intended to replace NQF measure #0139 in the PCHQR or to what degree these measures overlap. Additionally and as noted previously, the CDC has been revising its CLABSI methodology to exclude blood stream infections unrelated to central line placement in cancer patients, and members of our infection control staff have worked closely with the CDC in this



regard. Patients on chemotherapy with subsequent gastrointestinal toxicities and, in particular, patients with profound neutropenia or those that experience complications following stem cell transplantation (e.g., graft-versus-host disease or GVHD) may develop blood stream infections unrelated to central line placement. An appropriate CLABSI measure will exclude those infections unrelated to central line placement to avoid erroneous conclusions about infection rates in the cancer patient population.

Of note, we agree in concept with the use of the standardized infection rate (SIR) for comparison to other patients with equivalent risk. For example, when our members report CLABSI data through the CDC NHSN, patients are classified according to their inpatient unit—intensive care unit (ICU) or Specialty Care Area (SCA). This practice leads to more accurate calculations of expected values and, accordingly, more equitable comparisons across providers.

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### Alliance of Dedicated Cancer Centers

#### R. Donald Leedy

M3036—Reliability Adjusted Catheter-Associated Urinary Tract Infection (CAUTI)

Position: Due to the lack of measure specifications available for this measure and the potential overlap with NQF measure #0138 National Healthcare Safety Network (NHSN) Catheter associated Urinary Tract Infection (CAUTI) Outcome Measure, which is currently part of the PCHQR, we cannot provide meaningful input on the MAP's recommendation for this measure. We request that the measure developer provide specifications for the measure so that we may provide substantive comments on its adoption for the PCHQR.

Rationale: The ADCC supports the adoption of a revised CDC CAUTI measure, which utilizes for comparison appropriate inpatient units for the cancer population. If measure #M3036 incorporates these revisions, then we likely would support its adoption, pending review of the measure specifications.

Specific Considerations: CMS adopted NQF measure #0138 for the PCHQR for FY2014 reimbursement. It is unclear if the proposed measure is intended to replace NQF measure #0138 in the PCHQR or to what

degree these measures overlap. Of note, we agree in concept with the use of the SIR for comparison to other patients with equivalent risk. For example, when our members report CAUTI data through the CDC NHSN, patients are classified according to their inpatient unit—ICU or SCA. This practice leads to more accurate calculations of expected values and, accordingly, more equitable comparisons across providers.

Additionally, we recommend excluding from the measure cancer patients with indwelling genitourinary (GU) hardware, such as percutaneous nephrostomy and internalized ureteral stents. Such hardware frequently is colonized with bacteria and, in cancer patients with both indwelling GU hardware and urinary catheters, may lead to the erroneous assumption that such patients have CAUTIs when that may not be the case. An appropriate CAUTI measure will exclude these infections to avoid inappropriate conclusions about infection rates in the cancer patient population.

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### Alliance of Dedicated Cancer Centers

#### R. Donald Leedy

In summary, the ADCC supports adoption of most of the measures recommended for the PCHQR, but does not support the adoption of two of the proposed measures: NQF measure #0300 Cardiac Surgery Patients With Controlled Postoperative Blood Glucose; and, #M1643 Medicare Spending Per Beneficiary. The ADCC's positions for all proposed measures are summarized in Table 1. We urge the MAP to reconsider its recommendations with respect to NQF measure #0300 based on the concerns outlined in this letter.

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### American Academy of Hospice and Palliative Medicine

#### Dale Lupu

The American Academy of Hospice and Palliative Care (AAHPM) notes that there are currently NO measures for hospital performance touching on palliative care domains for seriously ill patients. As noted in our gap comment, HCAHPS systematically misses the experience of patients with serious illness or at end of life and a supplementary module to

HCAHPS is needed.

We note that ASCO is currently conducting a project to develop new measures for PPS-exempt Cancer Hospitals. Many of the measures to be developed fit palliative care domains. With additional testing and modification, these new measures may form the basis for a palliative care measure set for acute hospitals. We urge MAP to make development of a palliative care measure family applicable across settings, including hospitals, the highest priority.

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### **American Academy of Ophthalmology**

**William Rich, MD**

Comment on NQF 0564: Complications

The American Academy of Ophthalmology strongly disagrees with the MAP's decision to support NQF 0564: Cataracts – Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures. NQF 0564 was developed by the Academy and the Physician Consortium for Performance Improvement as a physician level measure that was never intended to serve as a measure of facility-level quality. This measure instead seeks to identify those complications from surgery that can reasonably be attributed to the surgeon and which reflect situations which - if untreated - generally result in significant avoidable vision loss that would negatively impact patient functioning. The adverse events described in the measure, such as errors in intraocular lens (IOL) placement, retinal detachment, and retained nuclear fragments, can only be controlled by the operating surgeon. The facility has no control over these actions, and it would be extremely inappropriate to measure individual ASCs or hospital outpatient departments according to their complication rates for these events.

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### **American Academy of Ophthalmology**

**William Rich, MD**

Comment on Selection of Measures for ASC Quality Reporting

The American Academy of Ophthalmology notes that the MAP has proposed several existing Physician Quality Reporting System (PQRS) measures for inclusion in the Ambulatory Surgery Center (ASC)

Quality Reporting Program. Using PQRS measures to evaluate ASC quality is both infeasible from a data collection standpoint and inappropriate from a quality improvement standpoint. PQRS measures require that quality actions are taken by individual physicians and are intended to measure quality of care at the individual physician level. They utilize data collected by the physician at the point of care and housed in records that are maintained within the physician office. ASCs do not have access to this data. While many ophthalmic ASCs may be adjacent to ophthalmologists' offices, the majority of freestanding ASCs have no physical connection whatsoever to their operating surgeons' private offices. These are truly independent facilities, offering surgical services from multiple disciplines provided by as many as dozens of surgeons from as many separate offices. ASCs serve exclusively as a venue within which a physician performs surgery. The ASCs themselves are not medical practitioners and are neither practicably nor legally trained nor equipped to evaluate patients for surgery. The individual surgeons on the medical staffs of most facilities are not employees, but independent contractors who charge for their services under their own Medicare provider numbers and who are covered under their own professional liability insurance policies. The ASC itself is staffed by registered nurses, operating room techs, and clerical staff, none of whom is qualified to examine patients or evaluate them for surgical outcomes. In fact, the ASC's professional liability policy specifically excludes coverage for diagnosis and treatment. Physician-level measures such as those used in PQRS measures were never designed for collection in the ASC or to serve as proxies for quality within the facility. Most importantly, these measures are not actionable by facilities. The Academy recognizes that there is a strong impetus to align measures across programs. However, this priority must be secondary to ensuring that quality measures are appropriate and actionable by the entity being measured for purposes of quality improvement.

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## American Academy of Ophthalmology

**William Rich, MD**

Comment on NQF 1536

The American Academy of Ophthalmology strongly disagrees with the MAP's decision to support NQF 1536: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. NQF 1536 was developed by the Academy as physician-level measure and was never intended to serve as a measure of facility-level quality. The measure requires that patients complete a visual function questionnaire both before and after their scheduled surgery. The results of the pre- and post-surgery questionnaires are then compared to assess improvement.

ASCs are ill-equipped to evaluate potential cataract outcomes because the facility is not involved in the baseline events preceding surgery against which outcomes are measured, or in the post-surgical events that encompass the healing process. The visual function questionnaires are distributed to the patient when they are seen in the physician's office for evaluation, not at the ASC. Further, any improvement in visual function is attributable to the individual surgeon, not to the facility where the surgery occurred. We do not believe that it is possible for ASCs as facilities to influence outcomes on this measure, therefore it is not appropriate to include the measure in the ASC Quality Reporting Program or the Outpatient Quality Reporting Program. CMS has considered similar measures for ASC in the past and has withdrawn them in acknowledgement of the fact that they are not appropriate for facilities.

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## American Academy of Ophthalmology

**William Rich, MD**

Comment on ASC Cataract Measure Development

The Academy understands that CMS is interested in prioritizing inclusion of a cataract measure in the ASC Quality Reporting program. We are very interested in working with CMS and other organizations with an interest in this issue to develop ASC-level measures for this procedure. Any cataract outcome measure developed for the ASC setting must relate to the ASC episode and measure what the facility controls. It should be capably measured by the facility with the

data available in the ASC chart. Most importantly, the outcomes data produced should be actionable by the ASC. The existing ASC quality measures including hospital transfer/admission, wrong site, wrong side, wrong procedure, wrong implant, patient burn, and patient fall all meet this test. There are clear actions that facilities can take to improve performance on these measures and reduce the incidence of adverse events – a stated goal of the ASC Quality Reporting Program. The Academy looks forward to working with CMS to develop similarly appropriate measures for cataract procedures in the ASC setting.

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## American Association of Eye and Ear Centers of Excellence

**Robert Betz**

The American Association of Eye and Ear Centers of Excellence (AAEECE) respectfully submits its comments on the Measure Applications Partnership (MAP) Pre-Rulemaking Report: Public Comment Draft issued by The National Quality Forum (NQF). We commend and support NQF and the MAP's effort to harmonize measures throughout the different sectors of health care delivery and the recommendation to include measures of outcomes of Cataract Surgery. We wish to share comments on the cataract measures that the MAP has recommended for reporting by ASCs and hospital outpatient providers.

The AAEECE is comprised of the world's premier centers for specialized eye and ear procedures. Eye and ear specialty hospitals have led the way as providers of high-quality, cost-effective outpatient health care services. The mission of these specialty institutions requires that they maintain leading edge technologies, enabling them to provide highly specialized services not available in general hospitals. AAEECE member facilities serve as models of cost efficiency and

high-quality care when surgery and services are rendered by specialty hospitals on an outpatient basis. Association members are major nation-wide referral centers with a commitment to teaching, research and hands-on patient care of the highest level of quality. These specialty hospitals routinely treat the most severely ill eye and ear patients.

AAEECE believes that it is premature for NQF to recommend Measure 1536: Improvements in Patient's Visual Function Within 90 Days Post Cataract Surgery for reporting by ASCs and Hospital Outpatient Departments. While we understand the potential value of a patient-centered measure, we do not believe the measure has been reviewed and tested at the facility level. In NQF's June 2012 "Surgery Endorsement Maintenance 2010 Technical Report" questions were raised about how the survey would be distributed and what sample sizes would be appropriate. These questions have not been addressed at the hospital or ASC level and they become even more complex since many centers have a large number of practicing physicians and the follow up assessment most often occurs in the physician office rather than in the hospital or ASC setting. It is not clear how NQF will assure that the results represent the institution rather than a small subset of the facility's practicing ophthalmologists. More importantly, in the June 2012 Report the steering committee noted that a "threshold of improvement" is needed and that this would be an important aspect of continued evolution of the measure, without it, the measure does not represent an objective measurement of the data. Although the tool is valuable for clinical practice we are concerned that without a threshold of improvement, the information gained will not be meaningful enough to make it a mandatory, CMS endorsed component of value based purchasing or to publish the results for public use/facility comparison.

AAEECE would like to propose a different measure for NQF and the MAP's consideration, based upon a quality benchmarking initiative adopted by AAEECE members: "Cataract Surgery: Difference Between Planned and Final Refraction," measured by the percentage of patients achieving planned refraction within plus or minus one diopter. Use of this measure is supported in professional studies and clearly defines a "threshold of improvement" which is a more objective measurement. This measure has been supported by leading eye hospitals internationally. AAEECE would be pleased to share the measure specifications for NQF and the MAP's consideration and would welcome an opportunity to meet with you to discuss this measure. We believe this measure is better suited for value based purchasing and public dissemination.

The AAEECE appreciates the opportunity to comment on this Measure Applications Partnership Pre-Rulemaking Report. We respectfully request that consideration be given to the issues we raised in finalizing the report. We offer our assistance with further study. If you have any questions regarding our comments, please contact me directly at [rbetz@aaeece.org](mailto:rbetz@aaeece.org) or at C (202) 271-2231.

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### **American Association of Neurological Surgeons**

#### **Koryn Rubin**

The American Association of Neurological Surgeons (AANS) appreciates the opportunity to comment on the National Quality Forum's (NQF) 2013 Measure Application Partnership (MAP) Pre-Rulemaking Report.

Measure 1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

Neurosurgery is not supportive of CMS maintaining this measure in the IQR program. The measure is currently undergoing revisions and without access to the full measure specifications it is difficult to make an evaluation as to whether the flaws with the measure have been resolved. The current measure is not appropriately risk adjusted and no testing has occurred. In its current form, the measure does not appropriately account for socioeconomic factors and resource use of safety net hospitals, and unfairly affects such institutions. Additionally, the HWR measure is not aligned with current modeling considerations focused on patient subgroups and their related risk factors and outcomes. It is generally accepted in most medical disciplines that focused risk adjustment algorithms perform best when applied to focused patient populations.

CMS must also take into consideration readmission related to trauma, staged procedures or instances outside of the surgeon and institution's control. CMS needs to ensure that if a patient has "staged" spinal surgery or other staged surgeries, which is necessary for some of the more complex deformity surgeries, that the second surgery is not classified as a "re-admission".

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## American Association of Neurological Surgeons

### Koryn Rubin

Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization: Neurosurgery is supportive of the MAP's recommendation not to support the adoption of this measure. The measure has issues with risk stratification and modeling. In fact, Devan Kansagra's article in JAMA (Kansagra, Devan, MD., et al. Risk Prediction Models for Hospital Readmission—A Systematic Review. JAMA. October 19, 2011—Vol 306, No. 15) raises the importance of risk prediction in hospital readmission measures. The specification attempts to account for planned readmissions and excludes readmissions where acute stroke is not listed as a principal diagnosis; however, it is still concerning that the c-statistic value is only 0.6, suggesting that the model does not have very high discriminatory power. Including hospital level factors and stroke severity to determine readmission factors would assist with appropriate risk stratification. Stroke: 30-day all-cause risk standardized mortality measures: Neurosurgery is supportive of the MAP's recommendation not to support these measures. We have concerns with the risk stratification and modeling and cannot support the intent of the measures. The data source is administrative/claims data and not direct clinical data. When evaluating the individual factors that are used in deriving the risk adjustment that bear on the risk of 30 day mortality, many of the significant factors are counterintuitive -- which is a problem when working with large administrative datasets where a huge "n" means nearly anything and everything is statistically significant. It also calls into question the modeling used to reach the risk adjustment numbers. For instance, valvular rheumatic heart disease decreases risk of in-hospital mortality by 10%? Cerebral ischemia/TIA, decreases mortality risk by 19%? The cited numbers are not realistic. However, there is recent evidence (Fonarow et al, Comparison of 30-day Mortality Models for Profiling Hospital Performance in Acute Ischemic Stroke Versus Without Adjustment for Stroke Severity, JAMA, 2012;308(3):257-264) that the use of clinical data such as the NIH Stroke Scale (NIHSS) leads to improvement in the hospital mortality models. In the previously referenced study there were considerable

differences in the hospital ranking when NIHSS was employed versus when it was not. The use of the NIHSS had a significantly better discrimination than the model not using the information.

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## American College of Chest Physicians

### Jeff Maitland

#### Part 1 (cont)

Measure ID - 1642 - Catheter-Associated Urinary Tract Infections (UTI)

Approve with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC is unclear about what is meant by "reliability adjusting."

Measure ID - 1370 - Catheter Associated Urinary Tract Infection (CAUTI)

Approve without comment. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure.

Measure ID - 38 - PSI 90 Complication/patient safety for selected indicators (Composite)

Disapprove with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC is concerned about the preventability of the complications included.

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## American College of Chest Physicians

### Jeff Maitland

#### Part 2 (cont)

Measure ID - 2755-HAC-8 - Composite measure of seven hospital-acquired conditions Disapprove with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC expressed its desire for harmonization between measures, especially between 2755 and 2756. Additionally, the QIC believes that measures referring to poor glycemetic control are not appropriate as it is

unclear what is meant by “good” glycemic control and creates a risk of unintended consequences (hypoglycemia). Lastly the QIC questioned the utility of the composite score, expressing confusion about how some of these measures relate to others. Measure ID – 2756 - HAC-10 - Composite measure of nine hospital-acquired conditions Disapprove with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC expressed its desire for harmonization between measures, especially between 2755 and 2756. Furthermore, the QIC believes that measures referring to poor glycemic control should not be used in any composite, as it is unclear what represents “good” glycemic control. This description sets up a scenario for unintended consequences (hypoglycemia). Lastly, the QIC expressed concern about the weight placed on the zero DVT rate, knowing that even in well-designed randomized control trials, there is not a zero event rate.

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### American College of Chest Physicians

#### Jeff Maitland

Part 3 (cont)

Measure ID – 3036 - Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI)

Approve with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. It appears that some measures are individuals and others are composite, so the QIC questions that if this measure is approved, what will happen to Measure 1642?

Measure ID – 845 - Severe Septic Shock Bundle

Disapprove with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC conceptually agrees with the need for this metric but not in its current form.

The evidence supporting sepsis performance measures is frequently not of high quality and occasionally contradictory. If local institutions

perform all but one, as a composite outcome, this could influence the final score. It would be better to have much more focused attention to the individual elements for which there is more robust evidence. In addition the QIC feels that there are significant problems with the measure specification in regard to case selection and transfers. The study, upon which this measure is based, should not become a national mandate on how to treat sepsis.

Measure ID – 464 - PSI 12: Post Operative PE or DVT

Approve with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. While the QIC approves this message, the QIC believes that Measure 499 would more appropriately cover this measure.

Measure ID – 3035 -Reliability Adjusted Central Line- Associated Blood Stream Infection (CLABSI) Approve with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC feels that this measure should be harmonized with Measure 2920, to avoid measure overlap.

Measure ID – 499 - VTE-6: Incidence of Potentially-Preventable VTE Approve with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC expressed its desire for harmonization between measures. Measure ID 566 - Central Line- Associated Blood Stream Infection (CLABSI) Approve with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC expressed its desire to see harmonization with other measures. Furthermore, the QIC questioned how many CLASBI measures are needed and expressed interest in achieving consensus on one.

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### American College of Surgeons

#### David B. Hoyt

Hospital Inpatient Quality Reporting

The MAP supported the inclusion of the Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) measure (NQF #1789). ACS has previously provided comments to NQF that we do not support the inclusion of this measure until it is better specified and evaluated. We especially opposed this measure for use in performance-based payment as it was previously specified. Our past concerns have highlighted that this measure is very broad with respect to populations evaluated and yet constrained to one outcome of uncertain meaning, therefore running contrary to “state of the art” modeling considerations for focusing carefully on patient subgroups and the risk factors and outcomes that are relevant to targeted subgroups. As a result, meaningful performance distinctions between different institutions for certain subpopulations appear likely to be clouded and does not provide actionable data. We understand that this measure is currently being updated and is pending NQF endorsement. We will follow its progress closely to be sure that there is consensus that it meets the state of the art modeling for risk factors and is appropriate for quality improvement and public reporting.

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#### **American Hospital Association**

##### **Nancy Foster**

Colonoscopy measures in the hospital OQR program: The CHA notes that NQF 0658 and 0659, both of which measure colonoscopy follow-up intervals, would be very difficult for hospitals to manage since endoscopy patients are often not tracked by hospitals post-procedure. In the absence of a tool, such as an electronic health registry, that enables long-term tracking by hospitals, this measure is not appropriate for a public reporting and accountability purpose. The AHA agrees with this assessment.

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#### **American Hospital Association**

##### **Nancy Foster**

Several AHA members provided measure-specific comments. While we did not include these comments in our letter, we believe these assessments highlight important problems with many of the proposed measures. We are pleased to submit them for the MAP’s consideration, and have noted where the member comments illustrate the issues discussed in

our comment letter.

Claims-based patient safety measures in the HAC program: The Connecticut Hospital Association (CHA) highlighted several limitations with these measures rendering them inappropriate for inclusion in the program. NQF 0363 (PSI #5 - Foreign Body Left During Procedure) fails to exclude foreign bodies that are intentionally left in when a surgeon feels it is clinically too dangerous to remove it. Moreover, NQF 0345 (PSI #15—Accidental puncture or laceration) is primarily a complication of surgeries during cases when a lysis of adhesions has been performed. This makes it a poor overall quality indicator, inappropriate for a program where even a rare occurrence of an event has the potential to reduce payments. The CHA also expressed concern about the usability of the composite measures created from claims-based safety measures. Specifically, NQF 0531 (PSI 90- Complication/Patient safety for selected indicators), HAC 8, and HAC10 include multiple indicators of often rarely-occurring events. The construction of the measures makes it difficult to drill down to identify specific cases where one of these events occurs. Data from quality measures must be actionable for hospitals to use it to drive improvement. The AHA agrees with CHA, and also highlights the concerns raised in our comment letter about using claims-based measures to identify relatively rare clinical events. We do not believe they demonstrate an adequate level of reliability or validity. We also urge that composite measures meet the same reliability and validity standards as other measures, and that composites are reported with sufficient detail to allow for providers to learn from identified issues. VBP Program - 3-item Care Transition Measure (NQF 228): The CHA notes this new tool is still unfamiliar to many hospitals, and is not yet ready for inclusion in the VBP program. The AHA agrees with this assessment, and notes that we believe new measures should be used in a pay-for-reporting program for at least one year before being moved into any pay-for-performance program, such as VBP.

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## American Nurses Association

### Maureen Dailey

Multiple MAP Hospital Workgroup members, the public, and ANA have identified core safety gaps, in the area of falls and pressure ulcers for consumers, purchasers, and all stakeholders in the Hospital Core Set. The MAP Safety Task Force included these measures in the Safety Family. ANA urges the MAP to add the NQF-endorsed falls measures (# 0141 and # 0202) and pressure ulcer (#0201) to the Hospital Core Set for use in CMS's IQR (Hospital Compare) program, employing data collected through a nursing-sensitive data registry, as a key first safety strategy. This is critical given CMS will not provide a CMS HAC measure update in 2013 on Hospital Compare leaving consumers, purchasers and other stakeholders without transparent quality information for falls and pressure ulcers. Moreover, the CMMI Partnership for Patients (PfP) has identified these existing NQF measures as important to the reduction of these high cost HACs in the HAC Reduction Program. Data collected using these measures are currently employed as the national comparison for the PfP by the Hospital Engagement Networks. Per multiple MAP comments, ANA agrees with the need to gain experience with HAC measures in public reporting prior to inclusion in pay for quality programs. These NQF-endorsed measures meet the IOM criteria of impact, improvability, and inclusiveness.

Another key gap is structural safety measures, including nurse staffing and skill mix. ANA urges the MAP to include both NQF-endorsed nursing structural measures, staffing (#0205 and #0204) in the IQR program using data collected in a nursing-sensitive data registry. Two decades of research has identified the association between low nurse staffing patterns and increased adverse events in hospitals. The Dual Eligible Workgroup specifically named nursing staffing measures as key to keep vulnerable, high-risk subpopulations safe and reduce care disparities. As the MAP has pointed out, key safety measures are critical for timely implementation in IQR to gain experience, even if there may be a need for "balancing" measures. Finally, Dr. Sofaer, has published research about the importance of these safety measures for consumers when making

decisions. Dr. Sofaer has also written reports (AHRQ, 2010) about useful techniques that can easily be employed to display these existing NQF measures in a way that is understandable on Hospital Compare.

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## America's Health Insurance Plans

### Carmella Bocchino

While we are supportive of the hospital performance measurement program metrics, we have a broad set of comments that apply across this set of measures. First, we continue to encourage use of all-cause and condition specific readmissions, mortality (such as stroke readmissions and stroke mortality), and patient safety metrics such as healthcare acquired conditions, as these measures address areas that are important to patients. Measures such as #0480 Exclusive Breast Milk Feeding may reveal significant cultural challenges that need to be addressed. Measures such as #0500 Severe Sepsis and Septic Shock: Management Bundle may be difficult to implement due to difficulties in identifying numerator criteria, which is likely given the bundling nature of hospital claims.

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## AmeriHealth Mercy Family of Companies

### Thomas James

AmeriHealth Mercy Family of Companies agrees with resolving conflicting incentives in the measures as described in the report. But does agree with the adoption of stroke readmits and stroke mortality should be used even if not NQF endorsed as long as there was a rigorous process to develop those measures.

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## Armstrong Institute for Patient Safety and Quality

### Matt Austin

I concur with the report's identified need for additional safety measures, especially in the areas of medication reconciliation and culture of patient safety.

On p.24 of the report, there is a concern noted that hospitals may receive an 'improvement' incentive in HVBP, but get a negative payment adjustment in the HAC payment reduction program, and that would be seen as confusing. I would disagree that



this is confusing and should be minimized. It is quite acceptable to reward improvements, but penalize for attainment.

Has someone thoroughly explored the possibility of hospitals reporting on PC-02 (Cesarean Section)? In Leapfrog's experience in having hospitals report on this measure, MANY hospitals were unable to easily identify the parity of the mother. And the struggles seem to be related to the state the hospital was located in.....Some states required that information, others did not. Something to explore/consider.

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### **ASC Quality Collaboration (ASC QC)**

#### **Donna Slosburg**

On behalf of the ASC QC, a cooperative effort of organizations and companies interested in ensuring ASC quality data is appropriately developed and reported, please accept these comments regarding the Pre-Rulemaking Report. The ASC QC's members and participants include the Accreditation Association for Ambulatory HealthCare; Ambulatory Surgery Foundation; Ambulatory Surgical Centers of America; American College of Surgeons; American Osteopathic Association, Healthcare Facilities Accreditation Program; AmSurg; Association of periOperative Registered Nurses; Florida Society of Ambulatory Surgery Centers; Health Inventures; Hospital Corporation of America, Ambulatory Surgery Division; Nueterra Healthcare; Outpatient Ophthalmic Surgery Society; Surgical Care Affiliates; Symbion; The Joint Commission; and United Surgical Partners, International.

With respect to the ASC QRP, the draft report indicates "Support" or "Support Direction" for measures #0564 and #1536 related to cataracts, and measures #0658 and #0659 related to GI endoscopy and polyp surveillance. All four are clinician-level measures already in use in the PQRS. They were not developed as facility-level measures, and have never been tested as ASC-level measures. Based on our review of the measure specifications, we believe testing would reveal significant issues in the ASC setting and that certain NQF criteria for endorsement, including scientific acceptability and feasibility, would not be met. We believe a recommendation of "Support" or "Support Direction" is premature, and inconsistent with MAP Measure

Selection Criteria for measures that are not NQF-endorsed. In our view, there is insufficient information regarding these measures to support a specific recommendation for the ASC QRP.

In addition, the measures MAP intends to "Support" (#0564 and #1536) are specified for registry-based reporting only. To submit data for these measures, providers must enroll in the Outcome PQRS Registry. However, CMS has not finalized, or even proposed, a registry-based reporting option under the ASC QRP. As a result, ASCs would not be able to use these measures in their existing format to meet reporting requirements.

It is our understanding that a "Support" recommendation indicates the measure is appropriate for immediate inclusion in the program measure set. Given the recognized need for testing and NQF endorsement, and the absence of a registry-based reporting option under the ASC QRP, #0564 and #1536 are not positioned for immediate inclusion. We do not believe the current recommendation of "Support" is consistent with the MAP's criteria for issuing such a recommendation.

In short, we believe the current MAP recommendations for the four ASC QRP measures are not appropriate in light of current MAP criteria and guidelines, and are in need of review and revision.

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### **Association of American Medical Colleges**

#### **Jennifer Faerberg**

The AAMC appreciates the development of the principles for hospital and physician measures. However, the principles are buried in an appendix at the end of the report and lose their effectiveness. As these principles are fundamental in the consideration of measures perhaps further work should be done to incorporate these principles into the measure selection criteria and therefore ensure they are applied consistently. The hospital workgroup had a robust discussion about when and if it was appropriate to include a measure in more than one payment program. The richness of that discussion was not included in the report which is a significant gap. To that end, the AAMC does not support the use of measures in more than one payment/

penalty program simultaneously. The design of the multiple payment incentive/penalty programs are inherently different and cause confusion when the same measure is rewarded for improvement in one case and then penalized based on performance in another. The AAMC strongly supports the MAP's call for removal of planned readmissions from the readmission measures. However, the AAMC believes this still falls short of what needs to be modified with the readmission measures. The AAMC continues to have serious concerns regarding the risk adjustment utilized in this measure. The Association has strong objections to the fact that the risk adjustment does not account for the socio-economic status of patients or the social determinants of health. Research has shown that these factors have an impact on patient outcomes and therefore have a statistically significant impact on readmission rates. In order to more accurately determine a patient's risk for readmission these factors must be included to ensure proper comparison across patients and providers and ensure there are no unintended consequences for the high-risk patients and the institutions that treat them. In addition, the AAMC believes that the measure should be modified to exclude the following patient populations:

- Transplants
- ESRD
- Burn
- Trauma
- Psychosis or substance abuse

These conditions/disease categories can result in multiple hospitalizations due to the type of illness or natural progression of their disease. Patients suffering from psychosis or substance abuse are often hospitalized multiple times within a short timeframe. As a result, these admissions should not be counted as readmissions and therefore be excluded from the measure population.

Brigham and Women's Hospital  
Partners HealthCare System

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### Harvard Medical School

#### James H. Philip

CMS Quality Measure 3040 needs to have continuous oximetry added to its rer=q There is not yet enough

evidence to require continuous monitor of breathing.

If there were such a requirement it should a general requirement and not specify specifics of CO2, Airway Sounds, or other measures of breathing.

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### California Hospital Association

#### Alyssa Keefe

*Revisions to Draft Principles:* CHA supports the draft principles developed by the hospital workgroup but believe further refinement is needed. CHA urges the workgroups to revisit their recommendations and to ensure that they have consistently applied these agreed upon principles. More specifically, the hospital workgroup had very lengthy discussions regarding the importance in considering overlapping incentives and unintended consequences that may result if a measure is adopted in, for example, the hospital value based purchasing (VBP) program and the hospital acquired conditions (HAC) penalty program. CHA strongly urges the MAP and CMS to not use the same measure in more than one pay for performance program because of the differences in the program goals and requirements, methodology for payment incentives or penalties, and differing time periods for performance measurement. Measurement duplication in programs like VBP and the HAC penalty program can lead to unintended consequences and the dilution of resources in hospitals, rather than focused and sustained efforts to achieve the goal.

CHA supports the MAP's recommendation for staged implementation of measure, reporting first to the Inpatient and Outpatient Quality Reporting programs prior to use in a pay for performance or penalty program. This recommendation should also be considered in looking forward to alignment with meaningful use as discussed above.

Readmissions Measures: CHA supports the MAP's support for inclusion of updated methodologies that account for planned readmissions for readmission measures. Further, we urge the MAP to encourage CMS to address the impact of socio-economic status on readmissions measures. There should be continued attention and analysis to determine whether there is a set of SES indicators that should be adjusted for to capture certain characteristics, such as the patient's ability to comply with

discharge/post-procedure instructions, or community infrastructure to support the patient after discharge, while balancing the critical need to avoid unintended consequences.

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**Cardiopulmonary, Neurology, Sleep Center,  
Anderson Hospital**

**Michael J. Range**

It is my understanding that the proposed standards are set up to require intermittent monitoring of patients on these devices. The clinical evidence seems very clear – post-op patients on PCA pumps, especially patients who may have an Obstructive Sleep Apnea (OSA) component, are at risk, especially in the first 24 hours. Considering the obesity epidemic in this country, the numbers of the non-diagnosed OSA patient population is in the millions.

As a Registered Respiratory Therapist, and Operational Director of Cardiopulmonary Services, I have witnessed my share of impending and acute respiratory failure in this patient population. Even an “every 15 minute check” does not provide the patient safety that is needed with this population.

I highly urge that you reconsider the current recommendation and require capnography, pulse oximetry, and heart rate monitoring continuously for the first 24 hours post-operatively when on a PCA pump.

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**Center to Advance Palliative Care**

**Diane Meier**

The Center to Advance Palliative Care notes that there are currently NO measures for hospital performance touching on palliative care domains for seriously ill patients. As noted in our comments related to measure gaps, HCAHPS systematically misses the experience of patients with serious illness or at end of life and a supplementary module to HCAHPS is needed.

We note that American Society of Clinical Oncology is currently conducting a project to develop new measures for PPS-exempt Cancer Hospitals. Many of the measures to be developed fit palliative care domains. With additional testing and modification, these new measures may form the basis for a palliative

care measure set for acute hospitals. We urge MAP to make development of a palliative care measure family applicable across settings the highest priority.

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**Central Ohio Anesthesia, Inc.**

**Michael W. Jopling**

I appreciate the attention that CMS has shown in the proposed Quality Measure #3040 for PCA monitoring. If adopted, this CMS proposed Quality Measure would require hospitals participating in the Medicare program to document respiratory rate, blood oxygenation, and sedation scores at least every 2.5 hours for the first 24 hours in individuals who are on patient controlled analgesia pumps (PCA) longer than 2.5 hours. Please alter this measure so that it applies to all patients receiving parental opioids and to include continuous monitoring of ventilation and oxygenation. If Quality Measure #3040 is not significantly modified, not only will it be ineffectual, but we will lose an opportunity to decrease a significant patient risk.

I have had significant interest in this area since your 1999 initiative to improve pain management, but that particular proposal had the unintended consequence of increasing risk of opioid induced respiratory depression. Unchecked, the expectation of patients increased, nurses were taught to administer more medication, and physicians were taught to order more medication. Unfortunately, many hospitals saw an increase in sentinel events where the probable root cause was opioid induced respiratory depression. We anticipated this and began an increased monitoring surveillance program utilizing capnography and pulse oximetry which has been quite successful in reducing risk of parenteral opioid respiratory depression.

During a conference sponsored by the Anesthesia Patient Safety Foundation (APSF) in 2011, I had the opportunity to participate in workshops and hear presentations from individuals that lost loved ones (spouses, children, parents) to opioid induced respiratory depression. None of the individuals that died had significant co-morbidities. The survivors were adamant during the conference that we come forth with solutions that were not targeted only to special or high risk groups so that a similar incident would not be experienced by others.

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**Central Ohio Anesthesia, Inc.****Michael W. Jopling**

It is my personal opinion and that of several patient safety organizations, APSF, the Institute for Healthcare Improvement, the Institute for Safe Medication Practices, and the Joint Commission, that only through continuous monitoring of oxygenation and ventilation during the duration a hospitalized patient is receiving parenteral opioids. These patient safety groups reached these conclusions after an evidence-based, careful review. This monitoring should not be limited to only those receiving PCA opioids. Significant risk exists for all patients receiving parenteral opioids via all routes of administration. Institution of quality measures are rare opportunities to greatly impact the direction and speed of improvement to healthcare. Your proposed Quality Measure #3040, unfortunately, is weak and may actually inhibit our current efforts to curb this significant risk factor in our healthcare system. Please consider altering your proposal to apply to all patients while receiving parenteral opioids, and to recommend continuous monitoring of ventilation and oxygenation through capnography and pulse oximetry in patients that are not actively ambulating during their entire hospitalization.

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**Children's Hospital Association****Ellen Schwalenstocker**

The Children's Hospital Association appreciates and agrees with the MAP discussion of issues and guiding principles, particularly the importance of identifying potential unintended consequences, distinguishing effective alignment from undesirable overlap and gaining experience with measures prior to use for pay-for performance. The Association also appreciates the inclusion of additional pediatric and maternal/child health measures, but notes that significant gaps remain.

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**Children's Hospital of Philadelphia****F. Wickham Kraemer**

The monitoring for PCA usage in children should be continuous oxygen monitoring through continuous pulse oximetry at least, with the addition of cardiorespiratory monitors.

Checking for sedation levels at 2 hour intervals would be appropriate, but what of sleep patterns that would be interrupted by the 24 hours rule. Continuous monitoring (specifically pulse ox) could obviate the need during night time hours for as frequent sedation scores.

Please do NOT include capnography as a requirement for patients getting opiate therapy. There is no proven benefit of adding this moderately invasive, often unreliable technology to opiate management. In many other settings, capnography is excellent, and as an anesthesiologist, I could not do my job half as effectively and safely without capnography.

I believe in safe management, but not overkill and costly non-proven therapies- see "BIS" monitor as an example of great promise with no benefit to the patient.

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**Consumer-Purchaser Disclosure Project****Tanya Altersas**

Under key issues, we urge MAP to clarify the language in this statement: "Some MAP members voiced concern regarding double and triple payment adjustments for hospitals, especially those hospitals serving large proportions of vulnerable populations." There was discussion of using measures in two payment programs, but no discussion - or intention by CMS as far as we are aware - of using measures in more than two payment programs. We do not agree with the notion that the Inpatient Quality Reporting program is a payment program, since it does not hold hospitals accountable for performance. Later in this section, the report states that "Measuring the same or very similar concepts within multiple programs can cause confusion for consumers, purchasers, and providers. Displaying related, but differing, performance scores for a single provider is confusing to consumers and purchasers. As a consumer/purchaser coalition, we soundly reject this argument. There are ways to display quality data information so as to make it understandable and usable to consumers and purchasers, and we have seen CMS work very hard in recent years to gather significant input from multiple stakeholders on this critical component of implementation We trust that they will do the same as implementation of HVBP and the HAC and Readmission Reduction programs

go into effect. Furthermore, we contend very strongly that for consumers, the importance of having certain measures implemented in more than one program in order to improve outcomes and reduce unnecessary errors and deaths takes significant precedence over the potential for confusion in the public reporting arena, particularly since this confusion can be eliminated.

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### **Consumer-Purchaser Disclosure Project**

#### **Tanya Alteras**

Later in this section there is the following statement “Given the programmatic structures of the Hospital Value-Based Purchasing Program (HVBP) and the Hospital-Acquired Condition Payment Reduction Program, it is possible for a provider to receive a positive score for improving on an HAC measure in the HVBP program while receiving a negative payment adjustment for the Hospital-Acquired Condition Payment Reduction Program as a result of performance on the same measure.” We ask that the final report provide equal attention and language to demonstrating how the double use of the same measure could also lead to a positive outcome. The tone of the preceding section feels very biased, and not reflective of the rich discussion that took place at the Coordinating Committee meeting.

Finally, in the section on General Considerations, we understand the statement “Program implementers should be particularly sensitive to providers serving low patient volumes when applying program measure sets and incentive structures” but we strongly urge MAP to make this report more reflective of the multi-stakeholder nature of this body and add a brief discussion on the need for program implementers to be sensitive to consumers’ needs for safe, efficient, patient-centered, high quality care.

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### **Consumers Union Safe Patient Project**

#### **Lisa McGiffert**

Generally, we strongly support the direction of this report on expanding public reporting and payment programs, as well as the reorientation the Medicare program is taking to better inform consumers of health care services and to align payments with performance, especially for health care-acquired

infections and other harmful adverse events. If all of these measures are adopted by CMS, this will move the country forward significantly in giving the public a fuller picture of provider performance rather than fragments of that picture and will make our health care system safer. While this report’s purpose is not to identify the problem of poor quality and unsafe care, we want to emphasize the gravity and urgency of addressing medical harm. At least one in four hospital patients is harmed, which amounts to approximately nine million people each year. An estimated 225,000 hospital patients die annually due to medical harm. And, we have no good estimates of the level of harm in other health care settings. This is a preventable problem -- public reporting and payment adjustments are appropriate and needed methods to stimulate more and improved prevention at all provider levels.

We support the Committee’s emphasis on outcome measures, rather than process measures, and would like to see this report recommend that HHS make a concerted effort to bring forward measures to fill the gaps identified in the report by providing funding for NQF to research and seek out outcome gap measures currently being used on a small scale and to solicit and assist those measure developers in submitting them for endorsement by NQF. We fully support efforts to expand measures to all health care providers, including all types of hospitals (acute care, specialty care, long-term acute care, small rural, large urban/trauma), ambulatory surgical centers, dialysis centers, long-term care/nursing homes, rehabilitation hospitals and services provided by physicians and other independently practicing providers.

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### **Consumers Union Safe Patient Project**

#### **Lisa McGiffert**

We are heartened that so many measures were considered, appreciate the work done to evaluate which measures should move forward, and are encouraged that so many are recommended. More is better – as we are just seeing the tip of iceberg now. While many may complain about the growing list of measures, we support this growth until the measures, taken together when reported publicly, allow for a comprehensive assessment of health care quality and safety. Further, we support restructuring

the Medicare payment system so that strong measures are combined to provide a compelling incentive for health care providers to improve safety and desired outcomes. We are concerned that the term “parsimony”, which can mean being careful with money and resources or unusually and excessively stingy, is included as a criteria for MAP to use in selecting measures and has become a commonly used when considering performance measures. Since this term has numerous meanings, the precise meaning should be articulated so there is no confusion by participants or readers regarding which definition is intended. While we support the careful use of resources, we fear the “stingy” meaning could be applied to this wave of consumer-driven demand for information about the safety and quality of health care.

This report identifies as a key issue for hospital programs “the need to differentiate valuable measure alignment from unnecessary measurement duplication,” and the report accomplishes that differentiation. We believe the gravity and urgency of the problem of medical harm warrants tying significant dollars to performance, especially to safety measures. We agree with those on the MAP who felt that approaching the problem from many directions sends a “strong signal to providers about the need for improvement and to adequately reward improvement.” As consumers, we are not confused by the different payment incentive programs. We can understand the difference between a hospital being penalized through the Medicare hospital acquired condition payment reduction program for harm to specific patients and the hospital value based purchasing program that financially rewards the same hospital for aggregately improving its safety. The confusion comes from presentation. In our opinion (and that of the experts – see Judith H. Hibbard, Jean Stockard and Martin Tusler Hospital Performance Reports: Impact On Quality, Market Share, And Reputation Health Affairs, 24, no.4 (2005):1150-1160) the key to alleviating confusion on the part of the public (and probably the providers) is providing a context and understandable explanations about what the information means. When this is done, reports have much more influence on consumers’ views and behaviors. Too often this data is released without appropriate explanation of how it fits into the overall efforts to improve the safety of care.

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## Consumers Union Safe Patient Project

**Lisa McGiffert**

“Unintended consequences” are mentioned repeatedly throughout this report, while validation of data is not mentioned once. It is imperative that benign terms like “unintended consequences” are discussed in the context of what they really represent: dishonesty, internal pressure on direct caregivers to overlook serious problems, practice of bad medicine and overall gaming of the system. These behaviors should be monitored and when a specific “consequence” is identified (e.g., inappropriately over prescribing antibiotics to avoid high infection rates), we support implementing balancing measures to monitor the inappropriate behavior. However, we strongly agree with the report that “implementation of high-value measures should not be unduly delayed by the lack of balancing measures.” Evidence obtained by HHS of hospitals that are gaming the system should be completely transparent to the public and those providers should be subject to penalties by HHS, especially when the behavior threatens the safety of patients such as overprescribing of antibiotics, which harms individuals and future populations by diminishing our ability to fight superbugs.

The real answer to this problem is validation of data, which we see as essential to creating a reporting system that the public trusts. Validation of the data should be built into the system; with the kind of data searching tools available today, there are probably multiple ways to identify those providers attempting to game the system. HHS should pursue new ways to do this and stop the whining about unintended consequences, which masks a real problem of dishonesty and manipulation.

We appreciate and support the report’s emphasis on the need to increase measurements for patient-centered care. We believe such measurements should include assessing outcomes from the patient perspective, including dignity and respect they encountered (or not) in the delivery of care. Our sense is that building on the current HCAHPS process is the best way to subjectively assess patient experiences, because of its standardized questions and process in randomly selecting patients to complete the survey. There should also be a built

in validation process to ensure that providers are not dishonestly gaming the system or manipulating the patients completing the forms. We have several suggestions for HCAHPS expansion:

- Add several questions to HCAHPS regarding medical harm to assess patient reported outcomes. There is clear evidence that health care providers underreport these events and a counterbalance of the patient perspective is badly needed.
- As soon as possible, test HCAHPS in health care environments other than hospitals so this tool can be used across providers, some of which are competing for patients (e.g., hospitals and surgical centers) and warrant an opportunity for comparison by the public.

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### Consumers Union Safe Patient Project

#### Lisa McGiffert

We would like to highlight a few specific measures:

- We strongly support tying infection measures to payments in the hospital value based purchasing program and, since the MRSA and *c. difficile* infection measures are near complete endorsement by NQF, we fully support adding these in the next round of HHS regulations on the HVBP program.
- We want to see more maternity related measures and strongly support the recommendation to include C-section rates in the hospital IQR program.
- We appreciate more attention to measures for physicians and other clinicians, but emphasize that pro-active attempts to identify reliable physician outcome measures should be activated. We recognize that MAP “supported the direction” of many of the outcome measures but are holding off until they are endorsed by NQF. Endorsement of these physician measures should become a priority. We are particularly concerned that not a single maternity outcome measure for physicians was endorsed, and recommend those with a “support direction” recommendation be placed on a fast track for NQF endorsement.
- We strongly support the addition of health care -acquired infection measures for inpatient rehabilitation facilities.

Finally, we find the guiding principles adopted by the hospital workgroup (Appendix I) inappropriately

hospital focused without consideration of consumer or public interests. The text of this report appropriately describes how this hospital workgroup used these guiding principles, but the appendix document that specifies the principles indicates that they will “inform future revisions to the MAP Measure Selection Criteria.” We strongly oppose MAP continuing to use them to guide future deliberations. The MAP Coordinating Committee did not vote to endorse these criteria and we object to them being used again without a formal endorsement.

In conclusion, this report represents an incredible step forward in assessing the safety and quality of our health care system. We are encouraged by HHS’ push for more outcome and patient safety measures.

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### DeKalb Regional Medical Center

#### Erik Magnusson

I would hope that CMS would consider continuous monitoring of patients while on PCA pumps not just relying on SATs but also Respiratory Rate or ventilation. This would include devices that monitor and record Respiratory Rate, or CO2. Since respiratory rate is the first decrease then CO2 is increased then SAT decreases, it makes sense to monitor respiratory rate or CO2 on a continuous monitor while on PCA pumps or moderate sedation. This way respiratory depression is caught at its earliest time.

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### Federation of American Hospitals

#### Samantha Burch

The FAH echoes the MAP’s support for inclusion of updated methodologies that account for planned readmissions for readmission measures. Further, we appreciate the ongoing discussion related to the impact of socio-economic status on readmissions and encourage the MAP to recommend to CMS that further work be done to address socio-economic status adjustments in readmissions measures. We see the purpose of risk adjustment as a means of controlling for variables that are beyond the control of the hospital. Therefore, we believe there should be continued attention and analysis to determine whether there is a set of SES indicators that should be adjusted for to capture certain characteristics,

such as the patient's ability to comply with discharge/post-procedure instructions, or community infrastructure to support the patient after discharge, while balancing the critical need to avoid unintended consequences.

The FAH recommends against using the same measure in multiple different programs. Each payment program has a different focus and we cannot predict the consequences of including measures in multiple programs. By including a measure in one program, hospitals are focusing heavily on that quality/performance issue. Measuring and penalizing hospitals for the same topic different ways creates confusion.

We strongly support the MAP's recommendation for staged implementation of measures – reporting first to gain experience with measures and then tying performance to payment.

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### **Genentech**

#### **Vanessa Reddy**

Genentech supports the MAP recommendation of measure O576 (Follow-up After Hospitalization for Mental Illness) for the use in the Inpatient Psychiatric Facilities Quality Reporting Program. This measure is highly relevant to the improvement of care coordination and patient health outcomes for patients with mental illness. The break in treatment due to a loss in follow-up after inpatient treatment has long been recognized as a significant issue in the care of patients with mental illness. Increased scrutiny and improved accountability for service providers will result in improvements for patient care and wellbeing, as well as benefits to patient families and the health care system.

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### **Greater New York Hospital Association**

#### **Lorraine Ryan**

Hospital Inpatient Quality (IQR) Reporting Program  
 GNYHA supports MAP's position that the IQR can be a valuable testing environment for new measures prior to inclusion in a pay-for-performance program. We also agree with MAP that updating methodologies for readmissions measures to exclude planned readmissions is critical to ensuring

that these measures are accurate, appropriately calculated, and provide actionable results from the hospital's perspective. Additionally, GNYHA supports the inclusion of the updated CDC-NHSN measures (M3035 and M3036) in the IQR that provide additional reliability adjustment for measures related to hospital-acquired infections, as they provide a better way to compare hospitals of differing characteristics and procedure volumes.

#### **Hospital Readmission Reduction Program**

As mentioned previously, GNYHA appreciates MAP's recognition that readmissions are often related to broader issues, such as access to care, socioeconomic status, community support, and other psychosocial factors.

#### **Hospital VBP and HAC Payment Reduction Program**

Alignment between the VBP and HAC programs is critical to the credibility of these pay-for-performance programs. We agree with MAP that careful considerations should be made in deciding which measures to include in both programs, so there are no overlapping measures and inconsistencies in calculating performance scores and double and triple reimbursement reductions. For the HAC Program, MAP indicated that one of the main discussion points was the potential unintended consequence resulting from overlapping measures in both programs. MAP also cautioned against using composite measures for the HAC program, noting that careful testing and weighting is required to ensure that such measures are scientifically rigorous. GNYHA supports MAP's caution against including composite measures in the HAC program. Additionally, we agree with the AHA's position that claims-based measures are unreliable for identifying HACs. In turn, GNYHA urges CMS to consider these factors when deciding on the final measure set for the HAC Program.

#### **EHR Incentive Program for Hospitals**

As we indicated in our comments last year, our members' experience with meaningful use measures has been unsatisfactory. As this remains the case for hospitals, GNYHA agrees with MAP's assessment that the program is complex and hospitals have difficulty understanding and implementing program requirements. In selecting measures to incorporate into the EHR incentive program, GNYHA urges the



Centers for Medicare & Medicaid Services (CMS) to consider the availability of truly electronically specified measures, alignment with other quality reporting programs, and the operational capacity and resources required by hospitals to comply with the “micro-specifications” of each measure.

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### **Greater New York Hospital Association**

#### **Lorraine Ryan**

GNYHA’s specific comments regarding certain measures under consideration by MAP are outlined below.

#### **NQF 0500 Severe Sepsis and Septic Shock: Management Bundle**

GNYHA has concerns related to the elements of this composite sepsis measure. The measure makes the assumption that all hospitals will be able to adhere to the necessary steps to achieving the proposed measure that maps to the processes included as part of Early Goal Directed Therapy (EGDT). However, both national and local experience suggests that many hospitals do not adhere to EGDT processes and frequently cite limitations of emergency department resources—specifically pointing to measurement of central venous pressure (CVP) and lack of staff to insert and monitor central venous catheters—as the reason. NQF Measure 0500 further fails to consider evidence in the literature indicating that alternative markers to CVP targets exist and are equally effective in monitoring patients’ achieving resuscitation goals. Lastly, there may be unintended consequences and harms associated with the use of central lines in situations where they are not required.

Over the past two years, the GNYHA/United Hospital Fund STOP Sepsis Collaborative has supported 57 hospitals in enhancing their clinical systems to recognize early and effectively treat patients presenting with severe sepsis and septic shock. To participate in the Collaborative, hospitals implemented a severe sepsis protocol in their emergency departments and intensive care units and tracked their protocol adherence. The Collaborative offered the hospitals a choice of adhering to either a protocol that included the use of ultrasound assessment of responsiveness to intravascular volume administration and gave the option of assessing

response to treatment using serial measurements of serum lactate measurement instead of mixed venous oxygen saturation or one that included the use of CVP monitoring. Through this initiative, participating hospitals achieved significant results, including a 22% reduction in severe sepsis inpatient mortality rates from January 2011 to September 2012. We believe it is the Collaborative’s diverse participants and inclusive approach that allowed us to achieve these results across a large group of hospitals with varying resources and staffing complements. Therefore, GNYHA strongly opposes the inclusion of the sepsis measure among MAP’s list of recommended measures for Federal rulemaking. Alternatively, GNYHA would like to see a companion measure that provides hospitals equally effective, but more practical clinical options for treating sepsis patients. We have submitted a separate detailed letter to NQF outlining our specific concerns with this measure and will be voting down this measure, which is currently slated for NQF re-endorsement.

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### **Greater New York Hospital Association**

#### **Lorraine Ryan**

#### **M3035 & M3036 Reliability-Adjusted CAUTI and CLABSI measures**

GNYHA supports MAP’s decision to include these updated CDC-NHSN measures under the IQR program. The reliability-adjusted standardized infection ratio, which takes into account differences in case-mix, exposure volume, and other unmeasured factors that were not reflected in the previous measure, will help account and improve variability in reporting for these measures. However, while we agree that these measures are an improvement, GNYHA does not support MAP’s recommendation to include these measures in pay-for-performance, including the HAC and VBP policies, as these measures need additional testing prior to being tied to payments and penalties.

**GNYHA Recommendation:** GNYHA recommends MAP to withdraw its recommendation to include the Reliability-Adjusted CAUTI and CLABSI measures (M3035 & M3036) in the HAC and VBP programs.

**M3038 Reliability-Adjusted Methicillin-Resistant Staphylococcus aureus (MRSA) measure**

MAP voted to “Support Direction” for this measure under the HAC program. GNYHA’s infection prevention advisory council and its measures workgroup have repeatedly indicated that public reporting for this measure would be ineffective and misleading to the public. Hospitals who conduct surveillance for MRSA have informed GNYHA that MRSA infection rates are very low and not meaningful for quality improvement efforts. These same statements were also made and substantiated at a recent New York State Healthcare-Acquired Infections Technical Advisory Workgroup comprising infection control and infectious disease specialists from across New York State.

GNYHA Recommendation: MAP should change its position from “Support Direction to “Do Not Support” for this measure.

#### M3040 Appropriate Monitoring of Patients Receiving Patient-Controlled Analgesia (PCA)

This measure was under consideration for the Meaningful Use program, and MAP’s decision was to “Support direction: Measure requires modification or further development,” indicating there were concerns regarding operationalizing workflows related to meeting this measure. We agree with MAP’s decision and rationale on this measure, and our members have indicated similar concerns with this measure.

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#### Icahn Medical center at Mount Sinai

##### E Frost

Monitoring only SPO2 does not assess adequacy of oxygenation, especially in patients receiving oxygen post op. Also, check q 2.5 hours allow too long a time for hypoxic brain damage to occur...continuous monitoring of ETCO2 and respiratory rate must be added.

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#### Individual Commenter

##### Teresa Goodell

PCA is a very widely-employed and effective method of providing pain relief. Studies have shown that it reduces total opioid dose, and in the vast majority of cases, is safe. While I share CMS’ concern for the cases where deaths are attributed to over-sedation with the use of PCA, I am skeptical of the value

of electronic monitoring (oxygen saturation and capnography) for all PCA patients in preventing future adverse events because of the nature of registered nurses’ work. PCA patients are often treated on general nursing (medical and surgical) units, where registered nurses care for 5-15 patients at a time. Many RNs work in large units, caring for patients who are widely physically separated. Unlike an intensive care unit, general nursing units have no central monitors that would sound an alarm, so depending on the physical layout of the nursing unit, the nature of the RNs assignment on a given shift, and the RNs workload, the RN may or may not hear and respond to an alarm in a patient’s room in a timely fashion, soon enough to revive an oversedated person. Furthermore, alarm fatigue is a significant concern in patient safety circles. When a busy RN responds repeatedly to false alarms, that nurse will decide after some time that responding to an alarm that is likely to be false is a lower priority than her other responsibilities, and eventually alarms are not even heard. Requiring further electronic monitoring will exacerbate this problem, and thus make the addition of electronic monitoring in non-ICU settings less effective. As with the institution of all new monitoring technologies, the end-user experience must be taken into account, or the technology will be rendered useless. I urge you to consider the actual environment in which these monitoring technologies would be put to use before mandating them.

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#### Mason General Hospital

##### Donna J. Scott

I am concerned about quality measure 3040 if it allows only for spot checking of pulse oximetry when patients are receiving narcotics through a PCA pump. I believe that guidelines that include continuous monitoring by pulse oximetry or capnography would increase our patient’s safety.

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#### Memorial Sloan-Kettering Cancer Center

##### David G. Pfister

Memorial Hospital for Cancer and Allied Diseases, the patient-care arm of the Memorial Sloan-Kettering Cancer Center, is the world’s oldest private cancer center, committed to exceptional patient care, leading-edge research and superb

educational programs. The 514-bed hospital admitted approximately 25,000 patients in 2011 and had approximately 500,000 ambulatory visits. MSKCC is one of the 11 cancer centers exempt by Congress from the effects of a prospective payment system because of its unique focus on cancer care and its specialty patient population and is therefore one of the institutions to which the PCHQR program applies exclusively. As such, we are committed to measures which demonstrate relevance for our unique patient population and distinguish among providers of cancer care. Please see our comments on the specific measures below:

Measure 0166: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) MSKCC has been participating in HCAHPS since 2010 and has found participation helpful. Since HCAHPS focuses on inpatient care only, however, which represents less than 5% of our cancer-related patient care, we support the development of a cancer-care specific patient experience instrument which evaluates cancer care provided in the ambulatory setting. We understand that such a survey is currently being field-tested and welcome the opportunity to participate in that process and assess the applicability of such an instrument to our unique patient population. Case mix, disease severity, and institution location within the United States (since HCAHPS scores appear to vary by geography) are appropriately considered in these deliberations.

Measures 0218, 0284, 0452, 0453, 0527, 0528, 0529, 0530: Surgical Care Improvement Project (SCIP) Measures Although as a PPS-exempt institution, MSKCC has not been reporting these measures to Hospital Compare, most of these measures have been collected internally and/or as part of our participation in the Greater New York Hospital Association (GNYHA)/Healthcare Association of New York State (HANYs)-based Partnership for Patients program in New York state. Avoidance of post-operative complications is associated with reduced surgical morbidity and mortality and as such, is important for our patients. With regard to measure 0300, we recommend additional testing in the cancer patient population before public reporting, since this measure has only been tested in cardiac surgery. In addition, we would recommend that results be categorized by type of surgery rather than reported

in aggregate format for the institution.

Measure 0753: Harmonized Procedure-Specific Surgical Site Infection Outcome Measure We support this measure and encourage the development of additional outcome measures in cancer care. MAP has identified survival as a specific gap in cancer measure development and we strongly support the development of such a measure for the comprehensive cancer centers.

Measure 0380: Multiple Myeloma - Treatment with Biphosphonates

While multiple myeloma is a serious disease, multiple myeloma patients represents a small proportion of newly diagnosed patients. A broader measure, such as the measure of osteoclast inhibitors for multiple myeloma and metastatic breast, prostate and lung cancers would be applicable to many more patients and may be available for reporting purposes by 2015. We therefore suggest that MAP consider delaying the inclusion of such a measure to the following year in order to avoid confusion on the part of patients, improve measure harmonization and improve resource efficiency. Should the measure be included as is, we recommend an additional exclusion of "cumulative duration of biphosphonate administration."

Measure 0382: Radiation Dose Limits to Normal Tissues MSKCC supports the inclusion of this measure in the 2015 measure set, although we suspect that results will demonstrate that the measure has topped out.

Measure 0383, 0384: Plan of Care for Pain; Pain Intensity Quantified-Medical Oncology and Radiation Oncology Pain control is an important aspect of cancer care and in general, MSKCC supports this measure, recognizing that consistency of assessment and data collection may be challenging. Future efforts to improve this measure through the use of pain score deltas, or a measure which compares pain intensity with potency of prescribed analgesics or other intervention would be welcome. In addition, we are concerned that reports of pain at a very low level (1 or 2) which may be incidental, transient and/or of less clear clinical significance, will prompt the use of "cut and paste" documentation of generic treatment plans to administratively address the issue. In such

cases, the measure may offer little incremental information to what is learned from patient experience questioning about provider attention to pain control.

**Measure 0389: Prostate Cancer Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients** This measure appears to be reasonable and straight-forward to document. We would suggest that the measure developer consider adding CT of the abdomen to the avoidance of overuse measure in addition to bone scan in low-risk patients.

**Measure 0390: Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients**

Compelling data exists to support the use of neo-adjuvant therapy and concurrent androgen deprivation therapy (ADT) in addition to adjuvant therapy. Selection criteria for high risk in major studies did not use PSA; most used tumor size and nodal status. Therefore, the risk assessment specified in the measure has not been prospectively assessed in answering the question of radiation therapy with or without ADT.

**Measure 1643: Medicare Spending per Beneficiary**

The measure as defined does not consider the appropriateness of care and is therefore not a true measure of quality. Spending alone does not capture efficiency or value. If the measure is used as defined, excluding patients who died during the episode may potentially reward institutions which have a high rate of deaths. Patients who died may have incurred high spending, but that spending would not be included in the calculation. Alternatively, patients who died early in the episode may have incurred low spending, which would also influence the calculation, but in the opposite direction. Case-mix adjustment methods should be specified. The time frame should ensure that the full-care experience is captured and is compared in context. The time frame of "episode" as defined may not be appropriate for PCHs, given the often chronic nature of cancer. In addition, we question whether the method used to assign patients to accountable institutions (i.e., inpatient visits) is appropriate for cancer patients, where over 95% of care is ambulatory.

**Measure 3035: Reliability-adjusted Central Line-Associated Blood Stream Infection (CLABSI)**

We recommend delaying implementation of the measure until the Center for Disease Control (CDC)-approved definition of CLABSI has been NQF endorsed. For MSKCC, the inclusion of patients with profound neutropenia and/or gut Graft Versus Host Disease (GVHD) accounts for approximately 35% of our CLABSI rate and as such, our CLABSI rate cannot be validly compared with other institutions whose patient population may not be similar.

**Measure 3036: Reliability-adjusted Catheter-Associated Urinary Tract Infection (CAUTI)** Patients with other indwelling genitourinary (GU) hardware such as internalized ureteral stents and percutaneous nephrostomies often have Foley catheters as well. Stents and nephrostomies are commonly colonized with bacteria; the collecting GU systems, either because of the underlying disease and/or physical irritation from the hardware frequently elaborate leukocytes in the urine. Based on the case definition, cancer patients with such indwelling hardware in addition to Foley catheters will be defined as having a UTI when such may not be the case. We recommend exclusion of patients with such GU hardware from the measure numerator. Again, thank you for the opportunity to comment on these important measures. The maintenance of the highest standard of patient care is of primary importance to our patients and our situation. We strongly support measurement efforts to make the quality of our care transparent to all.

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## **Mothers Against Medical Error**

### **Lenore Alexander**

Please change measure #3040. Continuous monitoring for post op patients is the only way to ensure these patients do not become part of the growing number of "dead in bed". It is disgraceful that we even question continuous monitoring in 2013 in The U.S.A.

Dr. Stoelting, president of the Anesthesia Patient Safety Foundation recommends all patients on controlled analgesics be continuously monitored electronically to ensure their safety. 2.5 hours is a long time. I took a 90 minute nap while staying with my 11 year old daughter, in her hospital room after surgery. I awoke to find my child cold and dead next to me. Two hours doesn't work.

Please change this, too many lives will be lost over something very easy to implement.

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## **National Association of Psychiatric Health Systems**

### **Kathleen McCann**

MAP input on IPH QRP measures includes a measure of follow-up after hospitalization for mental illness (O576). The discharge follow-up measure is specifically designed to be used with a managed care company that has “members.” The ability of such an organization to provide discharge referral and to track follow-up to those services through its database is totally different from the ability of the universe of facilities reimbursed under IPF PPS to follow its patients post-discharge. While HBIPS measures 6 and 7 address continuity of care for psychiatric patients, IPF PPS facilities do not have a database that would allow them to track whether a patient has arrived for an outpatient visit. The burden of calling individual (and often difficult-to-reach) consumers would be very significant and perhaps not a true measure of whether the patient arrived for treatment or not. (For example, the patient may not be able to be contacted by phone, but did keep the appointment.) The measure also raises significant confidentiality issues. It is not an appropriate measure to be considered for recommendation to the Centers for Medicare & Medicaid Services (CMS) for quality or payment purposes for all psychiatric hospitals and units.

A second measure under consideration is a measure of consumer evaluation of inpatient behavioral healthcare services (O726). While we acknowledge that this NQF-endorsed measure is a valuable step in developing a consumer evaluation tool, we think it has too many items for general use and that it has not been formally tested in non-state hospital settings. There has not been discussion of the tool within the larger psychiatric hospital community. It has not been normed for non-governmental hospitals and is not imbedded in the current vendor systems. It is not ready for consideration for quality or payment purposes for all psychiatric hospitals and units.

We continue to be concerned about the evolution of the two other measures, alcohol use screening (M2753) and assessment of status after discharge

(M2754). They were “supported in direction” by the MAP but are not NQF-endorsed. Should they achieve NQF endorsement, the measures should be reconsidered by the MAP before being recommended to CMS.

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## **National Bone Health Alliance**

### **Beatriz Duque Long**

NBHA believes considerable opportunity for improvement in patient management while in the hospital after osteoporotic fracture exists. Simple and low-cost interventions include: informing the patient that they have an osteoporotic fracture and thus a diagnosis of osteoporosis. It has been shown that this usually does not happen and that the patients leave the in-patient hospital setting with a lack of understanding of the etiology of their fracture. Additionally, providing the patient with concrete suggestions for follow-up of their osteoporotic condition as part of a standard discharge process should be considered. Initiating treatment with vitamin D and calcium would be an additional low-cost – high benefit intervention that can be started while in the hospital and continued upon discharge. Inclusion of these low-cost and simple measures during the inpatient hospital stay can ultimately be included in a standardized osteoporotic fracture care system for the hospital, which has been associated with reduced in-hospital costs.

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## **National Coalition for Hospice and Palliative Care**

### **Timothy Quill**

The National Coalition for Hospice and Palliative Care (NCHPC) notes that there are currently NO measures for hospital performance touching on palliative care domains for seriously ill patients. As noted in our gap comment, HCAHPS systematically misses the experience of patients with serious illness or at end of life and a supplementary module to HCAHPS is needed.

We note that ASCO is currently conducting a project to develop new measures for PPS-exempt Cancer Hospitals. Many of the measures to be developed fit palliative care domains. With additional testing and modification, these new measures may form the basis for a palliative care measure set for acute hospitals.

We urge MAP to make development of a palliative care measure family applicable across settings, including hospitals, the highest priority.

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### **National Osteoporosis Foundation**

#### **Beatriz Duque Long**

NOF believes considerable opportunity for improvement in patient management while in the hospital after osteoporotic fracture exists. Simple and low-cost interventions include: informing the patient that they have an osteoporotic fracture and thus a diagnosis of osteoporosis. It has been shown that this usually does not happen and that the patients leave the in-patient hospital setting with a lack of understanding of the etiology of their fracture. Additionally, providing the patient with concrete suggestions for follow-up of their osteoporotic condition as part of a standard discharge process should be considered. Initiating treatment with vitamin D and calcium would be an additional low-cost – high benefit intervention that can be started while in the hospital and continued upon discharge. Inclusion of these low-cost and simple measures during the inpatient hospital stay can ultimately be included in a standardized osteoporotic fracture care system for the hospital, which has been associated with reduced in-hospital costs.

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### **NY-Presbyterian Hospital**

#### **Brian Taylor**

NY-Presbyterian Hospital supports MAP's position that the Hospital IQR can be a valuable testing environment for new measures prior to inclusion in a pay-for-performance program. We support the MAP's recommendation that CMS be held to the reporting of a measure on Hospital Compare for 1 year prior to inclusion in a pay-for-performance program.

NY-Presbyterian Hospital agrees with the MAP's recommendation that hospital acquired infections be measured using the reliability-adjusted CDC NHSN measures for CLABSI and CAUTI. The reliability adjusted SIR will help account for and improve variability in reporting for these measures. We also agree with the MAP's recommendations that careful and deliberate consideration should be given to the development of a composite and weights for

individual measures that make up the composite. While we appreciate the removal of the HACs defined by administrative claims data, we noted that the MAP indicated support for a number of AHRQ PSIs. Although the additional risk adjustment for these indicators make them preferable to the current HAC measure set, the PSIs are still dependent on provider documentation and coder interpretation. We are also concerned that the MAP's preference for consideration of NQF measure #0141 and #0202 (falls, pressure ulcers) rely on participation in the nursing NDNQI registry, thereby shifting additional cost burdens to hospitals.

Alignment between the VBP and hospital-acquired condition (HAC) program is critical to the credibility of these pay-for-performance programs. NY-Presbyterian Hospital agrees with MAP that careful considerations should be made in deciding on measures for inclusion in both programs so there are no overlapping measures and inconsistencies in calculation of performance scores (e.g., as MAP indicated, a provider can receive a positive score on a HAC measure in the VBP program, and a negative payment in the HAC program) and related double and triple reimbursement reductions.

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### **NY-Presbyterian Hospital**

#### **Brian Taylor**

NY-Presbyterian Hospital supports the MAP's recognition of the current milieu of numerous, redundant, overlapping, and inconsistent measures that compromise the goals of HHS' regulatory programs. Hospitals continue to struggle to meet the vast number of measure reporting requirements at the local, state, and Federal level, and are becoming increasingly burdened with the nuances of each reporting program that require similar measures, but in slightly different formats or for different populations of patients. Discrepancies in measure specifications even across HHS' own programs lead to confusion for hospitals and consumers alike. Core measures and meaningful use measures, for example, should be entirely aligned, with a single specification manual rather than the current disparities between the core measures manual, the Health Information Technology Standards Panel (HITSP) manual, and individual core measure vendors' e-specifications

manuals. The resources in time, money, and expertise required to properly develop, test, and validate just one measure is such that hospitals are overwhelmed by the breadth and scope of quality reporting requirements. This burden not only fails to meaningfully contribute to information that can be used to improve patient care and outcomes but can imperil those very goals. Hospitals have a lot at stake in participating in each of these regulatory programs. We urge MAP to recommend that HHS harmonize its specifications for measures across programs to avoid inefficiencies and confusion. Additionally, we further encourage MAP to reinforce its position on avoiding duplication and inconsistencies across policy programs and specifically to avoid penalizing hospitals multiple times for performance on the same measure. Related to this duplication, HHS should also be mindful of conflicting scores being assigned to hospitals for the same measure across different programs. It is these types of inconsistencies that undermine the overarching goals of quality policy and detract from quality improvement work in hospitals.

NY-Presbyterian Hospital agrees with MAP that updating the readmission measure methodologies in the Hospital IQR program to specifically exclude planned readmissions is critical to accurate assessment of hospital readmission rates. We also agree with the MAP's recognition that readmission measures, whether in the Hospital IQR or Hospital Readmission Reduction Program, should be adjusted for patient socioeconomic risk factors. We would like to see the exclusion of patients with secondary diagnoses related to behavioral health issues as these also reflect broader social disparities that contribute directly to hospital readmissions. While we support the development of the Hospital-Wide Readmission measure, we are concerned that the inclusion of the HWR measure in addition to the condition-specific readmission measures in the Hospital Readmission Reduction program will unfairly subject hospitals to multiple reimbursement reductions. (E.g., heart failure readmissions are specified in NQF measure #0330 but heart failure readmissions are also picked up by the HWR NQF measure #1789).

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## **NYU School of Medicine**

### **Elana B. Lubit**

Thank you for sponsoring a safety measure for patients on PCA. However, as a practicing anesthesiologist, I believe that spot-checking oxygen saturation is not sufficient. Please revise the measure to allow for continuous oximetry during the initial phase on PCA.

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## **Outpatient Ophthalmic Surgery Society; Am Soc of Cataract and Refractive Surgery**

### **Michael Romansky**

Comment on ASC Representation on the MAP

ASCRS and OOSS share the concern submitted in comments by the ASC Quality Collaboration that the MAP must incorporate representation of experts from within the ASC community. The ASC industry is composed of over five thousand providers that perform 40 percent of the surgery procedures in the United States. ASCs are highly regulated and, effective in 2012, subject to quality reporting requirements. There exists an impressive commitment to and infrastructure for quality reporting in the ASC community; indeed, the ASC Quality Collaboration has developed six facility-level quality measures that have been endorsed by the NQF and adopted by CMS, enhancing the ability of surgery centers to report health outcomes and processes in a standardized manner to governments, insurers, accreditation entities, the public and others. The MAP should immediately act to ameliorate this gap content matter expertise by expanding ASC representation on relevant MAP entities.

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## **Outpatient Ophthalmic Surgery Society; Am Soc of Cataract and Refractive Surgery**

### **Michael Romansky**

Comment on NQF #0584: Complications from Cataract Surgery

ASCRS and OOSS strongly oppose the adoption of NQF 0584: Cataracts – Complications Within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures as an ASC-level quality measure. This measure, developed by the American Academy of Ophthalmology and the Physician Consortium

for Performance Improvement as a physician-level measure to identify complications attributable to the surgeon that embody the potential to lead to vision loss and diminished patient function. Such complications might include intraocular lens (IOL) placement errors, retinal detachment, retained nuclear fragments, wound dehiscence, and others that are within the control of the operating surgeon. These complications would rarely, if ever, be associated with improper care provided by the ASC. Moreover, for the reasons elucidated in our General Comment on MAP's Process for Selection of Measures, the facility would not be in a position to efficiently collect and report the data, as it would be located in the medical records of the surgeon. (And, even if the facility could comply, the exercise would be entirely redundant since the information would already have been collected and reported by the surgeon through the PQRS.) Our organizations also believe that it would be premature for the MAP to "support" this measure. NQF 0584 is specified for registry-based reporting only. In order to submit data for these measures, providers must enroll in the Outcome PQRS Registry; ASC providers are not able to so participate in this Registry because they lack the data to present and are ineligible for PQRS incentives. Until CMS finalizes a registry-based reporting option under the ASC Quality Reporting Program and approves one or more specific registries, ASCs would be unable to use these measures as currently formatted to meet reporting requirements. This measure is not consistent with MAP criteria and would be inappropriate for immediate inclusion in the quality reporting measure set. Our organizations look forward to collaborating with CMS, the ASCQC and others in developing appropriate ophthalmic ASC-level measures.

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### **Outpatient Ophthalmic Surgery Society; Am Soc of Cataract and Refractive Surgery**

#### **Michael Romansky**

Comment on NQF #1536: Improvement in Visual Function Within 30 Days of Cataract Surgery

ASCRS and OOSS strongly oppose the adoption of NQF 1536: Cataracts - Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery as an ASC-level quality measure. Similar

to our Comment on NQF #0584: Complications from Cataract Surgery, NQF#1536 was developed as a physician-level measure, not as a measure to evaluate ASC outcomes. Moreover, for the reasons elucidated in our General Comment on MAPS Process for Selection of Measures, the facility would not be in a position to efficiently collect and report the data, as it would be located in the medical records of the surgeon. (And, even if the facility could comply, the exercise would be entirely redundant since the information would already have been collected and reported by the surgeon through the PQRS.)

For example, it is common to check for the cataract patient's visual acuity at intervals of one-day, two weeks, and one month post-op. These refractions are usually performed in the physician's office and never in the ASC. The only visual acuity information that the ASC receives is part of the pre-operative ocular history and physical examination provided by the surgeon, and this is provided before surgery occurs. This information, as well as post-surgery visual acuity checks, would be located in the patient's medical record housed in the surgeon's office - not at the ASC. As such, it is impractical and unnecessarily burdensome for the ASC to be subject to such an outcome measure.

Our organizations also believe that it would be premature for the MAP to "support" this measure. NQF#1536 is specified for registry-based reporting only. In order to submit data for these measures, providers must enroll in the Outcome PQRS Registry; ASC providers are not able to so participate in this Registry because they lack the data to present and are ineligible for PQRS incentives. Until CMS finalizes a registry-based reporting option under the ASC Quality Reporting Program and approves one or more specific registries, ASCs would be unable to use these measures as currently formatted to meet reporting requirements. This measure is not consistent with MAP criteria and would be inappropriate for immediate inclusion in the quality reporting measure set.

Our organizations look forward to collaborating with CMS, the ASCQC and others in developing appropriate ophthalmic ASC-level measures.



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## **Outpatient Ophthalmic Surgery Society; Am Soc of Cataract and Refractive Surgery**

**Michael Romansky**

General Comment on MAPS Process for Selection of Measures

ASCRS and OOSS support the goal of harmonizing the quality measures applied to the various surgical environments – where appropriate. However, the MAPS recommendation that two Physician Quality Reporting System (PQRS) cataract-specific measures be adopted for ASCs reflects a fundamental misunderstanding of the operation of the surgery center. Simply stated, the ASC is ill-equipped to evaluate potential cataract outcomes because the facility is not involved in the baseline events preceding surgery against which outcomes are measured or the post-surgical events that encompass the healing process. Under the Medicare program, an ASC operates “exclusively” for the purpose of furnishing ambulatory surgical services to patients. Although the governing regulations permit the surgical facility to exist adjacent to a physician’s office under certain circumstances, Medicare ASC Conditions for Coverage state very clearly that the two entities must be physically, administratively, and financially separate from one another. Among the operative requirements: medical recordkeeping must always be maintained separately and exclusively from other operations. In other words, even though a physician in the clinic may perform surgery in the ASC next door, the medical records of one entity are never readily accessible by the other. As a practical matter, the ASC is staffed by registered nurses, operating room technicians, and clerical staff who are neither qualified to evaluate surgical outcomes nor located in the physician’s office where pre-operative and post-operative care might be efficiently and accurately evaluated. Physician-level measures such as those incorporated within PQRS were formulated to assess quality within the physician’s office. ASC-level measures should relate to episodes that occur within the ASC, encompass data that is available within the ASC chart, be collectable by ASC staff, and generate conclusions that are actionable by the facility. Our organizations look forward to collaborating with CMS, the ASCQC and others in developing appropriate ophthalmic ASC-level measures.

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## **Palmetto Health**

**Robin Appel Belz**

What should be our focus and what should matter most is the safety of our patients in whom we serve.

The fact remains that capnography in a spontaneously breathing patient is NEVER accurate. It starts out reading perhaps close enough, but as the hours pass, moisture builds up, the cannula gets moved and wal-la, you start getting erroneous readings that tell you absolutely nothing. It sounds good on paper, it seems wonderful when you read about it.....but those who actually use the technology absolutely hate it because it doesn’t work !!! Anesthesia is able to make it work for them because they are in a controlled environment with patients who are mechanically ventilated. They also give their patients drugs to dry up their secretions and their patients don’t move, talk, spit etc.

It drives me wild when I hear about mandate this and mandate that. When are those who make these mandates going to actually talk to those who work with these products and deal with PCA patients each and every day to see what is needed. Capnography is not the answer, that you can be certain!

Is respiratory monitoring perfect, I suspect not. Is continuous oximetry perfect, I suspect not. A monitor is worth nothing if it goes unmonitored and is ignored due to nuisance alarms.

Your best bet is central monitoring by someone paid to look at that monitor all night long and nothing else. Tie all the pulse oximeters into this central monitoring location. I don’t think anything else will work. We have a remote monitoring system in my hospital and we have saved 3 lives in the past year due to this system.

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## **PhRMA**

**Jennifer Van Meter**

While PhRMA recognizes the statutory requirement of the Medicare Spending per Beneficiary measure for use beginning in fiscal year 2014, we disagree with the MAP’s recommendation to support the measure prior to its NQF endorsement. This measure is the only one to receive a “Support” recommendation without NQF endorsement, and we

do not think that it should receive such an exception. Moreover, since its implementation is not required yet, there is ample time for the measure to proceed through the endorsement process. We urge the MAP to reconsider this decision by changing the recommendation status to “Support the Direction” with the rationale of needing endorsement prior to use. Such a change would be consistent with other MAP decisions and would prevent a precedent for future exceptions.

PhRMA also believes that cost measures should be reported in tandem with appropriate quality measures as a means of providing a contextual framework for interpreting the results. Without this quality context, the results of cost measures could be misinterpreted resulting in adverse unintended consequences. NQF support of these statements about quality and cost measure reporting is cited in the MAP report, and it should be applied in this situation as well.

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### Physician-Patient Alliance for Health & Safety

#### Michael Wong

I am the founder and executive director of the Physician-Patient Alliance for Health & Safety (PPAHS), and am writing to you on behalf of PPAHS regarding CMS’ proposed quality measure #3040 (the “Proposed Measure”). PPAHS is a non-profit advocacy group devoted to improving patient health and safety. PPAHS supporters and commentators include respected physicians, nurses, respiratory therapists, healthcare organizations, and patient safety advocates.

PPAHS has been particularly active in the area of opioid-induced respiratory depression. I invite you to review our website [www.ppahs.org](http://ppahs.org), as well as our supporters and those who provide us with expert opinion: <http://ppahs.org/our-health-experts/>

#### Patient Deaths Caused by Inadequate Monitoring

The Proposed Measure seeks to address a critical patient safety issue. I would like to draw your attention to the four patient deaths whose stories have been published on the PPAHS website:

Amanda Abbiehl

Louise Batz

Leah Katherine Coufal

Justin Micalizzi

On behalf of these and many other patients and their families, PPAHS encourages CMS to ensure that all patients using PCA are continuously electronically monitored with pulse oximetry and capnography, and not in the way that is currently proposed.

PPAHS asked health experts to provide their opinion on the Proposed Measure, and this is what they told us:

Frank Federico (member of the Patient Safety Advisory Group at The Joint Commission, and executive director at the Institute for Healthcare Improvement): As currently written, the CMS proposed quality measure runs the risk of looking like it is protecting patients, while in reality not going far enough. Although nurse spot checks on patients are advisable, pulse oximetry and capnography are essential risk prevention tools in any pain management plan. The proposed CMS quality measure should include continuous electronic monitoring.”

Matthew Grissinger (director, error reporting programs at ISMP): The CMS proposed quality measure regarding patient-controlled analgesia deals with a critical patient safety issue that hospitals need to urgently address. Errors with PCA occur and, unfortunately, sometimes with tragic consequences. However, for patients to be safe, we would strongly recommend that the proposed measure to monitor patients using PCA include continuously electronically monitoring them with oximetry for oxygenation and capnography for adequacy of ventilation. In addition, standardization of PCA procedures would greatly reduce PCA errors and adverse events.”

Robert Stoelting, MD (president of the Anesthesia Patient Safety Foundation): “the conclusions and recommendations of APSF are that intermittent ‘spot checks’ of oxygenation (pulse oximetry) and ventilation (nursing assessment) are not adequate for reliably recognizing clinically significant evolving drug-induced respiratory depression in the postoperative period. For the CMS measure to better ensure patient safety, APSF recommends that monitoring be continuous and not intermittent, and that continuous electronic monitoring with both

pulse oximetry for oxygenation and capnography for the adequacy of ventilation be considered for all patients.”

Problem: Proposed Quality Measure #3040  
Inadequately Protects Patients

Why does the Proposed Measure fall short of providing adequate patient safety?

CMS’s proposed quality measure applies to “All patient admissions with initiation of an opioid via an IV PCA device that is active for more than 2.5 continuous hours.” Once PCA has been initiated, the proposed quality measure has two aspects:

- When monitoring needs to occur.
- What needs to be monitored.

When Monitoring Needs to Occur

However, recommendations by the Anesthesia Patient Safety Foundation provide that these “spot checks” are not sufficient: Intermittent “spot checks” of oxygenation (pulse oximetry) and ventilation (nursing assessment) are not adequate for reliably recognizing clinically significant evolving drug-induced respiratory depression in the postoperative period

Matthew Grissinger (director, error reporting programs at ISMP) explains why “spot checks” and relying on pulse oximetry as a measure of a patient’s oxygenation are not effective enough: One reason why it is not effective is that a ‘periodic check’ and pulse oximetry would only catch an error, not prevent the error.

Additionally, the duration of the proposed CMS quality measure is “the first 24 hours after initiation of the first IV PCA opioid administration.” Surely, it would be more appropriate to monitor patients for the entire period that they are connecting to the PCA, rather than to stop monitoring after a predetermined period of time.

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## Physician-Patient Alliance for Health & Safety

### Michael Wong

What Needs to Be Monitored

The CMS proposed quality measure provides that patients using PCA be monitored for three

physiological factors: “respiratory rate, sedation score and pulse oximetry”. Each factor is discussed below, with associated recommendations by key healthcare organizations and health experts:

**Respiratory Rate:** Measuring for respiratory rate is not enough. The Pennsylvania Patient Safety Authority recommends monitoring of patients include “frequent assessment of the quality of respirations (not just a respiratory rate) ...” [emphasis added].

**Sedation Score:** Sedation scores measure how the patient reacts to stimuli and the patient’s reaction are scaled, for example, from “no response to stimulus” to “anxious or restless”. However, Mr. Grissinger explains that a patient’s sedation score may not be an accurate measure, “... current standard methods for assessing a patient’s level of consciousness do not take into consideration that overly sedated patients can be aroused and respond to questions. Even though these patients can be aroused for a brief period of time and may in fact be able to

speak, they immediately fall back into a state of oversedation. Accordingly, ISMP recommends observing the patient unobtrusively and noting both respiratory rate and depth of respiration in the absence of any stimulus.”

**Pulse Oximetry:** Monitoring a patient’s oxygenation by pulse oximetry is important. The Pennsylvania Patient Safety Authority recently stated, “However, while useful, pulse oximetry does not measure ventilation. Since oxygen saturation is a lagging indicator of respiration, pulse oximetry may not indicate a problem early enough for effective intervention. Pulse oximetry is even more problematic for patients who are receiving supplemental oxygen, since they may be adequately oxygenated even with dangerously depressed ventilation. Capnography, or endtidal

carbon dioxide monitoring, allows clinicians to track several indicators, but for purposes of PCA it is primarily used as a reliable monitor for respiratory rate, including apneic episodes. The Anesthesia Patient Safety Foundation (APSF) advocates monitoring both oxygenation and ventilation in all patients receiving PCA.”

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## Physician-Patient Alliance for Health & Safety

### Michael Wong

Dr. Frank Overdyk (executive director for research, North American Partners in Anesthesiology, and professor of anesthesiology at Hofstra North Shore-LIJ School of Medicine) explains the importance of PCA in managing pain, but also the need for continuous electronic monitoring of patients: *Spot checks of SpO<sub>2</sub>, as are commonly taken on med/surg floors, need to be eliminated from patient monitoring practice because these single measurements may mislead a provider into thinking the patient is fine when in fact they may be close to the precipice of unrecoverable respiratory depression. Entering a patient room and placing a pulse oximeter on their finger stimulates their consciousness and respiration sufficiently to falsely elevate their reading, particularly when they are receive supplemental oxygen. Once the provider leaves the room, this stimulus fades and the patient may lapse back into a dangerous level of respiratory narcosis.*

Although the Proposed Measure touches on a critical patient safety issue, the CMS measure only pays lip service to patient safety, as it goes against the recommendations of The Joint Commission, the Anesthesia Patient Safety Foundation, ISMP, and the Pennsylvania Patient Safety Authority.

Solution: How PCA Safety Checklist May Help CMS Monitoring

PPAHS recently released a concise checklist that reminds caregivers of the essential steps needed to be taken to initiate PCA with a patient and to continue to assess that patient's use of PCA. The PCA Safety Checklist can be viewed and downloaded free at [www.ppahs.org](http://www.ppahs.org) The checklist was developed in conjunction with renowned medical experts, including intensive care specialist and a leader in medial checklist development Peter J. Pronovost, MD, PhD, FCCM, Professor, Departments of Anesthesiology/Critical Care Medicine and Surgery, The Johns Hopkins University School of Medicine and Medical Director, Center for Innovation in Quality Patient Care, and Atul Gawande, MD, Professor in the Department of Health Policy and Management at Harvard School of Public Health, who is a surgeon at Brigham and Women's Hospital, Professor of Surgery at Harvard Medical School, and author of The

Checklist Manifesto.

The Physician-Patient Alliance for Health & Safety encourages CMS to adopt as a quality measure the continuous electronic monitoring of all patients using PCA with pulse oximetry for oxygenation and with capnography for the adequacy of ventilation. In addition, PPAHS offers its help and that of the undersigned, who has achieved sustained national and international recognition as a leading patient health and safety expert, and who is a founding member of the American Board of Patient Safety, s recently created board to certify and recertify physicians in patient safety through the American Board of Physician Specialties, one of the United States' main recognized physician multi-specialty certifying bodies.

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## Presence - United Samaritans Medical Center

### Kathy Pritchard

Literature demonstrates the only accurate way to monitor respiratory depression is with continuous capnography monitoring, that pulse oximetry alone does not provide any indication of this. While I agree, the vital signs and assessment should be performed every 2.5 hrs while patients are on a PCA, patients should also be monitored and assessed every 15 minutes for the first hour of initiating the PCA.

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## San Diego Patient Safety Council

### Tim Vanderveen

I am submitting the attachment which contains signatures of members encouraging NQF to support the Anesthesia Patient Safety Foundation's recommendations for continuous monitoring of all post-operative patients receiving opioids. APSF, the Institute for Safe Medication Practices, the Joint Commission, and the VA Center for Patient Safety have all endorsed continuous monitoring. The San Diego Patient Safety Council, with representation from 17 San Diego area hospitals, currently has undertaken the creation of a community standard for monitoring of patients outside the OR and ICU. The Council members are in unanimous agreement that continuous monitoring of all patients receiving PCA is required to prevent adverse events, and we are working together with this shared goal to create and

adopt best practices to improve the safe use of PCA.

“The proposed Measure #3040 to ensure the safety of patients using patient-controlled analgesia should include that all patients are continuously electronically monitored for oxygenation with oximetry and/or ventilation with capnography, as recommended by the Anesthesia Patient Safety Foundation.”

I wanted to clarify that the comments were in response to measure #3040 Appropriate Monitoring of Patients Receiving PCA (CMS), specifically the numerator “Patient admissions during which the maximum period between documented respiratory rate, sedation score and pulse oximetry does not exceed 2.5 hours during the first 24 hours after initiation of the first IV PCA opioid administration, excluding any period when PCA is discontinued” and the denominator “All patient admissions with initiation of an opioid via an IV PCA device that is active for more than 2.5 continuous hours”. We are proposing a change to continuous monitoring, coinciding with the guidelines set by Anesthesia Patient Safety Foundation, the Institute for Safe Medication Practices, the Joint Commission, and the VA Center for Patient Safety. I had 3040 in the subject line, but wanted to make sure this was not overlooked.

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## Society of Hospital Medicine

### Shaun Frost

SHM has a goal to broaden the performance measures used for performance improvement or accountability in the Medicare programs including the Hospital Acquired Condition Payment Reduction, Hospital Inpatient Quality Reporting, Hospital Readmission Reduction, Hospital Value-Based Purchasing, Medicare Physician Quality Reporting System, Physician Compare/Physician Feedback, and the Value-Based Modifier Programs.

Hospital Acquired Condition Payment Reduction Program

Many readmissions are preventable, and thus, hospitals need to take proactive steps to lessen the chance of a patient being readmitted. However, there are instances, despite the efforts of the health care team, where patients give informed refusal to medical

care that is necessary to prevent readmission. These patients often experience the same outcomes as patients discharged against medical advice and hospitals should not be penalized by the actions of patients who are more likely to be readmitted due to severe noncompliance with their recommended care. CMS should consider ways to account for such patients in the stated exclusion criteria. That said, SHM supports the inclusion of the following measures in the Hospital Acquired Condition Payment Reduction Program:

- Measure 1370 CAUTI. SHM appreciates that this measure is benchmarked against a standardized expected rate of UTI, an acknowledgement of the fact that some complications occur despite best practices. Most condition-specific measures would benefit from a similar design.
- Measure 566 CLABSI.
- Measures 1368 and 37. Surgical Deaths from complications: (pneumonia, VTE, sepsis, shock/arrest/GIB); and Puncture or laceration. SHM supports these measures and agrees that as a matter of transparency, these results should be publicly reported.
- Measure 3032 Retained Foreign Body, Measure 499 VTE incidence in those not receiving prophylaxis, and Measure 464 Post Op VTE.
- Measure 38 Patient Safety Indicators Composite.
- Measure 2755 Composite of 7 hospital acquired conditions. This measure includes many clinical conditions impacted by hospitalists, including glycemic control, CLABSIs, blood incompatibility, pressure ulcers, and falls. SHM supports the direction of this measure contingent upon NQF endorsement.
- Measure 2756 Composite of 9 hospital acquired conditions.

SHM has concerns about the following measures and does not support consideration for their inclusion in the program:

- Measure 474 Clostridium Difficile SIR. An unintended consequence of this measure could be universal screening for “C. Difficile” at admission, a practice, which will increase costs, but may not help with the outcome of preventing “C. Difficile” infections.

- Measure 582 Methicillin Resistant Staph Aureus (MRSA) Bacteremia. Before this becomes a hospital-level performance measure SHM would like to see further research and validation of the feasibility of prevention of MRSA bacteremia in the hospital setting.

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### Society of Hospital Medicine

#### Shaun Frost

Hospital Inpatient Quality Reporting Program

SHM supports the inclusion of the following measures in the Hospital Inpatient Quality Reporting Program:

- Measures 28, 29, 30. READM-30 (HF, AMI, PNEUM). These measures are currently reported on the Hospital Compare Website and function as part of the existing CMS Readmission Reduction Program. These measures are familiar to hospitals, and draw on the CMS administrative database and therefore, require no abstraction of hospital level resources to submit. The weakness of these measures is the narrow population of patients in the three diagnostic categories and only in FFS Medicare patients. Increasingly, hospitals function as part of integrated delivery systems with significant Medicare members enrolled in Medicare Advantage managed care plans, which are excluded from this assessment of performance. Serious consideration should be given to revise these measures to include both FFS and MA Medicare beneficiaries, or to move to a Hospital Wide Readmission measure like the Yale-CMS co-developed measure that looks at a broader group of diagnoses.

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### Society of Hospital Medicine

#### Shaun Frost

- Measure 1639. Hospital-Wide All Cause Unplanned Readmission Measure (HWR). As above, this measure is also supported by SHM as an alternative to the disease specific, narrower readmission measures. It is inclusive of the entire Medicare population regardless of diagnosis or availability of supplemental insurance plan. It attempts to eliminate planned readmissions, which is called for in the Affordable Care Act (PPACA), and still draws on claims data so does not require hospital level resources to abstract data.

- Measure 521. 30-day Readmission Following THA/TKA. SHM supports the design of this measure in that it is claims based, and does not require abstraction resources. In addition, we appreciate that it includes all patients over 65, not just FFS Medicare patients. A potential weakness is that many health systems are doing aggressive cost reduction work to shorten LOS for major joint replacement surgery patients in the context of bundling projects, such that in the future many total joint procedures as day surgeries with 23 hour outpatient bed status rather than in the hospital setting. For this reason this measure may be obsolete prior to completing the vetting and approval process.
- Measures 1637. 30-day Readmission COPD. This is a new measure that is being put forward for consideration prior to NQF approval and with the denominator still not defined (age >65 or age >40). We support this measure as it relates to a diagnosis for a high volume of inpatient admissions and where inpatient stabilization, discharge planning, and coordinated outpatient follow-up definitely lead to fewer rehospitalizations. We recommend the denominator include the broader population or at least include both FFS and MA – Medicare patients. We also recommend that CMS await formal NQF endorsement.
- Measure 2758. 30-day Readmission Stroke. SHM supports the direction of this claims based readmission measure that as written includes all Medicare discharges over 65 (not just FFS Medicare patients). SHM recommends that there be some additional work on the exclusions such that readmissions to an inpatient rehabilitation hospital or ward be excluded, as many stroke patients are discharged from the acute inpatient setting and readmitted to a rehab center as part of their care plan and this level of care does not need to be penalized.

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### Society of Hospital Medicine

#### Shaun Frost

- Measure 2757. 30-day COPD Mortality. SHM is supportive of this measure as a quality metric. The measure does draw on claims data and has appropriate exclusions, including an exclusion of patient deaths from the denominator if the patient

was transferred into a facility – this is critical if we are to eliminate a potential barrier for tertiary facilities to be willing to receive the highest acuity patients. Although the measure excludes patients on hospice in the preceding 12 months, it should also exclude patients who receive end of life planning and elect to be discharged onto hospice during the index hospitalization.

- Measure 524. 30-day Stroke Mortality. SHM recommends similar modifications to exclude patients who discharge onto Hospice care, as noted above in the 30-day COPD mortality measure. In addition, patients with devastating strokes that are converted to a ‘comfort care’ or inpatient hospice status during their index hospitalization should be excluded from the denominator. SHM supports the direction of this measure.
- Measure 3035. Reliability Adjusted Central Line Infection Rates. SHM supports the direction of this measure contingent upon NQF endorsement, but recommends including an exclusion for emergently placed lines. A difficulty in this and many other device complication measures are that small volume facilities will have difficulty with statistical validity as the performance changes dramatically with just one or two infections/complications. SHM recommends defining the threshold of line days where smaller facilities with low volumes are excluded from participation in the measure.
- Measure 3036. Reliability Adjusted Catheter Associated UTI Rate. SHM would support this measure with the appropriate exclusions, and contingent upon NQF endorsement. As written it needs to still call out that POA (present on admission) UTI should be excluded from the numerator.
- Measure 3038. Reliability Adjusted MRSA Bacteremia Rates. Although this measure is adjusted for case-mix acuity, it measures all cases of bacteremia, not just hospital acquired MRSA bacteremia. This measure does not take into account the background prevalence of MRSA in the community, which remains variable across the country. SHM agrees that hospitals should be held accountable for nosocomial infection rates, but not accountable for the prevalence of disease in the community. SHM supports the direction of this measure, contingent upon NQF endorsement.

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## Society of Hospital Medicine

### Shaun Frost

- Measure 3039. Reliability Adjusted C. Difficile Rates. The numerator and denominators definitions in this measure need to be further defined before they can receive SHM support. Different than above (3038) this numerator does call out that the measurement is of hospital acquired C. Difficile infection. Impeccable hand hygiene and compliance with recommended isolation precautions do influence performance and thus this area is suitable as a quality metric. However, C. diff is also influenced by community prevalence of the disease and the measure needs to adjust for background prevalence rates of C. Difficile perhaps by reporting as a ratio of facility rates / community prevalence (data obtainable via County and State health departments in most areas.) See comments above for the HAC measure #474, which addresses similar content. Harmonization of these measures is desirable. SHM would support the direction of this measure, contingent upon NQF endorsement.
- Measure 2698. AMI Episode of Care. Like measure 1643, this is primarily a utilization measure and its relationship to quality could be questioned. By limiting the denominator to those ICD-9 codes that represent AMI, this measure is more useful than measure 1643, for example. However, without other acuity adjusters in place it may not fairly characterize appropriate utilization. Smaller facilities that keep low acuity AMI patients, but transfer cardiogenic shock patients to tertiary care facilities that do balloon pumps and LVADs, will have a decided advantage over facilities providing more complex (and therefore expensive) interventions regardless of whether the patient situation appropriately dictated the intervention. As such, SHM supports the direction of this measure, contingent upon NQF endorsement.

SHM does not support the following measures for inclusion in the Hospital Inpatient Quality Reporting Program:

- Measure 3037. Reliability Adjusted Surgical Site Infection (SSI) Rate. Clearly, SSIs are a major quality concern and efforts to reduce them should be reported, however, most of these infections occur in the outpatient setting and fall under

global surgical fees, so surgeons do not regularly code post-hospital visits with an infection ICD-9 diagnosis. Thus the numerator would be variable and highly inaccurate. Institutions participating in the National Surgical Quality Improvement Program (NSQIP) have a clear methodology to do outpatient abstraction of infection complication performance data, in many hospitals this has led to reliable surveillance data on SSI. SHM suggests that an alternative pay for performance consideration might be to offer incentives to hospitals participating in this program, or to hospitals participating in NSQIP with better than average SSI rates.

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## Society of Hospital Medicine

### Shaun Frost

- Measure 845. Sepsis Management Bundle. Many hospitals across the country are trying to measure their compliance with the Sepsis bundle and performance monitoring is appropriate. However, with this bundle, this denominator can be obtained via coded data, the elements in the numerator as well as the various exclusions require laborious and time intensive chart review. Even if amended to a sampling methodology, data collection would be resource intensive. So while we support the concept, SHM considers this measure burdensome and would not endorse it in its current form. CMS would need to consider implementing coding for comfort care status in addition to inpatient hospice bed status and the presence of a palliative care consult in order to have coded data that would be in place to correctly exclude patients who are not getting aggressive treatment. It may be that identifying the bundle components that are to be measured and including them in EMR Meaningful Use performance metrics is a more useful way to hardwire a measurement system for sepsis compliance rather than a manual chart abstraction measure such as proposed.
- Measure 1643. Medicare Spending per Beneficiary. SHM supports appropriate utilization and performance reward programs that discourage inappropriate or unnecessary medical care, however, this measure is problematic. The collection of data may be too broad as all areas of the country are compared without any acuity adjustment. As a result, it may occur that over time urban areas

that over time disproportionately serve higher acuity and more chronically ill Medicare patients will underperform on this metric. Additionally, the measure excludes many population groups, including Medicare Advantage patients, dually eligible Medicare-Medicaid patients, etc.

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## Society of Hospital Medicine

### Shaun Frost

#### Hospital Readmission Reduction Program

In general, SHM supports inclusion of the hospital readmission reduction measures listed below. SHM acknowledges the difficulties in refining the numerators of readmissions measures to reflect only preventable readmissions. However, CMS should acknowledge that some readmissions are not preventable and therefore appropriate targets for benchmarks should be set with these readmissions measures. SHM would also support excluding elective readmissions unrelated to the index admission. Measures 28, 29, 30, 2760, 1637, 2758: 30 day readmits for CHF, MI, PNA, THA/TKA, COPD, Stroke. For measure 1637, SHM supports direction, contingent upon NQF endorsement.

#### Hospital Value-Based Purchasing Program

SHM supports the consideration of including the following measures in the Hospital Value-Based Purchasing Program:

- Measure 2149 3-item Care Transition Measure. SHM recommends exclusions for patients being discharged to a facility, patients with advanced dementia, and 'against medical advice' discharges other elopements.
- Measure 488 Influenza Vaccination for HCP.
- Measure 3035 Reliability Adjusted Central-Line Associated Blood Stream Infection (CLASBI) SHM supports this measure, contingent upon NQF endorsement.
- Measure 3036 Reliability Adjusted Catheter Associated Urinary Tract Infection (CAUTI) SHM supports this measure, contingent upon NQF endorsement.
- Measure 3038 Reliability Adjusted Methicillin Resistant Staph Aureus (MRSA) Bacteremia SHM supports the direction of this measure, contingent



upon NQF endorsement.

- Measure 3039 Reliability Adjusted Clostridium Difficile SIR Measures SHM supports the direction of this measure, contingent upon NQF endorsement.

In general, SHM does not support consideration of the following measures for hospital level performance accountability:

- Measure 455. Median time from ED arrival to ED departure for admitted patients. SHM sees the need to clarify if the observation patient time standard is longer or shorter or simply exclude observation cases from the measure. Also, the standard should be adjusted by case mix index and volume, and not just a baseline standard universal to all Emergency Rooms.
- Measure 477 Time from decision to admit from ED to ED departure. SHM sees that it will be very difficult to measure the decision time accurately and that it is subject to bias/error/manipulation. We support measures to improve ED throughput, but the design of the current measure remains challenging.
- Measure 474 Clostridium Difficile SIR Measure
- Measure 582 Methicillin Resistant Staph aureus Bacteremia

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### **Takoma Regional Hospital**

#### **Wendy Fairchild**

You should not make blanket statements or rules as patients are individuals and this should be up to medical staff to write orders. You would not want to do this to patients in Hospice or End of Life Care.

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### **Tri-Society (Gastroenterology)**

#### **Ronald Vender, Loren Laine, Thomas Deas**

Hospital Outpatient and ASC Quality Reporting Programs

The ASC is an important site of service for the practice of gastroenterology, providing a safe, patient friendly and cost-effective environment for the provision of medical care, such as colorectal cancer screening, for patients of all ages.

We recognize the current gaps in outpatient facility-level quality measures available for gastroenterology

in the Medicare Hospital Outpatient Quality Reporting Program (OQR) and Medicare ASC Quality Reporting Program (ASCQR). Our societies and others in the ASC stakeholder community are rigorously working to help address measure gaps in outpatient facilities that provide endoscopy services. ASGE is in the early stages of initiating the development of endoscopy unit quality indicators that will serve as the foundation for quality measures for outpatient endoscopy facilities.

Additionally, we look to organizations like the ASC Quality Collaborative (ASC QC) to bring together leaders from both the ASC industry and organizations with a focus on healthcare quality and safety. The ASC QC develops standardized measures appropriate for ASCs. To date, six of those measures have been endorsed by NQF and five are included in the ASCQ program which was launched on October 1, 2012.

Like those who offered public comments during the meeting, we are very concerned about using Clinician- and group-level measures for inclusion in outpatient facility quality reporting programs. The Hospital Workgroup supported the direction for inclusion of the following two endoscopy measures in the OQR and ASCR programs.

- Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use (PQRS Measure #185; NQF Measure #659)
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (PQRS Measure #320; NQF Measure #658)

While these measures capture data from individual providers, when taken as a whole, this information can inform the aggregate provider care provided in all practice settings. As a business practice, all facility settings should be benchmarking the aggregate individual- and group-level measure performance data of their providers to ensure that all providers in their practice are providing the highest quality of care. Just as care coordination is vital, so is removing variation within a practice when that variability is not based on evidence. While this data can inform the quality of care offered by providers at a facility, we are not confident that these clinician-level measures translate into appropriate facility-level measures. Facility-level measures must complement and work

in concert with clinician-level measures to ensure the highest quality of care and safety. We believe the immediate priority should be the development and use of facility-level specific measures for ASC quality reporting and improvement initiatives.

Based on public feedback during the meeting, it seems that the appropriate stakeholders, including government agencies, are working together to create thoughtful and appropriate quality measures for outpatient facilities that are based on evidence. We urge CMS and the NQF to allow some time for this process to move forward.

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### University of Minnesota Physicians

#### Barbara Gold

Please adopt measure #3040 to ensure the safety of patients using patient-controlled analgesia by ensuring that all patients are continuously electronically monitored for ventilation with capnography and oxygenation with oximetry, as recommended by the Anesthesia Patient Safety Foundation.

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### University of Texas-MD Anderson Cancer Center

#### Ron Walters, MD

Comment 1

On behalf of the Alliance of Dedicated Cancer Centers (ADCC), we welcome the opportunity to respond with comments on the 2013 draft of the Measure Application Partnership's (MAP) Pre-Rulemaking Report.

The ADCC comprises the eleven cancer centers that have a singular focus on cancer. The ADCC institutions are dedicated to advancing the nation's understanding of the causes, prevention, diagnosis, and treatment of cancer; providing innovative cancer therapies and the best possible care to patients; and, disseminating this knowledge to the community at large. The ADCC's members also collaborate to improve quality of care and outcomes for cancer patients. Because of our focused attention on cancer care only, Congress has twice protected the ADCC institutions from the shortfalls of a prospective payment system (PPS). While a PPS may be appropriate for most acute care hospitals, such a

system is inappropriate for dedicated cancer centers that have a singular focus on one disease – cancer. PPSs assume that an array of services and diseases will be provided and treated at such hospitals. Such a system is based on the law of averages (i.e., hospitals typically treat a wide array of conditions/diseases with varying acuity levels, where payments for some services offset payment for other services); also, PPSs typically have a significant lag time before new services and treatments may be integrated into payment rates.

Likewise, in the Patient Protection and Affordable Care Act of 2010 (ACA), Congress mandated that a separate reporting program be created for the ADCC institutions rather than applying an existing quality reporting program for PPS hospitals (e.g., the Inpatient Quality Reporting or IQR Program). Clearly, Congress recognized the unique nature of our institutions and of cancer treatment, which is primarily delivered in an outpatient setting, and the need for measures that account for the complex condition of cancer patients. Thus, measures adopted for our mandatory reporting program, the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, must be relevant and appropriate for our patients and must establish distinctions between providers of cancer care.

Our singular focus and unique payment status provide an important perspective on the recommendations included in this report for the PCHQR Program. We trust that the MAP will give due consideration to our comments since this program applies exclusively to the dedicated cancer centers.

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### University of Texas-MD Anderson Cancer Center

#### Ron Walters, MD

Comment 2

We appreciate the MAP's position that the measures in the PCHQR Program should be aligned with the measures in the IQR and Outpatient Quality Reporting (OQR) Programs. However, as noted in our comment letter to the 2012 MAP Pre-Rulemaking Report, we recognize the need to avoid the unilateral application of measures from these programs to the PCHQR. The need for measure alignment is clear, but it is crucial that the aligned measures are relevant to

cancer care to ensure that patients are appropriately informed about the quality of care in our centers and to prevent inappropriate diversion of scarce hospital resources from cancer-specific performance improvement and outcomes measurement. As an example, an IQR measure that specifies immunization would not be appropriate for immuno-suppressed cancer patients, since they are unable to mount an immune response. Such a measure applied to the dedicated cancer centers would have the unintended consequence of unnecessary and wasteful resource consumption. Furthermore, we support MAP's position in placing a high priority on measures of patient and/or caregiver experience and patient-reported outcomes. Our cancer centers place a high value on patient and caregiver quality of life and well-being during and after cancer treatment, and the ADCC supports including in the PCHQR a National Quality Forum (NQF)-endorsed, cancer-specific patient experience survey, which accommodates changing patient and caregiver needs across the continuum of care. Thus, we are following closely the development of the CAHPS for Cancer Care Survey (Cancer CAHPS), the first disease-specific Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey that is being developed and tested with support from the National Cancer Institute (NCI) and the Agency for Healthcare Research and Quality (AHRQ). Several ADCC institutions are considering serving as pilot sites for future testing of the Cancer CAHPS survey in 2013; however, no pilots have been conducted to date at the PPS-exempt cancer hospitals.

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**University of Texas-MD Anderson Cancer Center**

**Ron Walters, MD**

Comment 3

0166—Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Position: Consistent with the MAP's position, the ADCC supports the direction of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). However, we do not consider it the most appropriate survey for our patient population.

Rationale: The HCAHPS survey is widely used by PPS

hospitals, whose care delivery primarily is inpatient-based. Conversely, the vast majority of cancer care delivered at the ADCC centers is outpatient-based. Thus, adopting the HCAHPS survey for the PCHQR would yield a patient experience assessment that is not representative of our cancer care. Moreover, its adoption for the PCHQR may lead to imprecise comparisons between our hospitals, particularly given the large variation in bed size (and associated inpatient volume). A survey that focuses on care in the ambulatory setting, where volume differences will not have as great an impact, would not be encumbered by these measurement issues. Finally, the ADCC is concerned that adoption of the HCAHPS survey—coupled with adoption of a cancer-specific patient experience survey, which is likely to occur in a year or two—will constitute an unintentional federal mandate to burden patients of PPS-exempt cancer centers by over-surveying.

Specific Considerations: As noted above, the ADCC supports including in the PCHQR an NQF-endorsed, cancer-specific patient experience survey that accommodates changing patient and caregiver needs across the continuum of care. Cancer patients represent a distinct subset of patients requiring long-term treatment plans for a single diagnosis (3-6 months or more) across a variety of providers and outpatient/inpatient settings that are not always integrated or coordinated. Variations in diagnosis and treatment across time, location, and providers present confounding factors to measuring and validating patient and caregiver experience with care. Thus, the instruments for measuring consumer experience require substantial validation to ensure their appropriateness and utility in the cancer population and to demonstrate a positive correlation between quality outcomes and patient experience. [1] To our knowledge, the HCAHPS survey has not been tested specifically in a specialty population, such as cancer. Therefore, further testing would be required to ensure its appropriateness for the cancer population before it is used for reimbursement purposes under the PCHQR.

As the MAP is aware and as noted above, the Cancer CAHPS is the first disease-specific CAHPS patient experience survey and is being developed and tested with support from NCI and AHRQ. Research and development of this survey, which contains elements

applicable to inpatient and outpatient cancer care, began in late 2009. The results from an initial pilot study at six sites are expected to be made public by February 1, 2013, and additional, broader testing is needed before the survey is finalized. It is anticipated that the additional testing may be completed as early as within one year. The ADCC welcomes the opportunity to evaluate the Cancer CAHPS for its applicability for our patients. Furthermore, we are considering potential piloting and implementation of the Cancer CAHPS survey within our cancer centers. However, until the Cancer CAHPS has been validated through beta testing in a broader array of cancer care settings, including PPS-exempt and non-exempt cancer centers, and has been vetted through the NQF endorsement process, the ADCC is reticent to support the adoption of any patient experience survey for the PCHQR. Of note, four ADCC institutions are utilizing the HCAHPS survey to support internal performance improvement activities for our inpatient units. However, should the Cancer CAHPS (or a similar cancer-specific patient experience survey that is applicable to inpatient and outpatient cancer care) be validated for use in our hospitals, our leadership will give serious consideration to discontinuing the use of the HCAHPS to avoid over-surveying our patients, which has been associated with survey fatigue, leading to smaller response rates and decreased validity of survey results. Thus, if the HCAHPS is adopted for the PCHQR, we urge The Centers for Medicare and Medicaid Services (CMS) to make this a temporary adoption until a cancer-specific patient experience survey is validated and endorsed by the NQF. This position is of particular importance to ensure that the surveys applied to our patients are sensitive to the nuances of cancer care and that our patients are not overburdened by receiving multiple surveys for the same episode of care.

[1] Lee DS, Tu JV, Chong A, Alter DA. Patient satisfaction and its relationship with quality and outcomes of care after acute myocardial infarction. *Circulation*. Nov 4 2008;118(19):1938-1945.

Glickman SW, Boulding W, Manary M, et al. Patient satisfaction and its relationship with clinical quality and inpatient mortality in acute myocardial infarction. *Circ Cardiovasc Qual Outcomes*. Mar 2010;3(2):188-195.

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## University of Texas-MD Anderson Cancer Center

### Ron Walters, MD

#### Comment 4

#### Surgical Care Improvement Project (SCIP) Measures—General Surgery

0218—Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time

0284—Surgery patients on beta blocker therapy prior to admission who received a beta blocker during the perioperative period

0452—Surgery Patients with Perioperative Temperature Management  
0453—Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero

0527—Prophylactic antibiotic received within 1 hour prior to surgical incision  
0528—Prophylactic antibiotic selection for surgical patients

0529—Prophylactic antibiotics discontinued within 24 hours after surgery end time  
Position:

In general, the ADCC supports the MAP's recommendation to adopt these Surgical Care Improvement Project (SCIP) measures for the PCHQR. Rationale: The development of post-operative complications, including venous thromboembolisms (VTE) and surgical site infections (SSI), in a patient with cancer can lead to a life-threatening event, especially in those who are immunocompromised. Avoidance of these post-operative complications clearly leads to decreased morbidity and mortality, and the SCIP process measures (listed above) reduce the risk of these complications in surgical patients.

Specific Considerations: We appreciate CMS' approach in applying selected SCIP measures for our program, rather than unilaterally applying all SCIP measures, which may or may not be appropriate for our centers. We urge CMS to exercise due caution in developing implementation guidelines for adopting these measures for the PCHQR. To our knowledge, these measures have not been formally tested in a specialty population, such as cancer. Thus, despite

high compliance rates under these measures, our patients may experience higher infection rates unrelated to infection prevention protocols. Serious consideration must be given to relevant patient comparison groups, subsets and stratifications (e.g., by cancer type) and to appropriate exclusions where the recommended therapy is clinically inappropriate for our patients. Additionally, the required portion of population coverage for these measures is unclear. Consistent with their use in the IQR, we would expect that a patient sample would suffice. We trust that CMS will consider carefully these concerns in its rulemaking process.

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**University of Texas-MD Anderson Cancer Center**

**Ron Walters, MD**

Comment 5

Surgical Care Improvement Project (SCIP) Measures—  
Cardiac Surgery

0300—Cardiac Surgery Patients With Controlled  
Postoperative Blood Glucose

Position: The ADCC does not support the MAP's recommendation to adopt this measure for the PCHQR.

Rationale: Our centers rarely, if ever, perform the cardiac procedures included in this measure. In the rare event that one of our centers performs one of these cardiac procedures, the volume would be too low to provide a valid comparison. Such a measure applied to the dedicated cancer centers would have the unintended consequence of unnecessary and wasteful resource consumption. Moreover, this measure has not been validated for the cancer population.

Specific Considerations: Post-operative blood glucose maintenance is important for all patients. However, this measure is intended for and has been tested in cardiac surgery patients only, not in the cancer population. Thus, additional testing and vetting would be required to apply this measure to our surgical population.

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**University of Texas-MD Anderson Cancer Center**

**Ron Walters, MD**

Comment 6

0380—Multiple Myeloma – Treatment with Bisphosphonates  
Position: The ADCC supports the MAP's recommendation to adopt this measure for the PCHQR, subject to the modifications outlined below. However, we urge CMS to consider delaying adoption of this measure until development and testing of a new, broader measure is complete. Rationale: Bisphosphonates are the standard of care for preventing bone deterioration in multiple myeloma patients. However, bisphosphonates may be clinically inappropriate for some patients with multiple myeloma, and long-term use has demonstrated serious side effects in certain patients. [1] Furthermore, we are concerned that the adoption of this measure essentially would lock our clinicians into one standard of care when emerging studies suggest that Denosumab, an osteoclast inhibitor, may provide equivalent if not superior bone protection in these patients.[2]

Specific Considerations: Multiple myeloma is a serious disease, but it represents a small proportion of newly diagnosed cancer patients. We recommend that CMS utilize a similar, broader measure, such as the measure currently under development by CMS contractors, which addresses use of bisphosphonates and osteoclast inhibitors in patients with multiple myeloma as well as breast, prostate, and non-small cell lung cancers. This measure may be available for reporting as early as 2015. Thus, we recommend that CMS delay consideration of adopting NQF measure #0380 for the PCHQR until the broader measure has been fully tested, since switching to a new, broader measure within one year would prevent meaningful comparisons of data over time and would likely cause confusion in the minds of patients, for whom the quality reporting is intended. Additionally, it would not be resource-efficient for CMS, its contractors, or the ADCC institutions.

If adopted, we recommend that CMS work with the measure developer to apply exclusions that allow physicians to utilize other clinically appropriate therapies in patients where bisphosphonates were unsuccessful in preventing bone deterioration or where bisphosphonates are contraindicated.

[1] Bamias A, Kastritis E, Bamia C, et al. Osteonecrosis of the jaw in cancer after treatment with bisphosphonates: incidence and risk factors. *J Clin Oncol*. Dec 1 2005;23(34):8580-8587. University of Alabama at Birmingham. Osteonecrosis of the Jaw. 2013; [http://www.dentalpbrn.org/users/news/Osteonecrosis\\_of\\_the\\_Jaw.pdf](http://www.dentalpbrn.org/users/news/Osteonecrosis_of_the_Jaw.pdf). Accessed January 25, 2013.

[2] Henry D, et al. *EJC Supplements*. 2009;7(3):12. Abstract 20LBA. Wang Y, Lin B. In silico investigations of the anti-catabolic effects of pamidronate and denosumab on multiple myeloma-induced bone disease. *PLoS One*. 2012;7(9):e44868.

Lipton A, Fizazi K, Stopeck AT, et al. Superiority of denosumab to zoledronic acid for prevention of skeletal-related events: a combined analysis of 3 pivotal, randomised, phase 3 trials. *Eur J Cancer*. Nov 2012;48(16):3082-3092.

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#### University of Texas-MD Anderson Cancer Center

**Ron Walters, MD**

Comment 7

0382—Oncology: Radiation Dose Limits to Normal Tissues  
Position: The ADCC supports the MAP's recommendation to adopt this measure for the PCHQR, with the exclusion described below.

Rationale: This is a reasonable measure to adopt and reflects the standard of care.  
Specific Considerations: If adopted, we recommend that CMS work with the measure developer to apply the following exclusion to the measure: "Patients with metastatic disease treated for palliation." According to the NQF measure specifications, the measure would include patients with metastatic lung or pancreatic cancer receiving treatment for a metastatic site (e.g., bone or brain metastases) with 3D conformal radiation therapy for palliation. Dose limits to normal tissues may not always be applicable for such cases.

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#### University of Texas-MD Anderson Cancer Center

**Ron Walters, MD**

Comment 8

Pain Management Measures

0383—Oncology: Plan of Care for Pain – Medical

Oncology and Radiation Oncology (paired with 0384)

0384—Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)

Position: In general, the ADCC supports the MAP's recommendation to adopt these measures for the PCHQR, with the modifications outlined below.

Rationale: Frequently, cancer patients experience pain as a consequence of disease progression and as a side effect of treatment. Effective pain management for these patients is essential to maintaining or improving their quality of life during treatment and, in particular, at the end of life.

Specific Considerations: These measures reflect good concepts, but are hard to capture as written and, in certain cases, are too vague. Additionally, they seem insufficient to accommodate changes in level of pain across the continuum of care. For example, as pain intensifies along with progression of disease, a patient may require revisions to his or her plan of care for pain, but this nuance is not reflected in the specification for NQF measure #0383. Also of note, producing these indicators likely will require manual chart review for our cancer centers. Based on our high patient volumes, we recommend that, if implemented, CMS adopt a sampling approach rather than 100% population coverage.

Additionally, NQF measure #0383 would be improved by changing the title to "documented plan of appropriate/adequate care to address pain" and by modifying the numerator statement. As described in the NQF measure specifications, the numerator would suggest that patients with a pain intensity score of 1 or more should have a documented plan of care for pain. While we agree that all reported pain should be evaluated for potential treatment, patients with a pain score of 1 or 2 on a 10-point scale or with pain unrelated to cancer disease or treatment (e.g., an unrelated headache) do not require intervention in most circumstances, and the absence of documentation may lead to non-compliance in reporting this measure. Thus, we recommend that the numerator be revised to: "Patient visits that included a documented plan of care to address pain reported as moderate or severe—3 or more on a 10-point scale."

For NQF measures #0383 and #0384, the interpretation of the denominator statement (“All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain”) is too narrow in certain cases. For example, it does not measure appropriately the denominator in cases where patients are not candidates for chemotherapy or radiation therapy or where patients have completed chemotherapy and/or radiation therapy and are not in remission. We recommend that CMS work with the measure developer to revise the denominator statements for both measures to read: “All visits for patients, regardless of age, with a diagnosis of cancer seen in an oncology clinic who report having pain.”

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**University of Texas-MD Anderson Cancer Center**

**Ron Walters, MD**

Comment 9

0389—Prostate Cancer: Avoidance of Overuse Measure - Bone Scan for Staging Low-Risk Patients  
 Position: The ADCC supports the MAP’s recommendation to adopt this measure for the PCHQR.  
 Rationale: It is well-known that the overuse of advanced imaging leads to considerable cost waste in the healthcare system. Therefore, appropriate and efficient use of advanced imaging has clear benefits for patients and the public at large.  
 Specific Considerations: If adopted, we recommend that CMS work with the measure developer to clarify what is meant by “low risk” (e.g., low risk of metastasis) and to provide additional specifications categorize patients as “low risk.” Additionally, we recommend that the measure be revised to incorporate a literature-based time frame for the numerator (i.e., patients who did not have a bone scan performed within X days of diagnosis). Furthermore, we recommend that the measure steward consider revising the measure to address overuse of abdominal computed tomography (CT) in addition to bone scan.

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**University of Texas-MD Anderson Cancer Center**

**Ron Walters, MD**

Comment 10

**0390—Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients**

Position: In general, the ADCC supports the MAP’s recommendation to adopt this measure for the PCHQR, subject to the considerations described below.

Rationale: Hormonal therapy is the standard of care for prostate patients at high risk for recurrence.

Specific Considerations: This measure recommends a standard of care that exceeds the recommendations in the original study, but there is a strong basis for expansion based on the current literature. For example, there is compelling data to support the use of neoadjuvant and concurrent androgen deprivation therapy (ADT), rather than adjuvant ADT alone.[1]

If adopted, we recommend that CMS work with the measure developer to provide additional specifications to categorize patients as “high risk for recurrence.” For example, we question the use of prostate-specific antigen (PSA) testing for defining “high risk for recurrence” since the major studies on which this measure is based used tumor size and nodal status to assess this risk.[2] Additionally, we recommend that the measure be revised to incorporate a literature-based time frame for the numerator (i.e., patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin releasing hormone] agonist or antagonist) within X days of diagnosis).

[1] Denham JW, Steigler A, Lamb DS, et al. Short-term androgen deprivation and radiotherapy for locally advanced prostate cancer: results from the Trans-Tasman Radiation Oncology Group 96.01 randomised controlled trial. *Lancet Oncol.* Nov 2005;6(11):841-850.

Parker C. Androgen deprivation before prostate radiotherapy: how long is long enough? *Lancet Oncol.* May 2011;12(5):411-412.

Payne H, Mason M. Androgen deprivation therapy as adjuvant/neoadjuvant to radiotherapy for high-risk localised and locally advanced prostate cancer: recent developments. *Br J Cancer.* Nov 22 2011;105(11):1628-1634.

[2] Pilepich MV, Winter K, John MJ, et al. Phase III radiation therapy oncology group (RTOG) trial

86-10 of androgen deprivation adjuvant to definitive radiotherapy in locally advanced carcinoma of the prostate. *Int J Radiat Oncol Biol Phys.* Aug 1 2001;50(5):1243-1252.

Zurlo A, Collette L, van Tienhoven G, et al. Acute toxicity of conventional radiation therapy for high-risk prostate cancer in EORTC trial 22863. *Eur Urol.* Aug 2002;42(2):125-132.

Pilepich MV, Winter K, Lawton CA, et al. Androgen suppression adjuvant to definitive radiotherapy in prostate carcinoma--long-term results of phase III RTOG 85-31. *Int J Radiat Oncol Biol Phys.* Apr 1 2005;61(5):1285-1290.

D'Amico AV, Chen MH, Renshaw AA, Loffredo M, Kantoff PW. Androgen suppression and radiation vs radiation alone for prostate cancer: a randomized trial. *Jama.* Jan 23 2008;299(3):289-295.

Horwitz EM, Bae K, Hanks GE, et al. Ten-year follow-up of radiation therapy oncology group protocol 92-02: a phase III trial of the duration of elective androgen deprivation in locally advanced prostate cancer. *J Clin Oncol.* May 20 2008;26(15):2497-2504.

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### University of Texas-MD Anderson Cancer Center

#### Ron Walters, MD

Comment 11

0753—American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

Position: The ADCC supports the MAP's recommendation to adopt this measure for the PCHQR.

Rationale: The development of a surgical site infection in a patient with cancer can lead to a life-threatening event, especially in those who are immunocompromised. Avoidance of these infections clearly leads to decreased morbidity and mortality.

Specific Considerations: We urge CMS to exercise due caution in developing implementation guidelines for adopting this measure for the PCHQR. Serious consideration must be given to relevant patient comparison groups, subsets, and stratifications, particularly for patients with a suppressed immune

response. Additionally, the required portion of population coverage for these measures is unclear as well as the proposed reporting mechanism. Consistent with their implementation of the SCIP measures in the IQR, we expect that a patient sample would suffice. Likewise, our centers are open to reporting this measure through the Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN), through which we are currently reporting other infection rates. We trust that CMS will consider carefully these concerns in its rulemaking process.

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### University of Texas-MD Anderson Cancer Center

#### Ron Walters, MD

Comment 12

M1643—Medicare Spending Per Beneficiary Position: The ADCC does not support adopting the PPS Medicare Spending per Beneficiary (MSPB) measure for the PCHQR. Rationale: In general, the ADCC supports the establishment of an efficiency measure that takes into account the special nature of cancer care and the dedicated cancer centers; however, we do not believe that the MSPB measure, as applied to PPS hospitals, is able to serve such a function. After a preliminary review of the MSPB measure designed for PPS hospitals, it is clear that substantial testing and adjustments are needed before any consideration is given to applying this measure to the ADCC. Specific Considerations: We appreciate that the PPS MSPB measure is designed to capture pre-surgical testing and inefficiencies related to complications or readmissions, but the measure would not capture our efforts to minimize admissions. The ADCC institutions have been at the forefront of developing many of the advances that have allowed cancer care to be provided in the outpatient setting, which benefits patients and is more cost-effective than inpatient care. Moreover, the PPS MSPB "episode" does not appropriately reflect the way that cancer care is delivered. For example, patients often receive necessary treatment (e.g., neoadjuvant chemotherapy) that is unrelated to the admission in the three days prior to admission and in the 30 days after discharge. Such spending should not be captured in the MSPB calculation. Of note, CMS recognizes this distinction in care by establishing a



72-hour hospital preadmission rule for PPS hospitals and a 24-hour rule for the dedicated cancer centers. We also note that in the calculation of the MSPB measure for PPS hospitals, CMS price-standardized, risk-adjusted, and excluded other payments that recognize the extraordinary nature of care provided in some hospitals (i.e., disproportionate share hospital payments and indirect medical education) in order to avoid distortions when comparing efficiencies across hospitals. Similarly, we trust that payments made to dedicated cancer centers will not be included in any MSPB measure to avoid similar distortions. Furthermore, due to our advances in outpatient treatment, the inpatients that we serve have a higher acuity and severity of illness than in PPS hospitals. Therefore, appropriate risk-adjustment is vital. Lastly, should a similar measure ever apply to the ADCC institutions, the median hospital standard to which we are compared should not be that of a PPS hospital. Our singular focus on cancer compared to a PPS hospital's treatment of a variety of conditions would produce an inaccurate picture of efficiency.

**M3035—Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)**Position: Due to the lack of measure specifications available for this measure and the potential overlap with NQF measure #0139 National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure, which is currently part of the PCHQR, we cannot provide meaningful input on the MAP's recommendation for this measure. We request that the measure developer provide specifications for the measure so that we may provide substantive comments on its adoption for the PCHQR. Rationale: The ADCC supports the adoption of a revised CDC CLABSI measure, which excludes blood stream infections unrelated to central line placement and which utilizes for comparison appropriate inpatient units for the cancer population. If measure #M3035 incorporates these revisions, then we likely would support its adoption, pending review of the measure specifications. Specific Considerations: CMS adopted NQF measure #0139 for the PCHQR for FY2014 reimbursement. It is unclear if the proposed measure is intended to replace NQF measure #0139 in the PCHQR or to what degree these measures overlap. Additionally and as noted previously, the CDC has been revising

its CLABSI methodology to exclude blood stream infections unrelated to central line placement in cancer patients, and members of our infection control staff have worked closely with the CDC in this regard. Patients on chemotherapy with subsequent gastrointestinal toxicities and, in particular, patients with profound neutropenia or those that experience complications following stem cell transplantation (e.g., graft-versus-host disease or GVHD) may develop blood stream infections unrelated to central line placement. An appropriate CLABSI measure will exclude those infections unrelated to central line placement to avoid erroneous conclusions about infection rates in the cancer patient population. Of note, we agree in concept with the use of the standardized infection rate (SIR) for comparison to other patients with equivalent risk. For example, when our members report CLABSI data through the CDC NHSN, patients are classified according to their inpatient unit—intensive care unit (ICU) or Specialty Care Area (SCA). This practice leads to more accurate calculations of expected values and, accordingly, more equitable comparisons across providers.

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**University of Texas-MD Anderson Cancer Center  
Ron Walters, MD**

Comment 13

**M3036—Reliability Adjusted Catheter-Associated Urinary Tract Infection (CAUTI)**Position: Due to the lack of measure specifications available for this measure and the potential overlap with NQF measure #0138 National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure, which is currently part of the PCHQR, we cannot provide meaningful input on the MAP's recommendation for this measure. We request that the measure developer provide specifications for the measure so that we may provide substantive comments on its adoption for the PCHQR. Rationale: The ADCC supports the adoption of a revised CDC CAUTI measure, which utilizes for comparison appropriate inpatient units for the cancer population. If measure #M3036 incorporates these revisions, then we likely would support its adoption, pending review of the measure specifications. Specific Considerations: CMS adopted NQF measure #0138

for the PCHQR for FY2014 reimbursement. It is unclear if the proposed measure is intended to replace NQF measure #0138 in the PCHQR or to what degree these measures overlap. Of note, we agree in concept with the use of the SIR for comparison to other patients with equivalent risk. For example, when our members report CAUTI data through the CDC NHSN, patients are classified according to their inpatient unit—ICU or SCA. This practice leads to more accurate calculations of expected values and, accordingly, more equitable comparisons across providers. Additionally, we recommend excluding from the measure cancer patients with indwelling genitourinary (GU) hardware, such as percutaneous nephrostomy and internalized ureteral stents. Such hardware frequently is colonized with bacteria and, in cancer patients with both indwelling GU hardware and urinary catheters, may lead to the erroneous assumption that such patients have CAUTIs when that may not be the case. An appropriate CAUTI measure will exclude these infections to avoid inappropriate conclusions about infection rates in the cancer patient population.

Comment 14 (final)

In summary, the ADCC supports adoption of most of the measures recommended for the PCHQR, but does not support the adoption of two of the proposed measures: NQF measure #0300 Cardiac Surgery Patients With Controlled Postoperative Blood Glucose; and, #M1643 Medicare Spending Per Beneficiary. The ADCC's positions for all proposed measures are summarized in Table 1. We urge the MAP to reconsider its recommendations with respect to NQF measure #0300 based on the concerns outlined in this letter. Similarly, we urge CMS to give consideration to our concerns in its rulemaking process for the PCHQR.

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### Valley View Regional Hospital

#### Peggy Warner

Recent published studies recommend end title CO<sub>2</sub> or capnography as the monitor of choice. Those same studies prove that pulse oximetry alone is not recommended and does not monitor the patient's ventilation as capnography would.

## Section 7: Pre-Rulemaking Input on Post-Acute and Long-Term Care Performance Measurement Programs

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### American Academy of Hospice and Palliative Medicine

#### Dale Lupu

The American Academy of Hospice and Palliative Care (AAHPM) supports all of the hospice measures with the expectation that this measure set will continue to be refined and modified as experience is gained with the measures.

We note the dearth of measures addressing palliative care needs of patients in long term care settings other than hospice. We urge development of palliative care measures for rehabilitation and long term care settings. We also note that OASIS in home health needs further refinement to better include palliative care domains, when those are consonant with patient goals.

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### American Academy of Physical Medicine and Rehabilitation

#### Elliot Roth

The American Academy of Physical Medicine & Rehabilitation (AAPM&R) understands the grouping together of Post-Acute (PAC), Long-Term Care (LTC) and Inpatient Rehabilitation Facilities (IRF) and efforts by MAP to promote parsimony by recommending measures that are most applicable to the population served in each setting, but has identified some limitations to this approach. For example, the incidence of events such as catheter-associated urinary tract infections (CAUTIs), Central Line Associated Blood Stream Infection (CLABSI) with MRSA and *C. difficile* is vastly different across these settings. By aligning these, you are creating a test that IRFs are destined to pass. Measures like these highlight the uniqueness of the care provided within an IRF setting, but do not drive improved patient care for this population. This may be an

unanticipated consequence of the grouping of these care settings, and may take away from areas of focus that should be measured such as unassisted fall rates or thromboembolic events.

AAPM&R would also advocate that there be a greater recognition of the importance of patients' goals of care including achieving maximal functional improvement, discharge to a community setting, a safe transition to the next setting with coordination of care over a care trajectory, a decrease in care burden, patient and caregiver training and satisfaction with care. AAPM&R concurs with MAP's non-support of the Functional Change: Change in Motor score, due to the developmental stage of this instrument, and the lack of testing and validation in all patient care settings. Having a functional measure that can be used longitudinally across patient settings is attractive to physiatrists, but it seems premature to suggest that this unpublished and untested measure should be implemented at this time. Of concern will be how this measure will be employed with appropriate risk adjustments.

AAPM&R recommends that for inpatient post-acute settings, the FIM® score (and its derivatives), widely utilized for decades, and available for royalty-free use for the purposes of quality reporting, be utilized to capture functional change, at least until another measure or measures are developed with appropriate validity and reliability testing. AAPM&R supports the development of patient reported outcome measures for these settings. We join MAP in supporting the inclusion of several immunization measures across settings, but seeks clarification as to measure #1647 re: staff immunization. The descriptor of the numerator appears that this measure will have three different groups that will be computed separately (received vaccine /contraindication to vaccine /declined) and doesn't list any exemptions. There also is no discussion of how geographic variance based on state vaccine mandates will impact this measure.

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### American Health Care Association

#### Sandra Fitzler

Support submission of two antipsychotic measures for submission. Agree with concept of minimizing exclusions in antipsychotics but they should exclude

FDA approved diagnoses, which current measures do not exclude bipolar disorder and FDA approved diagnosis. This population constitutes approximately 2% of antipsychotic users in nursing homes. As currently constructed we oppose these two measures without addition of bipolar disorder as exclusion. We also support the development of a balancing measure for other neuropsychiatric medications besides just antipsychotics.

Rehospitalization measures. We agree with MAP that risk adjustment is necessary for both short rehospitalization measure and long stay measure. We also agree that as much alignment with other setting rehospitalization and hospitalization measures makes sense but that taken to an extreme can decrease the measure. For example a method that calculates and compares expected to observed readmissions makes sense but the risk adjustment variables should not be identical. Similarly, time frames of 30 days following hospital discharge make sense theoretically but may not compare with the average duration of SNF care or may miss significant size of the population receiving SNF care. We also believe that measure should be MDS based rather than claims based given the significant delay in reporting claim's based measures.

We disagree with MAP recommendation to support discharge to community. While we strongly support the development and use of such a measure, it must be risk adjusted.

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### American Hospital Association

#### Akinluwa Demehin

Several AHA members provided measure-specific comments. While we did not include these comments in our letter, we believe these assessments highlight important problems with many of the proposed measures. We are pleased to submit them for the MAP's consideration, and have noted where the member comments illustrate the issues discussed in our comment letter. Infection Measures for PAC/LTC programs: HealthSouth highlights several issues with using CAUTI, MRSA and C. difficile measures in rehabilitation settings. Principally, HealthSouth is concerned that CAUTI, MRSA and C. Difficile are not the most important areas for safety and quality improvement in rehabilitation patients. Several of

the other issues identified by the PAC Workgroup as areas of focus are much more important to the recovery and outcome of IRF patients. If IRFs spend time and resources focused on collecting, analyzing and improving the relatively small risks represented by the CAUTI, MRSA and C Difficile measures, they will have fewer --- and possibly no available resources to expend on those issues that are truly important to IRF patient outcomes. Further, these measures may prompt the use of diagnostic tests and antibiotics that create risks to patients beyond any potential benefit that the measurement might have. AHA joins with HealthSouth in urging the MAP to eschew these measures in favor of focusing on issues that are truly consequential for IRF patients. Leveraging existing UDSMR FIM tool to fill measure gaps: HealthSouth also notes that the IRF Quality Reporting program would benefit from developing functional improvement measures from the existing UDSMR FIM tool, which is already used in reporting to CMS. The AHA agrees with HealthSouth's concern that using measures outside of this tool creates an unnecessary burden. Immunization measures for short-stay post-acute care providers: Finally, HealthSouth notes that short-stay post-acute patients have access to influenza vaccination via multiple settings prior to arrival at an IRF. Moreover, obtaining an accurate, timely vaccination history is difficult. The AHA concurs that this measure should be excluded from the IRF quality reporting program.

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### **American Medical Rehabilitation Providers Association**

#### **Marsha Lommel**

The mission of inpatient rehabilitation hospitals and units (IRH/Us) is to help patients achieve improved functional status so that they can return to the community. With this focus in mind, we reviewed the measures recommended for IRH/Us. We do not support the CLASBI measure, in that so few central lines are used that it is not an appropriate quality measure. We are concerned that in the rare instances in which a central line was used and an infection occurred the IRH/U could have an inappropriately low quality score. As a result, we support the MAP's decision not to support this measure. The existing measures of functional improvement are in their infancy and are not ready for implementation. CMS is

working to further develop these measures but until this work is complete functional measures cannot be used for quality reporting. Work on these measures should be based on several principles including: risk adjustment should be done by diagnosis (RIC, IGC), demographic, and other factors; such measures should exclude patients discharged to acute hospitals or who died; testing should be completed; quality of life as measured by reduction in burden of care, increased mastery of one's environment, or other factors must be accounted for in any measure of functional change; and motor functional change, change in self-care, and change in mobility should be measured over the patient's entire stay as opposed to length of stay or by day.

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### **American Nurses Association**

#### **Maureen Dailey**

ANA agrees with the core measure areas identified by the PAC/LTC Workgroup and the desire to address the needs of diverse populations served within the settings covered. ANA urges the MAP to consider key nursing structural measures, including nurse staffing, in the public programs to fill a key safety gap. The importance of nursing structural measures to patient safety was noted in the CMS 2012 Nursing Home Action Plan: "Adequate quantity and quality of staffing in a nursing home are key determinants of the level of care residents receive" (p. 2). Moreover, the Dual Eligible Workgroup identified the need for nursing staffing measures in order to achieve quality outcomes, including safety, for subpopulations requiring complex care to reduce care disparities, improve safety, and better coordinate patient's goals in advanced illness care. Finally, the Affordable Care Act, requires posting of nursing home staffing data taken from payroll reporting on the Nursing Home Compare website for transparent, meaningful stakeholder viewing for decision making. It is critical that the CMS pilot test accurate nursing structural measures using payroll-based data, including staffing, and that this be evaluated ad hoc by NQF to promote expedient addition to the NQF portfolio for SNFs for the MAP's consideration.

Since the NQF SNF quality measures report in 2011 noted this measure gap, no nursing staffing measures have been endorsed for SNFs. Several of the core

SNF CMS outcome-focused quality campaigns will not achieve their goals without the appropriate balance of important structure, process, and outcome measures. For example, the CMS campaign goals to reduce overuse of antipsychotics, healthcare acquired conditions, avoidable readmissions, and ED use will not occur without key structural measures in place. The Partnership for Patients Readmission Action Team has identified workforce issues as one of the key areas to prevent unwanted avoidable care through avoidable admissions from nursing homes.

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### **American Occupational Therapy Association**

#### **Susan Lin**

As the national professional association representing the interests of more than 140,000 occupational therapy practitioners and students, the American Occupational Therapy Association (AOTA) is pleased to be a member of the National Quality Forum (NQF). Occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners provide critical occupational therapy services to clients in post-acute care and long-term care (PAC/LTC) settings, such as rehabilitation centers, home health, nursing homes, and long-term care hospitals. AOTA appreciates this opportunity to provide comment on the NQF Measure Applications Partnership's (MAP) Pre-Rulemaking Report.

#### General Comments

AOTA is interested in NQF's idea of having a virtual "measure incubator", where stakeholders can collaborate with funders, developers, EHR vendors, healthcare systems, and local collaborators. We would like to receive additional information about this virtual platform.

#### Home Health Quality Reporting

AOTA supports MAP's recommendations on measures under consideration and finalized measures for home health quality reporting. Occupational therapists in home health can synthesize patients' functioning across daily activities, safety, environmental supports and barriers, and participation in meaningful activities, in order to design treatment plans to improve functional and

healthy outcomes. We gladly offer our assistance to help MAP identify the most salient and parsimonious set of quality measures for home health. Measure GapsAOTA agrees with MAP's assessment of measure gaps across clinical settings and populations. More measures need to be developed or revised so that they can be used across the continuum of care, especially as we strive to improve and measure the effectiveness of care coordination strategies. AOTA recognizes that filling these measure gaps requires many stakeholders to address the complexities associated with improving health care access and quality. Occupational therapists are willing to share their knowledge and measures with respect to patient engagement, goal attainment, safety, care coordination, and mental and behavioral health. AOTA is pleased with MAP's diligent progress to improve and welcomes opportunities to assist with MAP's quality reporting work, particularly in the areas of inpatient rehabilitation facilities, nursing homes, and home health. Please do not hesitate to contact AOTA for further information.

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### **American Society of Nephrology**

#### **Bruce A. Molitoris**

#### Adult Measures

Measure 2771: Percentage of adult ( $\geq 18$  years old) hemodialysis and peritoneal dialysis patients whose ESA dose is unchanged or increased when the hemoglobin value reaches or exceeds 11.0 g/dL. ASN concurs with MAP's recommendation not to support measure 2771 at this time. A performance measure that requires a change in ESA dose based on a single laboratory value does not accurately reflect the care provided and does not consider patient-specific circumstances. ASN suggests that a more well-designed measure would examine the averages of data over the course of several months and allow for individualization of patient care. Furthermore, insufficient evidence exists to expect a reduction in ESA dose for every patient whose hemoglobin level exceeds 11.0 g/dL. Clinical trials indicated an increased risk for adverse events when the ESA was dosed to achieve target levels of 13.0 g/dL or higher.

Measure 2772: Percent of adult ( $\geq 18$  years old) hemodialysis and peritoneal dialysis patient months at a facility during the year for which a patient had

a low achieved hemoglobin (<10 g/dL or missing), a low ESA dose (<75 units/kg/session of epoetin alpha, <0.2 mcg/kg/session of darbepoetin alpha, or missing), and was followed in the subsequent month by a red blood cell (RBC) transfusion. Exclusions: Receiving dialysis < 90 days, had < 6 sessions reported during the month, etc. ASN concurs with MAP's recommendation not to support measure 2772. Currently, there is a lack of high-quality scientific evidence to support this measure and there is no scientific basis that a "low" ESA dose is the only determinant of need for transfusion, as the measure implies as written. Acute interceding illnesses, such as gastrointestinal bleeding and surgical procedures, can result in abrupt decreases in hemoglobin that may require blood transfusions unrelated to the quality of care provided in dialysis facilities. Furthermore, because the measure as written examines transfusions in the month after a low hemoglobin count or ESA dose, patients who receive a transfusion before the start of the next month (i.e. in the month that the low hemoglobin level is obtained) would not be identified by this measure as written. It is also important to recognize that nephrologists and dialysis providers have little control over most transfusions—a majority of transfusions are ordered by emergency room physicians, hospitalists, and other providers in in-patient settings. It is unclear whether this measure could be implemented in a way that distinguishes which provider type ordered the transfusions, risking unfairly penalizing dialysis units. Lastly, the meaning and implication of a "missing" hemoglobin or ESA dose is unclear.

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### American Society of Nephrology

#### Bruce A. Molitoris

Measure 1454: Proportion of patients with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL.

ASN does not agree with MAP's recommendation to support Measure 1454. The only evidence that high serum calcium is associated with death risk is based on observational studies. Furthermore, what defines high serum calcium—and should be benchmarked—is not consistent across studies that have shown an association with death risk. There is little or no scientific basis of selecting a serum calcium

concentration above 10.2 mg/dL as indicative of poor patient care or predictive of poor patient outcomes. It is also not clear that there is a performance gap in this area. Implementing Measure 1454 also creates the potential for 'cherry-picking' patients who are not likely to trigger this measure, jeopardizing access to care for certain patients without providing any clear overall population benefit.

Measure O255: Percentage of adult (>= 18 years old) hemodialysis and peritoneal dialysis patients with serum phosphorus measured at least once within the month. ASN does not agree with MAP's recommendation to support Measure O225. Measure O225 is a purely process-based measure, and it is not clear that there is a significant performance gap in this area. Therefore, it is unlikely that this measure would make a meaningful difference in patient outcomes and likely that it will add to the administrative burden and cost for dialysis facilities.

Measure 2059: Percentage of adult (>= 18 years old) hemodialysis and peritoneal dialysis patients with serum calcium measured at least once within the month. ASN agrees with MAP's conclusion not to recommend this measure. Like Measures 1454 and O255, there is a lack of evidence of a performance gap in care; this measure is, as with others, a process measure only that is unlikely to significantly improve care.

Measure 2775: This measure reports the percentage of adult hemodialysis and peritoneal dialysis patient-months in the following ranges of serum phosphorus: <3.5 mg/dL; 3.5-4.5 mg/dL; 4.6-5.5 mg/dL; 5.6-7.0 mg/dL; >7.0 mg/dL (The normal range for serum phosphorus is 2.5-4.1 mg/dL).

ASN agrees with MAP's recommendation not to support Measure 2775. The sole purpose of this measure appears to be to gather descriptive data on the distribution of serum phosphorus in dialysis facilities. The serum phosphorus ranges identified in the measure description are arbitrary and not based on any strong available scientific evidence: Variation exists in the available literature regarding the thresholds above which risk of mortality is elevated. Furthermore, there is no evidence from clinical trials that reducing elevated serum phosphorus levels has a tangible effect on any patient outcome.

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## American Society of Nephrology

### Bruce A. Molitoris

Measure 1438: Proportion of patients who have documentation of receiving a new post-dialysis weight prescription from a nephrologist in the reporting month.

ASN does not agree with MAP's recommendation to support Measure 1438. Although monitoring fluid balance is important, there is no evidence that simply reporting the post dialysis (dry) weight was documented is associated with and leads to improved outcomes for patients. Documenting patients' post-dialysis (dry) weights could easily be re-prescribed monthly—even automatically via an electronic health record program—to comply with the metric without truly assessing the best fluid balance for the patient. Finally, ASN questions whether the measure description is correct: it appears the denominator includes all patients on dialysis instead of patients on dialysis during the specific month of the study.

Measure 1463: Risk-adjusted standardized hospitalization ratio for admissions for dialysis facility patients.

ASN agrees with MAP that this measure concept is promising but requires modification or further development before implementation is considered. Specifically, ASN is concerned about the limitations of risk adjustment for this measure. Centers for Medicare and Medicaid Services (CMS) Form 2728 is completed at the time of dialysis initiation, and hence cannot accurately reflect patient comorbidities at the time of a hospitalization that occurs remote in time from when the form was completed. There are also significant concerns about the accuracy of the 2728 form even at the time of dialysis initiation. Until such time as there is a mechanism in place to use claims data or other means of concurrent assessment of comorbidities and hence risk of hospitalization, ASN does not support use of Measure 1463. ASN is also concerned that this measure could lead to cherry-picking of healthier patients or patients with primary care physicians over patients without one, or patients with other less desirable characteristics such as a history of gastrointestinal bleeding or malignancy.

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## American Society of Nephrology

### Bruce A. Molitoris

Measure 2132: Ratio of the number of index hospital discharges that resulted in a readmission within 30 days of discharge for Medicare-covered dialysis patients treated at a particular dialysis facility to the number of readmissions that would be expected given the discharging hospitals and the characteristics of the patients.

ASN supports the concept of Measure 2132 but has several concerns about the measure as proposed, detailed below. However, given that more than 30 percent of dialysis patients are readmitted within 30 days, ASN acknowledges that a well-designed hospital readmission metric has substantial merit.

- The CMS Technical Expert Panel convened to develop the proposed measure has not supported it.
- In order for a readmission to be attributable to a dialysis facility, there needs to have been an opportunity for the dialysis facility to affect care; for instance, if the patient comes to the dialysis facility one day after hospital discharge and requires readmission, this should not affect the dialysis facility as there was no opportunity for the facility to intervene.
- The modeling in the two-stage model may introduce biases, a concern that would need to be better explored before implementing this measure. For example, it is unclear how the model would perform in communities where there is only one major hospital and/or one major dialysis facility versus those where there are many of one or both.
- The list of adjusters may be too extensive, such that the potentially modifiable patient conditions that can be addressed to reduce readmissions may contribute too much.
- The potential for a single patient to count a maximum of 12 times in the denominator may be weighing an individual patient too much, potentially marginalizing access to care for high risk patients.
- Body Mass Index (BMI) information on CMS Form 2728 should not be used. Given the heterogeneity of weight (wasting and anorexia, edema, etc.) at the time of dialysis initiation, interpretation is difficult. And similar to the Standardized Hospitalization

Ratio for Admissions, there is no face validity to the concept that baseline BMI based on Form 2728 is relevant to a readmission several years later, even if statistically significant.

- The adjuster for functional disability and quadriplegia are lumped together, although they are not comparable clinical characteristics.
- The metric needs to specify the definition of “acute care hospitals.”

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### American Society of Nephrology

#### Bruce A. Molitoris

· The term “Planned Admissions” needs to be tailored to the dialysis population. For a dialysis measure, vascular access or peritoneal access placement/creation are typically planned and should be counted as such. In reviewing the Methodology from CMS’s Hospital-Wide Readmission Measure (May 2012 Report) that resulted in the definition of “planned” used in this metric, there was very little internal medicine input and no apparent nephrology input. There is a mention in this document that “fluid and electrolyte disorders” disqualify an admission from being planned, and this could be problematic for dialysis patients as this is a common code that is used. Another code that can be misused is “acute and unspecified renal failure,” while a code that may affect vascular access creation is 237—complication of device, implant or graft (e.g., a graft clotted and a patient therefore has a new graft or fistula created). Additional review is needed to make sure that these general medicine measures can be accurately applied to the dialysis population. · In the presentation of draft data from 2009, there are some facilities that are marked outliers. Before any codification of a metric, these positive and negative outliers need to be examined as they may provide clues to measure validity and potential fixes.

Measure O369: Risk-adjusted standardized mortality ratio for dialysis facility patients. MAP supports use of Measure O369; ASN also supports the concept of Measure O369 but is concerned about the data the measure uses for risk adjustment, which is unspecified. As detailed above, data on CMS Form 2728 are not a true reflection of a patient’s co-morbid conditions at the time of death and inappropriate

for use as a risk adjuster. Dialysis providers would be penalized for highly complex patients with multiple significant co-morbid diseases. Similar to Measure 1463, basing risk adjustment on the 2728 form could potentially lead to cherry-picking of healthier patients or patients with primary care physicians over patients without one, or patients with other less desirable characteristics. Moreover, the proposed measure does not address, and may even penalize dialysis providers who include robust advanced care planning, palliative care, and/or hospice services to improve end-of-life care for patients. A measure like O369 would be helpful if it used data from sources other than CMS Form 2728 that is more precise for risk adjustment.

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### American Society of Nephrology

#### Bruce A. Molitoris

Measure O258: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) In-Center Hemodialysis Survey. The proportion of patients answering each of response options for each of the items summed across the items within a composite to yield the composite measure score. ASN concurs with MAP’s support for Measure O258. The CAHPS measures many useful components of a patient’s experience in the in-center dialysis unit. ASN is not certain that the description of the numerator and denominator was clearly delineated in the MAP document, but the society supports the CAHPS survey.

Measure 1460: Number of hemodialysis outpatients with positive blood cultures per 100 hemodialysis patient-months. ASN agrees with MAP’s recommendation to support Measure 1460, provided that it is limited to patients with central venous catheters and includes patients in home hemodialysis programs. Moreover, the society is concerned that the measure not unfairly penalize small units. ASN also recommends excluding samples that may turn out to be “contaminants” such as organisms commonly associated with skin flora that are not true bacteremia. Measure 2769: Risk adjusted facility level transfusion rate “STrR” for dialysis patients. ASN agrees with MAP’s recommendation not to support this measure, and concurs that the concept would require considerable modification or further



development. In particular, ASN is concerned that gaps in information and testing exist. For instance, there are difficulties involved with tracking and reporting transfusions given in an in-patient hospital versus an emergency room outpatient setting. Moreover, there is no way of telling how many transfusions were administered the way they are currently coded. Transfusions are coded to indicate if they were given on any single day, not the number of transfusions given. Thus, by this metric, a patient who receives two transfusions in one day provides half the transfusion events compared with a similar patient who receives two transfusions on two separate days. ASN is also concerned that the “expected” threshold for transfusion may vary from place-to-place or provider-to-provider and is often influenced by acute medical or surgical issues unrelated to the quality of care delivered in dialysis facilities.

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## American Society of Nephrology

### Bruce A. Molitoris

Measure 2769: Risk adjusted facility level transfusion rate “STrR” for dialysis patients.

ASN agrees with MAP’s recommendation not to support this measure, and concurs that the concept would require considerable modification or further development. In particular, ASN is concerned that gaps in information and testing exist. For instance, there are difficulties involved with tracking and reporting transfusions given in an in-patient hospital versus an emergency room outpatient setting. Moreover, there is no way of telling how many transfusions were administered the way they are currently coded. Transfusions are coded to indicate if they were given on any single day, not the number of transfusions given. Thus, by this metric, a patient who receives two transfusions in one day provides half the transfusion events compared with a similar patient who receives two transfusions on two separate days. ASN is also concerned that the “expected” threshold for transfusion may vary from place-to-place or provider-to-provider and is often influenced by acute medical or surgical issues unrelated to the quality of care delivered in dialysis facilities.

Measure 2774: Percentage of eligible patients for whom the facility has evaluated risks, benefits, and alternative treatment options for anemia and the

patient participated in a decision regarding anemia treatment strategy.

ASN concurs with MAP not to recommend use of Measure 2774 at this time. While involving patients in their care is critical to best clinical outcomes, it is not clear how Measure 2774 would work in practice. There are no defined, standardized expectations for explaining risks and benefits of transfusions and treatment options, so it is not clear that a measure like this would result in meaningful patient outcomes.

Measure O226: Percentage of end-stage renal disease patients aged 6 months and older receiving hemodialysis or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31 who either received, were offered and declined, or were determined to have a medical contraindication to the influenza vaccination.

ASN agrees with MAP’s support for the concept of Measure O226. Influenza illness contributes to more than 36,000 deaths annually, indicating that it has a significant public health impact.

However, few randomized controlled trials have been performed in high-risk populations, and it is widely known that the efficacy of the influenza vaccine is blunted in dialysis patients due to an attenuated humoral immunity response. Despite the lack of significant high-quality evidence as to the utility of a dedicated influenza vaccination program in decreasing the risk for hospitalizations and morbidity/mortality from influenza, this initiative seems reasonable when considering that it is generally safe, seems to be a low-risk intervention, and may be cost-effective. If implemented, tracking patients who received the vaccine at another facility (i.e., a hospital or primary care clinic) would have to be addressed in a manner that does not unduly burden dialysis providers to accurately record when and where this vaccine was given. One of the most important factors in preventing outbreaks of influenza is the vaccination of all dialysis facility occupants—physicians, nurses, dialysis techs, social workers, etc. ASN recommends including dialysis facility staff as well as patients in this measure.

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## American Society of Nephrology

### Bruce A. Molitoris

Measure 1653: Inpatients 65 years and older and 6-64 years of age who have a high-risk condition who are screened for 23-valent Pneumococcal Polysaccharide Vaccine (PPV23) status and vaccinated prior to discharge if indicated.

ASN agrees with MAP's recommendation not to support this measure at this time. Neither the dialysis facility nor the outpatient treating nephrologist typically have control over vaccination or other care provided during a hospitalization.

Measure O251: Percentage of end-stage renal disease patients aged 18 years and older receiving hemodialysis during the 12-month reporting period and on dialysis >90 days who: (1) have a functional autologous AVF (defined as two needles used or a single needle device [NOT one needle used in a two-needle device]) (computed and reported separately); (2) have a functional AV graft (computed and reported separately); or (3) have a catheter but have been seen/evaluated by a vascular surgeon, other surgeon qualified in the area of vascular access, or interventional nephrologist trained in the primary placement of vascular access for a functional autogenous AVF or AV graft at least once during the 12-month reporting period (computed and reported separately).

MAP supports this measure, and ASN supports the concept of this measure but suggests a few modifications that should be addressed prior to implementation. ASN recommends that patients with limited lifespan, who are on hospice care, or are expected to receive an imminent transplant should be excluded. ASN also recommends that the requirement for annual evaluation by a vascular surgeon or interventional nephrologist be eliminated as this creates an undue burden on patients and physicians, increases unnecessary costs of care, and would not necessarily lead to improved outcomes.

Additionally, nephrologists should be able to certify that certain patients are not appropriate candidates for a fistula (such as patients near the end of life who are not in hospice) and those patients should be exempted from the measure. ASN also believes that the requirement should only be for referral for

AV access evaluation; whether a referred patient is actually seen for evaluation is largely under the control of the patient, not the dialysis facility. Lastly, ASN recommends tracking the total number of patients who are deemed 'catheter dependent' to monitor for unusually high (e.g. 30 percent) 'catheter dependent' rates.

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## American Society of Nephrology

### Bruce A. Molitoris

#### Pediatric Measures

ASN believes the Quality Improvement Program structure is not adequate at this time to include pediatric metrics due to the low number of patients insured by Medicare in most pediatric facilities. However, the society supports efforts to develop pediatric-specific measures, in addition to measures that apply to both pediatric and adult ESRD patients, in an effort to provide improved care and create greater transparency for pediatric patients and their families.

Measure 1418: Percentage of all pediatric (less than 18 years old) patients receiving in-center hemodialysis (irrespective of frequency of dialysis) with documented monthly adequacy measurements (spKt/V) or its components in the calendar month. ASN believes it is reasonable to ask that pediatric patients have dialysis dose assessed and consequently agrees with MAP's support for the concept of this measure. However, the society recommends adding that, as for adult patients, pediatric patients should have a minimum dose of dialysis as determined by achieving a spKt/V of >1.2.

Measure 1424: Percentage of all pediatric (less than 18 years old) hemodialysis and peritoneal dialysis patients who have monthly measures for hemoglobin. ASN concurs with MAP's support for this measure if evidence suggests there is a performance gap that necessitates it.

Measure 1425: Percentage of pediatric (less than 18 years old) in-center hemodialysis patients (irrespective of frequency of dialysis) with documented monthly nPCR measurements. ASN concurs with MAP's support for the concept of this measure but recommends adding a target nPCR. Information on pediatric hemodialysis

patient nutritional status supports the use of nPCR to monitor nutritional status in these patients. Assessment of nutrition status is an essential component of hemodialysis adequacy measurement. nPCR should be measured monthly by using either formal urea kinetic modeling or algebraic approximation.

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### **American Society of Nephrology**

#### **Bruce A. Molitoris**

Measure 1433: Percentage of all pediatric (less than 18 years old) hemodialysis and peritoneal dialysis patients with hemoglobin less than 11.0 g/dL and in whom simultaneous values of serum ferritin concentration were less than 100 ng/mL and transferrin saturation (TSAT) was less than 20 percent who received IV iron or were prescribed oral iron within the following 3 months.

ASN agrees with MAP's support for the concept of this measure provided that it is limited to pediatric patients receiving ESA therapy. As written, the measure suggests that a hemoglobin count less than 11.0 g/dL in the presence of low TSAT and serum ferritin concentration must be treated. Insufficient evidence exists to support such a recommendation. However, the evidence for treating patients with low iron parameters is stronger for patients also treated with ESAs.

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### **American Society of Nephrology**

#### **Bruce A. Molitoris**

##### **Additional Comments**

ASN appreciates the opportunity to comment on the NQF MAP Pre-Rulemaking Input Report. Unfortunately, the NQF comment submission website limits public commenters to providing no more than 3,000 characters in each of the nine comment sections for the 209-page draft report. The draft report reviews 478 potential quality measures that, if implemented by CMS or other payers, will have a powerful influence on the care patients receive. This comment letter on just 21 of those measures is nine pages long and exceeds 20,000 characters. Patients deserve thoughtful, nuanced consideration of the scientific evidence supporting potential quality measures—and of the measures'

potential intended and unintended consequences. Developing high-quality performance measures is an extremely difficult process that demands meticulous deliberation of the possible risks and benefits. In future years, ASN recommends that NQF eliminate restrictions on the number of characters public commenters may use on the comment submission website so stakeholders may provide more detailed, meaningful feedback.

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### **America's Health Insurance Plans**

#### **Carmella Bocchino**

We are supportive of the need for strong care transition measures; however, additional work needs to be performed in this area to identify measures that best address the issue of care transitions in post-acute and long term care settings.

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### **AmeriHealth Mercy Family of Companies**

#### **Thomas James**

AmeriHealth Mercy Family of Companies agree that there is a need for a strong care transition measure. Currently there is no consensus on those transition of care measures. We encourage the MAP and NQF to work with measure developers and measure users on strong transition of care metrics.

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### **AMGEN Inc.**

#### **Sharon Isonaka**

Amgen appreciates and supports the efforts to identify new anemia quality measures for consideration of inclusion in the Medicare End Stage Renal Disease (ESRD) Quality Incentive Program (QIP), and we understand the Measure Application Partnership's (MAP) recommendation to "Support Direction" of these measures because we agree that they are not ready for implementation. Currently, the QIP lacks quality measures to protect patients from negative outcomes associated with the under-treatment of anemia, including the consequences associated with increased red blood cell transfusions. Avoiding the need for transfusions is a widely recognized treatment goal in this vulnerable population. Accordingly, the ESRD QIP is statutorily required to include "measures on anemia management that reflect the labeling approved by

the [FDA] for such management and measures on dialysis adequacy.” However, as the manufacturer of EPOGEN® (epoetin alfa) - an available anemia therapy - we are concerned that these measures either lack evidence to support their use or do not meet statutory requirements as written. We have specific comments regarding Measures 2771 and 2772. Measure 2771 references the EPOGEN product labeling in the measure description, yet does not adequately reflect the labeling as indicated, which is inconsistent with the requirement under the QIP statute that measures reflect FDA-approved labeling. The dosage and Administration section of the EPOGEN USPI indicates within section 2.2 (Patients with Chronic Kidney Disease) that: “If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Epogen.” Importantly, Section 2.2 also states that “When adjusting therapy consider hemoglobin rate of rise, rate of decline, ESA responsiveness and hemoglobin variability. A single hemoglobin excursion may not require a dosing change.” The proposed measure 2771, as written, would require an action in response to a single hemoglobin  $\geq 11$  g/dL. This is inconsistent with the plain language of the label which directs physicians to adjust hemoglobin levels as appropriate based on a number of factors and advises that a single hemoglobin value may not require a dosing change. For Measure 2772, we support the measure’s low hemoglobin threshold since evidence consistently shows that hemoglobin less than 10 g/dL is strongly associated with the risk of transfusion. Yet, there is no evidence to support the specific dose or dosing strategy that is specified in the measure description. The EPOGEN USPI recommends dosing based on individual patient response and need.

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### Association of Rehabilitation Nurses

#### Terrie Black

The Association of Rehabilitation Nurses appreciates the opportunity to comment on the Pre-Rule Making Report for Post-Acute and Long-term Care Performance Measurement Programs. We concur with the MAP’s intention and desire to align measure across the post-acute care continuum when possible.

However, the recommendation to include indicators on influenza and pneumococcal vaccinations is not supported by our association. The purpose of

rehabilitation is to promote functional recovery and achievement of goals by patients so that they may function to their maximal potential in the least restrictive environment. The vaccination indicators do not represent the quality or outcomes of rehabilitation programs. Furthermore, there are numerous opportunities for patients to receive immunizations in other healthcare settings prior to admission to rehabilitation.

We do support the MAP’s decision not to include CLABSI measure as that is a rare occurrence in rehabilitation.

The IRF Quality Reporting System could be greatly enhanced by further developing and expanding core measures such as mobility and self-care. We do support these indicators with the caveat that they are risk-adjusted and diagnosis/impairment group specific with definitive inclusion/exclusion criteria.

While we concur with the MAP’s intention to align measures whenever possible, we do not support measures that are not clinically relevant or representative for a given setting or patient population - measures must be meaningful in order to be useful. We further advocate that whatever measures are selected, that the collection (and reporting) of such measures does not present an undue burden on the organizations or facilities implementing them.

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### California Hospital Association

#### Alyssa Keefe

Immunization Measures: CHA agrees with the comments made by several groups regarding the inclusion of patient immunization measures in the inpatient rehabilitation setting. As noted in our comments to CMS when these measures were proposed prior to implementation, we believe that there are significant opportunities for over vaccination as the vast majority of patients are transferred from the inpatient setting where vaccination is also a measurement reporting requirement. We believe strongly that resources scarce should be dedicated to measures that are appropriate to the settings and that duplicative measures that divert resources from important areas of performance improvement should be removed.

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### **Center to Advance Palliative Care**

#### **Emily Warner**

The Center to Advance Palliative Care notes that there are currently NO measures for hospital performance touching on palliative care domains for seriously ill patients. As noted in our comments related to measure gaps, HCAHPS systematically misses the experience of patients with serious illness or at end of life and a supplementary module to HCAHPS is needed.

We note that American Society of Clinical Oncology is currently conducting a project to develop new measures for PPS-exempt Cancer Hospitals. Many of the measures to be developed fit palliative care domains. With additional testing and modification, these new measures may form the basis for a palliative care measure set for acute hospitals. We urge MAP to make development of a palliative care measure family applicable across settings the highest priority.

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### **Center to Advance Palliative Care**

#### **Diane Meier**

The Center to Advance Palliative Care supports all of the hospice measures with the expectation that this measure set will continue to be refined and modified as experience is gained with the measures.

We note the dearth of measures addressing palliative care needs of patients in long term care settings other than hospice. We urge development of palliative care measures for rehabilitation and long term care settings.

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### **Federation of American Hospitals**

#### **Samantha Burch**

The FAH is disappointed in the recommendation for inclusion of the C. difficile measure in the IRF program. While this is a serious issue and should be measured in a number of other settings, it is in low incidence in the IRF setting. Resources would be better spent on issues related to patient safety directly associated with the types of services provided in the IRF.

Post-acute providers, particularly those with short-stay patients, should not be considered an

appropriate setting to report patient immunization measures. Given the short duration of patients' stay, their earlier access to immunization from multiple settings, and difficulty obtaining accurate and timely immunization history, the benefit to burden ratio would be quite low.

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### **Federation of American Hospitals**

#### **Samantha Burch**

The Inpatient Rehabilitation Facility (IRF) and Long-term Acute Care Hospital (LTCH) quality reporting programs would be greatly enhanced by reporting on measures that are directly related to the care provided in those settings. The FAH supports MAP's recommendation that alignment must be balanced with consideration for the heterogeneity of the patient needs across settings. We continue to urge MAP to select measures for these varied post-acute settings that will yield more meaningful clinical improvement in each respective setting.

For instance, in the IRF setting implementation of measures more focused on a patient's ability to ambulate and perform activities of daily living would be appropriate. The purpose of medical rehabilitation providers is restoring or improving patients' functional deficits and impairments so they can resume productive lives in their homes and communities. We encourage MAP to recommend that tools currently in use, such as the UDS FIM®, be evaluated and that discussions take place to see if it could be brought through the endorsement process at NQF.

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### **HealthSouth Corporation**

#### **Dexanne Clohan**

HealthSouth appreciates the desire to align performance measurement across PAC/LTC settings but we agree with the MAP's conclusion that alignment must be balanced with consideration for the heterogeneity of patient needs across settings. We urge MAP to make recommendations to avoid an overly burdensome administrative process by selecting measures that will yield more meaningful clinical improvement in each respective setting. We agree that the two measures in the current program, CAUTIs and pressure ulcers, are limited and do not

reflect the central purpose of medical rehabilitation providers—restoring or improving patients’ functional deficits and impairments so they can resume productive lives in their homes and communities. We agree that the IRF Quality Reporting Program could be greatly enhanced by addressing IRF-specific core measure concepts and safety issues. The most fundamental core measure for IRFs should pertain to patients’ functional improvement and discharge to the community. While MAP cites functional measures are “still in development,” the UDSMR FIM® tool has been used industry wide for over two decades and is already reported to CMS. The FIM® tool is available to CMS free of charge and has been offered to NQF for perpetual use, royalty free. Modifying this core measure already in standard use by IRFs for functional improvement would create a significant burden for training and documentation. Also, we agree with the MAP’s lack of support for the proposed CLABSI measure due to its low incidence in IRFs. We propose that MRSA and *C. difficile* measures should not be supported due to similarly low incidence of <2% among rehabilitation patients. While clinically important, the low frequency of these infections would create unnecessary administrative costs without meaningful or effective quality improvement. Additionally, establishing these infections as quality measures has the potential to impose additional costs without necessarily improving patient health status and also has the potential for patient harm. For example, the presence of MRSA does not definitely indicate an infection over basic colonization. Utilizing MRSA for a quality measure would increase the costs related to unnecessary diagnostic measures, increase the misdiagnosis of MRSA infections and the use of unnecessary antibiotics – most unfortunately, high-powered drugs that would further contribute to the antibiotic resistance of MRSA infections. Lastly, post-acute providers, particularly those with short-stay patients, should not be considered an appropriate setting to report patient immunization measures. Given the short duration of patients’ stay, their earlier access to immunization from multiple settings, and difficulty obtaining accurate and timely immunization history, the benefit to burden ratio would be quite low.

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## Kidney Care Partners

### Linda DeRuvo-Keegan

Kidney Care Partners (KCP), a coalition of members of the kidney care community that includes the full spectrum of stakeholders related to dialysis care—patient advocates, health care professionals, dialysis providers, researchers, and manufacturers and suppliers—organized to advance policies to improve the quality of care for individuals with both chronic kidney and end-stage renal disease (ESRD) appreciates the opportunity to comment on the Measure Applications Partnership (MAP) Pre-Rulemaking Public Comment Draft Report. We commend the National Quality Forum (NQF) for convening MAP to undertake the important work of reviewing and providing input on measures under consideration for federal programs in calendar year 2013.

This letter serves to express KCP’s concerns regarding the evidence pertaining to a recommendation in the draft report that pertains to the measure Influenza Immunization in the ESRD Population (MUC 198/NQF 0226), developed by the Kidney Care Quality Alliance (KCQA). The report notes: (1) the measure may not address a high-leverage opportunity; and (2) while the MAP supports the direction of the measure and agrees that the concept is promising, it believes that the measure is “not ready for implementation” and requires “modification or further development”. We believe these two assertions are, at their core, erroneous and baseless. And while we have significant concerns about both, we are troubled by the second in particular.

#### Evidence the Measure Addresses a High-leverage Opportunity

The assertion that the measure may not address a high-leverage opportunity stemmed from the suggestion by a Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup member that recent evidence indicates that the influenza vaccine might have a smaller effect on morbidity and mortality, generally, than previously thought, and that support of this measure will divert measurement resources from other aspects of care where there may be a more categorical link to improved outcomes. In fact, the commenter did not acknowledge, or was not aware

of, data supporting the importance of vaccinating against influenza in this extremely vulnerable population:

1. Infectious disease is the second leading cause of death among ESRD patients, and pulmonary infectious mortality is ten-fold higher in the ESRD than in the general population.<sup>1,2</sup>

2. Influenza vaccination of ESRD patients is highly effective. Influenza immunization has been shown to decrease the risk of all-cause, infectious, and cardiac-related mortality, as well as the risk of all-cause and infectious-related hospitalization in both hemodialysis and peritoneal dialysis patient.<sup>1,3,4,5</sup>

Despite these data, including longstanding clinical guidelines directing care providers to immunize this high-risk population,<sup>6,7</sup> only 65 percent of all ESRD patients received the influenza vaccine in 2010, falling short of the 90 percent goal established for Healthy People (HP) 2010 and HP 2020<sup>8,9,10</sup>. Clearly, this is a high-leverage opportunity for quality improvement. We further note that an influenza immunization measure dedicated specifically to the ESRD population is of vital importance, given the special health care needs of these patients (e.g., only inactivated influenza virus should be used in this population) and the fact that the majority of ESRD patients receive the bulk of their routine medical care within dialysis facilities. Specification of measures for performance assessment at the dialysis facility level utilizes this unique arrangement as a means to accurately and effectively assess the quality of care provided to ESRD patients.

<sup>1</sup> Gilbertson D, Unruh M, McBean A, Kausz A, Snyder J, Collins A. Influenza vaccine delivery and effectiveness in end-stage renal disease. *Kidney Int.* 2003;63(2):738-43.

<sup>2</sup> Sarnak M and Jaber B. Pulmonary infectious mortality among patients with end-stage renal disease. *Chest.* 2001;120:1883- 1887.

<sup>3</sup> Nichol K, Baken L, Nelson A. Relation between influenza vaccination and outpatient visits, hospitalization, and mortality in elderly persons with chronic lung disease. *Ann Intern Med.* 1999;130:397-403.

<sup>4</sup> Nichol K, Margolis K, Wuorenma J, et al. The

efficacy and cost effectiveness of vaccination against influenza among elderly persons living in the community. *NEJM.* 1994;331:778-84.

<sup>5</sup> Nichol K, Wuorenma J, Von Sternberg T. Benefits of influenza vaccination for low-, intermediate-, and high-risk senior citizens. *Arch Intern Med.* 1998;158:1769-76.

<sup>6</sup> Recommendations of the Advisory Committee on Immunization Practices (ACIP). Centers for Disease Control and Prevention. MMWR Recomm Rep. 2010;59(rr08):1-62.

<sup>7</sup> American Academy of Pediatrics Committee on Infectious Diseases. Policy statement: recommendations for prevention and control of influenza in children, 2010-2011. *Pediatrics.* 2010;126(4):816-26.

<sup>8</sup> U.S. Department of Health and Human Services: Healthy People 2010 (2nd ed). Washington, DC, U.S. Government Printing Office, 2000.

<sup>9</sup> U.S. Department of Health and Human Services: Healthy People 2020. Washington, DC, U.S. Government Printing Office, 2010.

<sup>10</sup> U.S. Renal Dialysis System, USRDS 2012 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States. 2012.

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## Kidney Care Partners

### Linda DeRuvo-Keegan

Regarding the MAP's assertion that the measure is not ready for implementation and/or requires modification or further development, the facts simply do not support MAP's rationale:

1. MUC 198/NQF 0226: Influenza Immunization in the ESRD Population has been endorsed by NQF and deemed suitable, as currently specified, for accountability. The MAP's rationale is thus at odds with the conclusions drawn by NQF's own rigorous and thorough Consensus Development Process. The measure was field tested in a nationally representative sample of more than 50 dialysis facilities; we hazard an educated guess such testing was as rigorous as any measure in NQF's portfolio and more rigorous than most. Does MAP intend to cast doubt on the validity and authority of this process?

2. The measure is completely harmonized and aligned with the NQF Influenza Immunization Standard Measure Specifications published in NQF's 2008 National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations Report. The measure is consistent with the current clinical guidelines released by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices and the American Academy of Pediatrics, as well as with the HP 2020 goal to immunize 90% or greater of high risk individuals against the flu. We are completely puzzled and astonished by the recommendation for further development and modification of the measure.

Moreover, we are concerned that the disparity between MAP's rationale compared to NQF's Steering Committees, NQF Members, the Consensus Standards Approval Committee, and NQF's Board is a source of considerable confusion for health care stakeholders; it suggests a lack of clear goals in this most looks to NQF and the bodies it convenes for standardization and consistency.

KCP believes that the ESRD influenza immunization measure is important and that the scientific evidence demonstrates it improves health care and health outcomes in the United States. We also encourage MAP, as we do CMS, to work with the kidney care community to recommend measures based on a strategic blueprint and that that are tailored to meet the clinical goals and operational issues facing dialysis beneficiaries and those who provide them with life-sustaining care.

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### **National Coalition for Hospice and Palliative Care**

#### **Timothy Quill**

The National Coalition for Hospice and Palliative Care supports all of the hospice measures with the expectation that this measure set will continue to be refined and modified as experience is gained with the measures.

We note the dearth of measures addressing palliative care needs of patients in long term care settings other than hospice. We urge development of palliative care measures for rehabilitation and long term care settings. We also note that OASIS in home health needs further refinement to better include

palliative care domains, when those are consonant with patient goals.

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### **Outpatient Ophthalmic Surgery Society; Am Soc of Cataract and Refractive Surgery**

#### **Michael Romansky**

Comment on NQF #0584: Complications from Cataract Surgery

ASCRS and OOSS strongly oppose the adoption of NQF 0584: Cataracts - Complications Within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures as an ASC-level quality measure. This measure, developed by the American Academy of Ophthalmology and the Physician Consortium for Performance Improvement as a physician-level measure to identify complications attributable to the surgeon that embody the potential to lead to vision loss and diminished patient function. Such complications might include intraocular lens (IOL) placement errors, retinal detachment, retained nuclear fragments, wound dehiscence, and others that are within the control of the operating surgeon. These complications would rarely, if ever, be associated with improper care provided by the ASC. Moreover, for the reasons elucidated in our General Comment on MAP's Process for Selection of Measures, the facility would not be in a position to efficiently collect and report the data, as it would be located in the medical records of the surgeon. (And, even if the facility could comply, the exercise would be entirely redundant since the information would already have been collected and reported by the surgeon through the PQRS.)

Our organizations also believe that it would be premature for the MAP to "support" this measure. NQF 0584 is specified for registry-based reporting only. In order to submit data for these measures, providers must enroll in the Outcome PQRS Registry; ASC providers are not able to so participate in this Registry because they lack the data to present and are ineligible for PQRS incentives. Until CMS finalizes a registry-based reporting option under the ASC Quality Reporting Program and approves one or more specific registries, ASCs would be unable to use these measures as currently formatted to meet reporting requirements. This measure is not consistent with MAP criteria and would be



inappropriate for immediate inclusion in the quality reporting measure set.

Our organizations look forward to collaborating with CMS, the ASCQC and others in developing appropriate ophthalmic ASC-level measures.

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## Uniform Data System for Medical Rehabilitation

### Elizabeth Demakos

Uniform Data System for Medical Rehabilitation (UDSmr) welcomes this opportunity to comment on the Measures Application Partnership (MAP) Pre-Rulemaking Report: Public Comment Draft released in January 2013. UDSmr is the world's largest government independent repository of rehabilitation outcomes and IRF-PAI data, drawn from more than 850 acute units and freestanding rehabilitation hospitals. Because of our longstanding leadership position in the rehabilitation industry, we have been recognized as objective evaluators of the data used to measure the outcomes and quality of inpatient rehabilitation.

The need for process measures is widely recognized, but the use of meaningful, tested outcomes measures is equally important. The FIM® instrument is currently being used in comprehensive inpatient, sub-acute, long-term care, and home care programs that provide rehabilitation services. The instrument has 18 items (13 motor, 5 cognitive). Motor items are further classified into areas of self-care, sphincter control, transfers, and locomotion; cognitive items are further divided into communication and social cognition subscales. Each item is rated on a seven-level ordinal scale, with 7 representing Complete Independence and 1 indicating Total Assistance. The assigned rating measures an individual's function and reflects the amount of assistance required from

another caregiver for the individual to complete daily activities, commonly referred to as the patient's burden of care. The instrument is routinely administered to the patient upon admission to inpatient rehabilitation and again at discharge. As a result, the tool can measure the patient's progress throughout therapy by calculating the rating gain from admission to discharge. This indicator is certainly a functional outcome measure, and it can be used to assess the quality of services provided at the facility in terms of aggregate gains by patient population. The combination of the length of the rehabilitation stay and the FIM® gain allows efficiency outcomes to be assessed at the patient level and the facility level. For over 25 years, the FIM® instrument has been used by thousands of facilities and tens of thousands of clinicians to perform millions of assessments. Its reliability (including inter- and intra-rater, internal consistency) and validity (content, construct, predictive, criterion-referenced) has been proven and referenced in hundreds of peer-reviewed publications. (See linked bibliography.)

We strongly and respectfully suggest the MAP committee consider the FIM® instrument because its items satisfy MAP's need for each of the following measures: Functional Outcome Measure: Change in Mobility: Locomotion: Walk, Wheelchair; Stairs; Transfers: Bed, Chair, Wheelchair; Transfers: Toilet; and Transfers: Tub, Shower Functional Outcome Measure: Change in Self-care: Eating, Grooming, Bathing, Dressing – Upper Body, Dressing – Lower Body, and Toileting Functional Change: Change in Motor Score: All 13 motor items (the 11 above, plus Bladder Management and Bowel Management) These measures are currently being used royalty-free by IRFs as part of the CMS IRF-PAI, which is used for Medicare reimbursement. UDSMR is planning to submit the FIM® instrument to NQF for endorsement.

## Section 8: Feedback Loops

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### American Academy of Neurology

#### Bruce Sigsbee

On October 3-4, 2012, the NQF Neurology Phase II Steering Committee reviewed 18 measures: nine measures developed by the AAN and nine measures for dementia developed by the AAN in conjunction

with the American Geriatrics Society, American Medical Directors Association, the American Psychiatric Association, and the American Medical Association convened PCPI. The NQF Steering Committee was charged with reviewing the measures and recommending them for endorsement based

on whether or not they met the following four criteria: importance to measure and report, scientific acceptability of the measure properties, usability and feasibility. Only 1 of the 18 measures was approved during the two day meeting, which represents a 6% endorsement pass rate. This is not congruent with the average endorsement pass rate of approximately 58%. The Steering Committee voted to endorse one epilepsy measure: Counseling for Women of Childbearing Potential with Epilepsy. The Steering Committee determined that seventeen of the submitted measures failed to pass the importance criterion and were therefore not recommended for endorsement.

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### **American Medical Rehabilitation Providers Association**

#### **Marsha Lommel**

We recognize the tremendous effort NQF staff undertakes to develop these reports and the tight deadlines. However, we remain concerned that the current process does not allow for appropriate feedback from stakeholders. The process in which public comments are limited to 3,000 characters does not provide an adequate opportunity to discuss the rationale for support or rejection of a particular quality measure under consideration. Additionally, the public should be provided an opportunity to comment on each measure under consideration for each workgroup rather than have only a brief comment opportunity on the full range of measures being considered.

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### **American Nurses Association**

#### **Maureen Dailey**

In order to create a Learning Health System called for by the IOM, the efficient use of two-way communication is necessary as described in the MAP report. ANA applauds the MAP's call for efficient feedback loops to evaluate measure use, experience, and effectiveness. ANA, along with our affiliated nursing specialty societies, and NQF nursing members, are ready to engage with NQF to support the identification and use of these important feedback loops.

The National Database of Nursing Quality Indicators (NDNQI), the only international nursing data registry and nursing member of the National Quality Registry

Network (NQRN), is also prepared to provide feedback based on the surveys from our > 1900 participating hospitals and share information on safety gains using effective measures. Moreover, the Partnership for Patients Hospital Engagement Network hospitals, representing more the 80% of the nation's hospitals are also a rich source of feedback as to effective structure, process, and outcome measures, including clinically-enriched measures from NDNQI, that contribute towards the reduction of hospital acquired conditions (HACs) and avoidable readmissions. The NDNQI data on falls and pressure ulcer rates are being used for national comparisons using NQF-endorsed measures for the Partnership for Patients.

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### **America's Health Insurance Plans**

#### **Carmella Bocchino**

We are supportive of implementation of feedback loops to gather input on measure implementation experience. Feedback and lessons learned from implementation should be shared with the measure developers and the MAP to allow for enhancements to measures being developed and to ensure implementation of "best in class" measure. It will also be important for NQF to receive feedback on the endorsement process and any needed improvements.

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### **AmeriHealth Mercy Family of Companies**

#### **Thomas James**

AmeriHealth Mercy Family of Companies agrees with the principles of feedback loops as the report calls for. It will be important for MAP and NQF to be able to receive input from all stakeholders on the measure development process.

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### **Children's Hospital Association**

#### **Ellen Schwalenstocker**

The Children's Hospital Association strongly supports a more systemic approach to understanding measure implementation experience, including the use of feedback loops.

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## Greater New York Hospital Association

### Lorraine Ryan

Adequate time is needed to take all these considerations into account. HHS provided MAP the list of measures under consideration on December 1, and MAP was given two months to provide a detailed report to HHS that incorporates feedback from multiple stakeholders and the public. This short time window is insufficient to properly review the measures, solicit feedback, and provide a meaningful response to HHS on the measures under consideration. Additional time will also allow MAP to provide more detailed rationale to the stakeholders and public on how they came to their decisions. GNYHA Recommendation GNYHA urges MAP to request that HHS provide them with the measure list earlier to give MAP and relevant stakeholders more time and information to properly review and comment on the measures under consideration for Federal rulemaking.

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## PhRMA

### Jennifer Van Meter

PhRMA supports MAP's recommendation to establish feedback loops to better understand and evaluate measure implementation by various stakeholders. Insights into successful feedback loops may be gained from sources such as patient registries, regional health alliances, or the Veterans Health Administration, which use regular feedback to improve care practices as well as measure use and reporting. For example, feedback from patient registries can be used to examine treatment options and effects of therapies for patients with depression. They can also help identify trends for successful care, reduced adverse events, and improved outcomes. Therefore, we encourage feedback from reliable sources that can provide insights into measure implementation to improve quality care.

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## Takeda Pharmaceuticals

### Deborah Walter

Takeda Pharmaceuticals America, Inc. and Lundbeck LLC support MAP's recommendation to establish feedback loops to better understand measure implementation efforts and challenges. We agree that successful feedback loops may include insights received from patient registries, regional health

alliances, and the Veterans Health Administration. In particular, registries provide an opportunity to learn more about the nuances of depression therapies and patient responses to them. Feedback from registries may also help identify trends in treatment adherence and outcomes improvement. A number of patient registries are being used to study treatment options and effects for patients with depression, as well as to identify components necessary for successful care and improved outcomes. We encourage feedback from these groups on their experiences implementing mental health measures to improve depression care.

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## The Joint Commission

### Margaret VanAmringe

Feedback Study/Assessing Unintended Consequences of Measures

The Joint Commission is pleased that there is consideration being given to a study to evaluate how measures are used in quality improvement. We urge that such study is not just descriptive as to what, where, and how measures were implemented, but that it also provides specifics as to whether or not the actual measures themselves and their specifications were useful to achieving important goals. The Joint Commission would also like to see some focus on the area of unintended, adverse consequences associated with certain measures used for public reporting and in pay-for-performance programs. We believe that one should closely monitor and evaluate measures that are used to encourage changes in the way care is delivered. The MAP has discussed "balancing measures" and while those are important, we should further encourage CMS to remain aware of potential negative unintended consequences and perform the necessary actions to decrease or mitigate the risk of their occurrence.

Of particular concern are the readmission measures. The Joint Commission is very supportive of finding ways to reduce avoidable admissions, but there are some reports that patients are being turned away as inpatients when they could greatly benefit from an admission, for fear of potentially escalating reportable readmission episodes. For example, in an effort to reduce hospital admission rates, patients may be placed in a "holding" observation status -- which may also have serious financial implications for the patient and their family.

## Section 9: General Comments

### American Academy of Hospice and Palliative Medicine

#### Dale Lupu

AAHPM is submitting a supplementary file that shows a crosswalk AAHPM developed between the MAP measurement framework for hospice and palliative care and the recommended measures endorsed by MAP. This crosswalk clearly shows that there are no or few measures of palliative care domains for hospitals, long-term care hospitals, or ESRD - all settings caring for people with serious illness. The current discussion of measure gaps does not sufficiently highlight the complete absence of palliative care measures for hospitals. We note that ASCO is currently conducting a project to develop new measures for PPS-exempt Cancer Hospitals. Many of the measures to be developed fit palliative care domains. With additional testing and modification, these new measures may form the basis for a palliative care measure set for acute hospitals. We urge MAP to make development of a palliative care measure family applicable across settings, including hospitals, the highest priority. While we have noted the urgent need to develop measures for the hospital setting, we also note that there are many missed opportunities to improve the quality and continuity of care across the illness trajectory, including home-based care. The palliative care measure family should ideally be cross-cutting across the entire illness trajectory and all sites of care. Most patients prefer to be home if possible, and our care setting and measure system should support and reflect this.

### American Academy of Otolaryngology

#### Peter Robertson

The American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) is the world's largest organization representing specialists who treat the ear, nose, throat, and related structures of the head and neck. The Academy represents approximately 12,000 otolaryngologist—head and neck surgeons who diagnose and treat disorders of those areas. The AAO-HNS appreciates the opportunity to provide comment on the Measure Applications Partnership

(MAP) Pre-Rulemaking Report.

We commend MAP for the substantial undertaking to review and provide recommendations on many hundreds of measures. We support MAP's proposal that CMS make measures under consideration available earlier for review. We agree that such a proposal would allow for greater collaboration between MAP, CMS and medical specialty societies.

In addition, we support MAP encouraging clinician participation in CMS quality initiatives such as PQRS. The AAO-HNS believes that the number of otolaryngologists participating in programs such as PQRS can be increased by including measures specific to our specialty. In addition, we encourage CMS to adopt the MAP's guiding principle that measures should first be implemented in PQRS to obtain experience, including non-NQF endorsed measures.

The AAO-HNS thanks the MAP for reviewing measures developed by the American Medical Association convened Physician Consortium for Performance Improvement (AMA-PCPI) in conjunction with the AAO-HNS related to Otitis Media with Effusion (OME) (NQF 0655, 0656, 0657) and Adult Sinusitis (M2414, M2415, M2416, M2417, M2418, M2419, M2420, M2421, M2422). The AAO-HNS thanks the MAP for supporting the three OME measures and their recommendation to support the direction of eight on the adult sinusitis measures. The AAO-HNS encourages CMS to adopt all of these measures for inclusion in PQRS during the 2014 rule-making process.

### American Association of Neurological Surgeons

#### Koryn Rubin

Overall, the AANS is supportive of the MAP's efforts to align CMS quality programs. There is a need for physicians to have the ability to report on a single set of measures throughout CMS' various quality programs. This is especially important as the programs move away from incentives and become punitive. We are also encouraged by the MAP's goal to incite greater clinician participation by reducing clinician reporting burden with the intent of adding

greater value to the system. The current perception by physicians, especially neurosurgeons, is that the current quality measures within CMS' quality programs provide little value, do not improve care, and are cumbersome to collect. One of the greatest burdens that remain is data collection and collation.

We are also concerned with MAP's recommendation for CMS to identify a set of measures on which all clinicians should report across programs, regardless of specialty. A one-size-fits-all approach does not work in measuring physician performance. The evaluation of a primary care provider or other specialist is much different than a neurosurgeon. For example, a neurosurgeon's patient mix is different from an internist as he or she typically only interacts with a patient for an acute episode.

Furthermore, if the NQF MAP's goal is to capture metrics for defining the quality of clinical care then it should avoid linking cost and quality. Once we have better definitions for quality in health outcomes, and establish how we will measure these outcomes, as opposed to the process measures that are currently in PQRS then the MAP should begin the discussion on value of care. There is yet to be a validated connection established between increased quality and decreased cost. Therefore, Neurosurgery greatly believes quality and cost are two separate discussions, until measure implementation, in programs such as the Medicare Shared Savings, begin to demonstrate an actual decrease in health care spending.

Please see Clinician and Hospital Performance Measurement sections for comments on individual measures.

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### **American College of Physician Executives**

#### **Bill Steiger**

The American College of Physician Executives (ACPE), representing more than 11,000 high-level physician leaders in all types of health care organizations across the U.S., fully supports the MAP Pre-Rulemaking report and NQF's plan to submit the final report to Health and Human Services on February 1st. As an organization devoted to improving health care through the empowerment of physician leaders, ACPE has already embraced quality

measurement as one of the nine essential elements that ACPE believes to be critical in any health care reform efforts. The nine essential elements are:

- Quality-centered
- Safe for all
- Streamlined and efficient
- Measurement-based
- Evidence-based
- Value-driven
- Innovative
- Fair and equitable
- Physician-led

A comprehensive survey published by ACPE this month about various types of quality measures found that physician leaders are very wary of any attempts to measure their performance. However, they did show support for efforts, such as MAP's, that are based on data and scientific analysis rather than public opinion. Complete survey results and analysis can be viewed at [acpe.org/measures](http://acpe.org/measures)

Thank you for your efforts to create the MAP report. ACPE believes the more than 700 performance measures go a long way toward standardizing the measurement process. Please don't hesitate to contact us if ACPE can assist in any way.

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### **American College of Surgeons**

#### **David B. Hoyt**

We are very appreciative of the opportunity to provide feedback and recognize the volume of work and strict timeline under which the MAP operates. However, we strongly believe that a two week comment period is not a reasonable amount of time for public comment for the MAP Pre-Rulemaking Report. The Report reviewed more than 500 measures and did not provide clear supporting materials for the public and NQF members. A thirty day comment period would allow for more thoughtful public comment and greater provider participation.

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### **American Hospital Association**

#### **Linda E. Fishman**

On behalf of our more than 5,000 member hospitals, health systems and other health care

organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) 2013 pre-rulemaking report. The AHA strongly supports the premise of the MAP's work—that is, improvement in our nation's healthcare system can be catalyzed by selecting quality measures in federal reporting and payment programs focused on aspects of care that a broad array of stakeholders believe to be important.

We also believe that the MAP's goal of fostering stronger alignment between quality reporting and payment across care settings and programs is critically important to the long-term success and sustainability of health care quality improvement efforts. Broadly defined, alignment means that measurement priority areas are the same across payment programs. It also means that the decision to use particular measures in a particular program is driven by a consistent set of principles. At a time when health care resources are under intense scrutiny, the alignment of quality reporting and payment efforts across settings and programs would reduce the data collection burden and the unnecessary duplication of efforts. Alignment also would help balance the allocation of limited resources between data collection and actual efforts to improve performance. The AHA appreciates the progress of the MAP in improving the alignment of quality reporting efforts across programs this year.

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### American Hospital Association

#### Linda E. Fishman

Moving forward, we urge the MAP to take additional steps to more concretely enhance the alignment of quality measurement reporting and payment efforts. The MAP has several operational and strategic levers at its disposal to promote stronger alignment. For example, the MAP can incorporate concrete guidance for measure selection into its process. Moreover, the MAP's statutory mandate to review all quality measures being considered for federal programs affords it a unique strategic opportunity to look across programs and measures, identifying tightly scoped, actionable areas in which strong measures are available to drive improvement across settings and programs. This year's committee deliberations,

as well as the draft report, contain many crucial building blocks to take this next step. Thus, as the MAP finalizes its report, we offer the following recommendations:

- The Hospital and Clinician Workgroups developed guiding principles to help inform the selection of measures across programs. Similarly, the Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup identified several measurement areas – such as patient engagement, care coordination and safety – that lend themselves to quality improvement across multiple care settings. We recommend that the MAP integrate the principles and priority areas into one overarching set of guidance that can be applied to all programs that it reviews. We recommend a potential integrated set of principles in the next section.
- The AHA also recognizes that some individual programs may require principles that reflect their specific needs and goals. Given our role in the Hospital Workgroup, we have offered suggested edits to the hospital principles to align them with our recommended overall principles.

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### American Hospital Association

#### Linda E. Fishman

- The MAP stands at the intersection of measure endorsement, driven by the National Quality Forum (NQF), and measure implementation, governed by the Centers for Medicare & Medicaid Services (CMS). Given its unique positioning, the MAP can strategically use its own processes to drive alignment efforts, as well as recommend process changes to NQF and CMS that enhance the MAP's effectiveness. Specifically:

- o To further promote alignment and a focus of quality measurement resources across the health care delivery system, the MAP should identify two or three specific priority areas for measurement each year, and recommend that CMS implement them across its programs. This approach would go one step beyond an examination of the relative numbers of MAP-recommended measures in each priority area of the National Quality Strategy (NQS). Instead, the MAP would select a limited number of aspects within a priority area, such as patient safety, to address aggressively each year with available measures.

- o To allow for adequate time to vet individual

measures, and strategically select priorities across programs, the MAP should recommend that CMS provide a list of measures under consideration earlier in the process.

o To better understand the burden of measurement, the MAP should urge NQF to undertake a study so that such considerations can be incorporated in MAP's deliberations.

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### American Hospital Association

**Linda E. Fishman**

#### AN INTEGRATED SET OF MAP MEASURE SELECTION GUIDING PRINCIPLES

We commend the work of the Hospital and Clinician Workgroups in developing guiding principles for measure selection. These principles demonstrate the clear progress that the MAP has made in harnessing the input of multiple stakeholders to inform its decisions. We also appreciate the PAC/LTC Workgroup's identification of "high-leverage" areas of performance measurement most likely to stimulate improvement across multiple care settings. When taken together, the guiding principles and high-leverage measurement areas are highly relevant to all of the programs that the MAP reviews. Moreover, these combined principles and high-leverage measurement areas provide concrete, step-wise guidance that can be applied easily during MAP committee deliberations to foster greater alignment of quality measures across federal programs. We have consolidated the principles from the workgroups, as well as the priority measurement areas from the PAC/LTC Workgroup, into a single set of principles for use by all MAP workgroups:

1. Measures under consideration for CMS programs should be chosen to ensure a focus on the areas patients, providers and other stakeholders believe to be most important. The MAP believes patient engagement, care coordination, safety and cost/access are critical aspects of care for which there should be care setting-appropriate measures across programs.

2. Measures used in reporting and payment programs should be consistent with the purpose and goals of each program. Inclusion of each measure should support improvement in the safety, quality and

efficiency of care delivered to the patients whose care is actually covered by that program.

3. When measures used for public reporting and in pay-for-performance programs successfully encourage changes in the way care is delivered, there can be unintended, negative consequences. CMS should work with other key stakeholders to monitor for these unintended consequences and, when appropriate, take steps to decrease the chances of negative effects from the unintended consequences; for example, including measures that provide a countervailing pressure.

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### American Hospital Association

**Linda E. Fishman**

4. The MAP believes that there is a logical sequence of actions for implementing measures in federal programs:

a. All measures should be reviewed and endorsed by the NQF prior to inclusion in a federal program. This is meant to ensure that each measure is important, scientifically sound, useable and feasible to collect.

b. Each measure should then be included in a national public reporting program for at least one year prior to inclusion in a pay-for-performance program. In this manner, the results can be monitored to be sure that there is variation in performance; the causes for variation are identified and, if related to patient characteristics (such as severity of illness), appropriate adjustments are made to the measure; and potential unintended consequences of measurement and public reporting can be identified and addressed.

c. Measures identified as being sufficiently important and having performance that is not uniformly excellent should be considered for inclusion in an appropriate pay-for-performance program where the incentive/disincentive will provide greater inducement for change.

d. Monitoring of a measure's performance should continue throughout its use in a pay-for-performance program. When there is evidence of consistent and sustained excellent performance, the measure should be retired from performance-based incentive programs and public reporting programs. This

will create room for identification of additional improvement opportunities and inclusion of new measures.

e. In rare instances, some of the steps in the sequence may be skipped, such as when a measure has already been reported broadly in another national quality data collection program or when the issue is considered to be so urgent that adoption of the measure into public reporting or inclusion in an incentive program is needed immediately. Exceptions to the sequence outlined in steps 4a-4d should be rare. The process should be the one typically used because each step is critical to ensuring patient care is changed in ways that are likely to improve outcomes, and that providers are fairly compared.

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### American Hospital Association

#### Linda E. Fishman

5. The NQF endorsement status of measures currently used in, or being proposed for, quality reporting and payment programs should be applied in a number of ways:

- a. Measures that are not NQF-endorsed, but are already finalized in programs should be submitted for NQF review. If a measure does not receive endorsement, it should be removed from the program.
  - b. Measures that lose their NQF endorsement also should be removed from the programs.
  - c. NQF-endorsed measures used in federal programs must be applied in a manner consistent with how the measures are specified and tested when endorsed. If CMS intends to use a given measure differently in a program, the measure should not be implemented until testing results for this new use demonstrates a comparable level of reliability and validity as when it was initially reviewed by the NQF. Since NQF endorsement is predicated on measures being used as developed, the same data collection methods and patient populations must be used in federal programs.
6. It is important that there be parsimony in the selection of measures to ensure the providers being measured are focused on critical aspects of care that need improvement, and to ensure patients can find

information without being overwhelmed by data. Parsimony can sometimes be enhanced by using the same measure in multiple programs. However, careful consideration should be given to how the programs work together, whether inclusion in two programs creates the right emphasis on an issue, and whether there is the opportunity for confusion coming out of the disparate applications of a measure. Specifically:

- a. If the same measure is used in more than one pay-for-reporting program, the performance benchmarks, data collection periods and performance periods must be consistent across programs.
- b. The same measure should not be used in more than one pay-for-performance (i.e., payment penalty) program because there are often inconsistencies in the programs' goals, reporting methods and performance benchmarks. These inconsistencies can lead to confusion about the true state of organizational performance. Instead, if CMS wishes to strongly emphasize a measure, that measure should be given a greater weight within one penalty program.

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### American Hospital Association

#### Linda E. Fishman

#### APPLICATION OF OVERARCHING MEASURE SELECTION PRINCIPLES TO HOSPITAL PROGRAMS

We fully support the MAP's proposal that articulated principles are needed to help all stakeholders understand what makes a measure appropriate for one program, but perhaps not appropriate – or not yet ready or appropriate – for another. The principles in the previous section apply to all programs, but each program often has its own unique issues with applying measures. Thus, the AHA recommends several edits to the Hospital Workgroup's guiding principles to align them with the overall guiding principles outlined above, and to address specific areas of concern.

Inpatient and Outpatient Quality Reporting. The AHA largely agrees with the principles articulated for the Inpatient Quality Reporting (IQR) program, especially the first principle, which states that measures ought to first be publicly reported for at least a year before being considered for inclusion in a pay-for-reporting program. Hospitals have



more than a decade of history in public reporting of quality metrics. As clearly documented in The Joint Commission's 2012 Annual Report: Improving America's Hospitals, hospitals have responded to publicly reported data with substantial improvements in care on most measures. Inclusion of high priority measures in the Inpatient and Outpatient Quality Reporting Programs encourages progress while also giving hospitals the opportunity to learn of potential unintended consequences, biases in the data, or barriers to improvement that must be dealt with to enable better care. It also allows policymakers time to identify the measures that warrant the added emphasis of linking payment to performance to generate improvement.

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### American Hospital Association

#### Linda E. Fishman

We also strongly support the notion of parsimony articulated in the last principle. Changing existing processes to get better outcomes requires energy, resources and focus, and that means being judicious about how many measures are chosen for application to each sector of the health care delivery system. The AHA's only suggested change in this section of the Guiding Principles is to simply add "and Outpatient Quality Reporting" to the heading. While we realize the Hospital Workgroup was only evaluating the IQR measures at the time these principles were articulated, we see no reason to believe these principles would be any different for the outpatient counterpart program, and therefore urge the MAP to make this adjustment.

#### Value-Based Purchasing (VBP).

The AHA also supports the concepts articulated in the principles on VBP, including the principle suggesting that measures (or composites) included in VBP should demonstrate opportunities for improved performance. We do, however, suggest some language changes. One of the sub-bullets addresses measures with concerns about potential unintended consequences. The notion of unintended consequences is ubiquitous in measurement, but the likelihood of such an occurrence varies with the subject matter being assessed and the amount of pressure brought to bear on performance by inclusion in pay-for-reporting and/or

pay-for-performance programs. For example, there is growing concern about the unintended consequence of creating more antibiotic resistant organisms as we measure whether or not surgical site infection prevention steps and the pneumonia treatment steps occurred in a timely fashion in the IQR system, even before such measures were linked to payment. We believe that monitoring for unintended consequences should be ubiquitous, and that policymakers should consider implementing steps to prevent unintended consequences. This is especially important when considerable pressure is being brought to bear for performance, or the potential severity of the unintended consequence is significant.

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### American Hospital Association

#### Linda E. Fishman

Thus, we suggest that the second sub-bullet under VBP be included in the more general statement of principles for which we advocate above. If the MAP chooses not to adopt that suggestion, then the following bullet should be moved to the "Additional Considerations" section of the hospital principles to make clear it is not simply a principle for VBP measures:

- AHA-suggested language: Unintended consequences can occur when measures used for public reporting and pay for performance successfully encourage changes in the way care is delivered. HHS should work with other key stakeholders to monitor for these unintended consequences and, when appropriate, take steps to decrease the chance of ill-effects from the unintended consequences, such as by including measures that provide a countervailing pressure.

Hospital-Acquired Conditions (HAC) Payment Penalty Program. In articulating principles for the Hospital Readmissions Reduction and HAC Payment Penalty Programs, the MAP suggests it would be important to consider overlapping incentives and their unintended consequences. We believe that the MAP meant to address overlapping incentives between these two programs and the VBP program. We suggest the following language to clarify:

- AHA-suggested language: In adopting a measure for pay-for-performance programs, stakeholders

should consider whether the measure is appropriate for more than one program, such as the VBP and HAC programs. The different constructs of the programs and the disparate ways in which good versus bad performance is identified could potentially send conflicting signals to the providers being measured because their performance in one program could appear acceptable or even good, but in the other program may appear unacceptable or deserving a payment penalty. To avoid such conflicting signals, it may be appropriate to consider giving heavier weight to a measure in one program, and removing it from the other.

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### **American Hospital Association**

#### **Linda E. Fishman**

With regard to the use of claims-based measures for the identification of HACs, we continue to believe that claims represent an inadequate data set from which to cull the clinically relevant information that is needed to identify HACs. We are particularly concerned about using claims to identify relatively rare events, such as many of the conditions in the current HAC payment program that do not allow a patient to be moved into a higher-paying diagnosis-related group (DRG) as a result of a HAC. When the HAC occurs rarely, even one misidentification from the claims data can adversely impact the hospital's payment. This is particularly concerning if Medicare uses claims-based measures that were validated on all payer databases, but applied for payment purposes to Medicare fee-for-service (FFS) data only. A report CMS commissioned from Mathematica showed how unreliable many of these measures are when applied only to the Medicare FFS claims.

We urge the MAP to express an explicit preference for measures that have been demonstrated to be reliable and valid in the way CMS intends to use them. In many instances, CMS uses the measures as they were reviewed by NQF, and NQF endorsement should be sufficient justification of the measure's scientific acceptability, if used as reviewed. However, where CMS will use a measure in a manner other than intended by the NQF, the AHA urges the MAP to directly state that the measure must be separately tested and verified that it is reliable and valid.

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### **American Hospital Association**

#### **Linda E. Fishman**

Readmissions.

The AHA supports the principles articulated with regard to the readmission measures that should be included in the Hospital Readmissions Reduction Program. In particular, we support the second sub-bullet under the bullet that begins, "Particularly salient points from the MAP Guidance ..." This sub-bullet urges that readmission measures should exclude planned readmissions. The algorithm created by Yale University researchers to give some consistency to the exclusion of planned readmissions is a significant improvement over the initial readmission measure specifications. However, there is a growing body of research supporting the notion that improving care across the continuum in ways that will lead to better outcomes and fewer readmissions is a "team sport." It will require appropriate action not only by the hospital, but by providers in the community, the patient and the family. When the community lacks a sufficient number or array of other providers, or other environmental factors interfere with a patient's path toward wellness, it is unfair to hold the hospital responsible for those factors. We urge the MAP to call explicitly for consideration of socioeconomic adjustments in measures that rely on actions outside the control of the hospital as a principle guiding the selection of readmission measures and other measures that span the care continuum.

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### **American Hospital Association**

#### **Linda E. Fishman**

STRATEGIC ADVINCE FOR THE MAP TO MAXIMIZE ITS IMPACT

The integrated measure selection guiding principles are but one tool that MAP can use to encourage alignment across programs. As the MAP enters its third year, it is poised to play an even more pivotal role. The MAP's statutory mandate to review all quality measures being considered for federal programs affords it a unique opportunity to look across programs and measures, identifying the health care delivery system's best opportunities for aligned measurement. The MAP also can work with

its key partners – CMS and NQF – to recommend and implement process changes that enhance its effectiveness in executing its role. The AHA’s strategic recommendations to the MAP are outlined below.

**Identification of Concrete Measurement Priorities.** The MAP has a unique opportunity to identify tightly scoped, actionable areas in which strong measures are available to drive improvement across care settings and programs. The MAP could identify the top two or three priority areas for measurement each year and suggest that CMS implement them aggressively across its measurement programs. High-level quality measurement and improvement priorities have been outlined in the NQS. The MAP’s draft report illustrates that MAP-recommended measures address each priority area within the NQS. However, we recommend that the MAP select a limited number of aspects within a priority area, such as patient safety, to aggressively address each year with available measures. This prioritization will allow for resources to be focused, increasing the likelihood of success. At the same time, this prioritization strategy facilitates parsimony.

The draft report details a large number of measure gaps. While identifying such gaps is important and should continue, it can take years to develop the measures that fill identified gaps. In the meantime, the MAP could encourage a more concentrated effort to improve quality in certain priority areas where enough measures to succeed already exist.

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### **American Hospital Association**

**MAP Specificity of Recommendations on Measures.** The MAP also should include additional categories or rationales for committee decisions on measures beyond the established criteria of Support, Support Direction, Phased Removal, Do Not Support or Insufficient information. In particular, this year’s MAP discussions revealed that the term “Support Direction” was ambiguous. For example, in some circumstances, members may agree to support the direction of a measure conditioned upon NQF endorsement. In other situations, members may agree to support the direction of a measure that is not fully specified because they would like to see a more robust development of that measure.

Committee decisions should be communicated to CMS with more clarity.

**MAP Recommendations to CMS.** CMS is a critical partner in the MAP review process. CMS not only provides the list of measures for review, it also actively participates in committee discussions. The AHA encourages the MAP to provide concrete guidance to CMS each year about how it can enhance the quality of its participation in the process.

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### **American Hospital Association**

#### **Linda E. Fishman**

In this year’s report, we suggest that the MAP include a section titled “Recommendations to CMS on the MAP Review Process” that conveys the following:

MAP participants have repeatedly requested, in both MAP and external meetings, that CMS provide a list of the measures under consideration earlier than Dec. 1. In the last two review cycles, MAP members have been asked to review hundreds of measures within a two-week period to prepare for the workgroup meetings. Given that MAP members are volunteers with full-time jobs, this timeframe makes meaningful review of the measures very challenging. In fact, at times, the Hospital Workgroup discussions demonstrated that members are struggling to gain a command over the substance of the measures they have been asked to review. Further, the short timeframe makes it difficult for MAP participants to solicit and receive comments from their organizational members, who often possess important insights about how well a measure will achieve its objectives and what can be done to improve it. In terms of widely vetting quality measures, this outreach is important.

MAP members have suggested using a “rolling” release of measures under consideration, which could take place throughout the year. Others have suggested an earlier transmittal of the full list of measures under consideration to the MAP – at least 60 days earlier than the current timeframe. We strongly urge CMS to adopt either or some combination of both strategies so that MAP members can provide well-researched, thoughtful and meaningful feedback to CMS. At the same time, CMS should use the guiding principles articulated by the

workgroups to limit the number of measures under consideration provided for MAP review.

Finally, the MAP plays a vital role in assessing the acceptability, value and feasibility of quality measures for inclusion in the payment and penalty programs. Given the MAP's crucial role in bringing together stakeholders to comprehensively evaluate whether a measure makes sense for a particular program, we encourage CMS to propose only measures for rulemaking that have been considered by the MAP.

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### American Hospital Association

#### Linda E. Fishman

MAP Recommendations to NQF. The NQF serves as the health care sector's primary organization for coordinating quality measure development, endorsement and review across a wide spectrum of conditions and care settings. Given NQF's integral role in the MAP review process, we encourage the MAP to provide NQF the following guidance.

First, we encourage the NQF to study and provide information on the burden of quality measurement so that the MAP can use it in its deliberations. Measures should be recommended for payment and penalty programs only when they add value, and should never be implemented simply because a process or outcome can be measured. There must exist a way for providers to improve care based on the results of the quality measure data. Otherwise, resources for quality improvement are wasted

The AHA has begun to collect information from its members on the burdens of quality measurement, and we look forward to sharing our knowledge with the NQF and MAP. Our initial findings demonstrate that the types of burdens of quality measurement vary for the different types of data collected. For example, abstracted measures are particularly cumbersome to collect because of the time and labor involved and the detailed nature of the work, while HCAHPS measures cause hospitals to incur substantial costs for vendor support.

As NQF studies the issue of measurement burden, the AHA recommends NQF consider the following issues:

- The types of labor involved in each type of data

collection, including abstracted, survey reported, structural and claims-based data collection.

- The time involved for providers to learn about and implement the measures as they change.
- The time involved for providers to collect and report the data.
- The costs for technology and vendor assistance.
- The barriers that exist to successful implementation of quality measures.

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### American Hospital Association

#### Linda E. Fishman

We also recommend that NQF provide additional information to the MAP on whether measures recommended for individual programs are actually tested for those settings. Providing this information in advance of MAP committee deliberations on measures would help expedite the review process. In no circumstance should a measure approved for one setting be endorsed for a second setting before the measure is tested in the second setting. CONCLUSION With a consolidated set of guiding principles for measure selection and enhancements in its strategic positioning, the AHA believes the MAP would be poised to play an even more crucial role in driving measurable improvement within the health care delivery system. Thank you for the opportunity to comment. If you have questions, please contact me or Akin Demehin, AHA senior associate director for policy, at (202) 626-2365 or ademehin@aha.org.

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### American Medical Association

#### James L. Madara

##### Overall Categorization of Measures

During the 2012 MAP pre-rulemaking process, the AMA and other stakeholders advocated for additional, more specific categories to capture and communicate the issues raised upon review of quality measures for use in government programs. We are thankful that the MAP responded to these concerns by adding the categories of "insufficient information" and "phased removal." The MAP pre-rulemaking report, however, primarily uses the "support" or "do not support" categories when reviewing and making recommendations regarding measures. Further, some measures assigned to the "do not support"

category are placed there without an explanation for not supporting the measure, while other measures categorized as “do not support” have a specific explanation concerning why the measure should not be supported or the measure is categorized as “insufficient information” with an explanation of what additional information is needed to move forward with the measure. In some cases, the MAP recommends “do not support” for measures because “NQF endorsement [has been] removed.” Yet, the measure (for example, 1030 and 1031) has never been reviewed by the NQF. Inconsistent use of these categories creates unnecessary confusion and can be misleading.

To clear up this confusion and provide more accurate information, the AMA urges the MAP to make greater use of the “insufficient information” and “phased removal” categories. Also, the AMA recommends that the MAP take steps to ensure a more consistent and standardized approach in categorizing measures and describing why a measure is categorized in a certain manner. For example, the MAP Workgroup Chairs could meet prior to making recommendations to the MAP to develop a strategy for increased use and greater standardization of these categories.

#### Need for Appropriate Experts in Workgroup Discussions

The MAP workgroup discussions benefit from the input of key experts and stakeholders familiar with the quality measures being discussed by that workgroup. While the AMA is not advocating that the MAP duplicate the NQF endorsement processes, we believe the MAP would benefit greatly with increased participation of qualified experts and stakeholders during the discussions of particular quality measures. Specifically, the AMA urges the MAP to develop a more detailed discussion guide that easily identifies the specific measures that will be discussed and the time of day that discussion will occur. This will allow qualified experts to know in advance when to expect that a measure will be discussed, and help ensure their availability for the discussion. Having measure developers and/or other clinical experts in the room at the appropriate times will help foster a more accurate and focused discussion of the specific measures under consideration. Further, if the MAP knows that more information will be needed for

discussion about a particular measure, or that the discussion is going to be particularly complicated, the AMA urges the MAP to clearly indicate this in the discussion guide.

#### Recommendation for Streamlining Adoption of Measures into Federal Programs

The AMA understands it is not realistic to expect that CMS can add all of the measures to its programs. This is due to limited resources, as well as the various stages of the proposed measures, e.g., specification, testing, and endorsement. In this light, it may be more practical for CMS to provide the MAP with a three- or five-year measurement plan for all of its programs, and share certain measures with the MAP in accordance with the plan. This would allow the MAP to better focus its efforts on measures that have a more realistic chance of being adopted in one to two years, while signaling to measure developers what they should prioritize with regard to measure specifications, testing, or eMeasure development. This will help streamline how CMS shares measures with the MAP, which will in turn help streamline and make more efficient the MAP pre-rulemaking process.

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### American Nurses Association

#### Maureen Dailey

ANA applauds the thoughtful work of the NQF staff and MAP group members and agrees with the MAP that careful balance among the MAP groups is needed to ensure the measures and measure gaps identified are meaningful and important. ANA and all the NQF Nursing Organizational Members stand ready to nominate qualified nurses for appointment to MAP groups. Nurses, the largest group of healthcare professionals and the proximal caregiver across care settings and populations have knowledge, experience, and skills to contribute effectively on all MAP groups. Specifically, nurses who represent the nursing and team perspective bring important knowledge and skills to the MAP groups regarding the attributes the IOM identified for important measures: impact, improvability, and inclusiveness. In particular, ANA requests the MAP consider qualified nurse participants for all 2013 MAP Task Forces. ANA agrees with the MAP that quality measurement data should be leveraged for multiple purposes, such as Maintenance of Certification

(MOC), and to reduce clinician reporting burden. An area for MAP exploration is MOC for disciplines other than physicians. The IOM has convened the Standing Committee on Credentialing Research in Nursing. One likely topic the Committee will consider is research to inform the impact of individual and organizational credentialing in nursing on improving healthcare performance, quality, and outcomes. Maintenance of certification is accomplished in nursing through a variety of mechanisms including reexamination, continuing education, self-assessment, and ongoing clinical practice. Nursing specialties have made significant contributions to quality improvement and measurement. Moreover, reporting of patient-reported survey outcomes by all interprofessional clinicians via registries, in hospitals or other settings of care, is important to bridge the gap until electronic health record uptake and meaningful use advances.

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### **American Society of Pediatric Nephrology**

#### **Joseph Flynn**

End-Stage Renal Disease Quality Improvement Program (QIP)

ASPN is excited that multiple pediatric quality measures for end-stage renal disease have been endorsed by NQF. We feel that these measures, ID numbers 1344, 1352, 1347 and 1351 are both clinically and operationally appropriate. ASPN fully supports efforts to develop pediatric-specific measures in addition to measures that apply to both pediatric and adult ESRD patients, in an effort to provide improved care and create greater transparency for pediatric patients and their families. At this time, however, the QIP structure is not adequate to include pediatric metrics due to the low number of patients insured by Medicare in most pediatric facilities. Thus, the ASPN is poised to work with CMS and the kidney care community to develop a way to improve access to quality metrics for pediatric-only facilities that takes into account the limited number of Medicare patients these facilities serve.

Medicare Physician Quality Reporting System (PQRS)

ASPN also echoes the Renal Physicians Association's strong support of measure ID numbered 2523, 2525, 2527, 2522, 2524, 2526, 2528 and 2530 as they are

considered for the Physician Quality Reporting System.

We appreciate the inclusion of quality measures in programs administered by CMS that have undergone extensive review to ensure greatest level of scrutiny, to make sure that quality measures make sense and are appropriate in the clinical setting. We seek the inclusion of pediatric patients in the QIP in the future and are eager to work with all parties to achieve that goal.

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### **American Society of Nephrology**

#### **Bruce A. Molitoris**

Overall, ASN recommends that MAP, NQF, and other entities proposing or implementing quality measures prioritize outcomes measures over process measures, and that any measures being considered should address a gap in care or a clear opportunity for improvement. Any process measures that are considered should be process interventions—such as using acetylsalicylic acid for presumed myocardial infarctions—rather than process monitoring—such as checking calcium levels monthly. Furthermore, any measure being considered for inclusion in a quality improvement initiative should already have been endorsed via a formal consensus-based process, such as the NQF process. Finally, ASN suggests that data collection should rely on claims and easily obtained clinical information that does not require extensive chart review or access to multiple data sources. Several of the proposed MAP measures would require complex data collection, a challenge that could have been considered and addressed in an NQF process in advance.

ASN is committed to participating in the consideration and selection of evidence-based quality measures related to kidney disease care and kindly submits the following specific comments on the measures related to end-stage renal disease for your consideration. ASN appreciates the opportunity to comment on the NQF MAP Pre-Rulemaking Input Report. Unfortunately, the NQF comment submission website limits public commenters to providing no more than 3,000 characters in each of the nine comment sections for the 209-page draft report. The draft report reviews 478 potential quality measures that, if implemented by CMS or other payers, will

have a powerful influence on the care patients receive. This comment letter on just 21 of those measures is nine pages long and exceeds 20,000 characters. Patients deserve thoughtful, nuanced consideration of the scientific evidence supporting potential quality measures—and of the measures' potential intended and unintended consequences. Developing high-quality performance measures is an extremely difficult process that demands meticulous deliberation of the possible risks and benefits. In future years, ASN recommends that NQF eliminate restrictions on the number of characters public commenters may use on the comment submission website so stakeholders may provide more detailed, meaningful feedback.

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#### **AmeriHealth Mercy Family of Companies**

##### **Thomas James**

AmeriHealth Mercy Family of Companies respectfully suggests that in creating the balance of parsimony (to reduce burden and focus attention) that we not become too limited in the areas of quality measurement. There may need to be a reconsideration of the processes around measure gap identification and measure development to maximize improvement in quality of systems and of outcomes. This may take a look at how other disciplines measure complex multivariant processes; and borrow from such diverse views as the social sciences and engineering.

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#### **AMGEN Inc.**

##### **Sharon Isonaka**

By way of our participation in this pre-rulemaking public comment period conducted by the National Quality Forum (NQF) Measure Application Partnership (MAP), Amgen would like to note our appreciation for the opportunity to comment on quality measures under consideration by the Centers for Medicare and Medicaid Services (CMS) for potential use in 2013 federal rulemaking. Amgen supports evidence-based quality improvement initiatives and believes that such initiatives offer a valuable opportunity to improve care for patients, especially those with cardiovascular disease, cancer, osteoporosis, and end-stage renal disease. In particular, Amgen favors comprehensive measures to

improve lipid screening and lipid control. Although there are a few cancer-specific quality measures, in future years we hope CMS and the MAP consider inclusion of more measures that focus on quality improvement for cancer care. Amgen strongly believes that patients with post-menopausal osteoporosis, as well as those at greatest risk for developing post-menopausal osteoporosis and related fracture events, would substantially benefit from even more thoughtful and comprehensive quality measure development and implementation of both process- and outcomes-oriented metrics across appropriate federal programs. Finally, Amgen supports enhanced collaboration and partnership between measure developers and other engaged stakeholders to address on-going gaps and suboptimal performance in the prevention, screening, treatment, and reporting of these serious conditions.

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#### **Armstrong Institute for Patient Safety and Quality**

##### **Matt Austin**

On p.15 of the report, there is a mention of NQF considering 'graded endorsement', but no details were given on what that would look like....Could you please expand on what that would be?

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#### **ASC Quality Collaboration (ASC QC)**

##### **Donna Slosburg**

###### **A. ASC Representation on the MAP**

We recognize the efforts that have been made to balance the MAP's composition so that stakeholders and subject matter experts are appropriately represented. Although we are aware of ASC nominations, we have not been able to identify any MAP member who is directly and routinely involved in the ASC industry. Knowing the MAP seeks members who are invested in the outcomes of measurement decisions, we are pleased to share highlights of the substantive investment the ASC industry has made in advancing quality. To date, the NQF has endorsed six facility-level quality measures for ASCs developed by the ASC QC, all of which address focus areas such as patient safety, serious adverse events and processes to prevent surgical site infections. These measures have enhanced the ability of ASCs to report health care outcomes and processes in

a standardized manner to interested stakeholders. The ASC QC has also established voluntary public reporting of ASC quality data on the ASC QC website. These endeavors have been undertaken independently and voluntarily, and accomplished without federal incentive or penalty. They underscore the commitment of the industry and its stakeholders to performance measurement and improvement - and its ability to work collaboratively to achieve consensus and effect change. With approximately 5,300 Medicare-certified facilities across all 50 states, ASCs are an integral part of the health care delivery system. In fact, ASCs perform 40 percent of all outpatient surgeries and procedures in the United States - more than 22 million per year. Recognizing that ASCs constitute an entirely separate and unique health care supplier under federal regulations, the lack of ASC industry presence on the MAP is, in our opinion, a significant gap in representation and content matter expertise. As the MAP continues to work to assure optimal stakeholder balance, we believe that ASC representation is essential. We request this oversight be remedied as soon as possible, and certainly before the MAP Hospital Workgroup considers additional ASC matters.

#### B. MAP Public Comment Procedures

MAP takes pride in operating in a transparent manner, including soliciting and responding to public comments. In its strategic plan, MAP describes methods to facilitate stakeholder engagement. We believe that an essential part of the bi-directional flow of information is the consideration of public comments during MAP meetings. While MAP agendas currently include opportunities for public comment, these opportunities are scheduled after member discussion and voting on agenda items has been completed. We have found this particularly frustrating when key information has not been presented or misinformation is not corrected prior to decision-making. We strongly recommend MAP administrative procedures be revised such that public comment is solicited prior to, rather than after, voting on agenda items.

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#### Association of American Medical Colleges

##### Jennifer Faerberg

The AAMC appreciates the progress MAP has made

in its second year of operation. The discussions were robust with more of a strategic focus than occurred previously and allowed for critical conversations to occur. The AAMC supports MAP continuing to move in this direction. While the AAMC appreciates the progress MAP has made in its second year, there is still room for improvement. There is a distinct imbalance in the way measures are reviewed at the coordinating committee dependent upon site of service. Given the number of measures to review for the physician workgroup it is difficult to get to any level of detail for any particular measure and therefore, for the most part, the product from the workgroup stands. However, that is not the case for the hospital measures. A significant number of measures were re-voted at the coordinating committee without strong support from the full committee and without the benefit of the rich discussion at the workgroup level that lead to the final recommendation. The AAMC asks the MAP review that process to ensure a level of consistency, where possible, in the review of recommendations from the workgroups at the Coordinating Committee level. There seemed to be some confusion around the intention behind certain measures included in the measure list from CMS. In one instance, the use of an infection measure was questioned as the specifications were still being finalized and testing had not yet occurred. The group later learned that CMS was only considering the measure in an out year given its stage of development, which was unknown to the workgroup initially. It would be helpful in the future if CMS could provide more context to the measures, where appropriate, to inform the workgroup discussions.

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#### California Hospital Association

##### Alyssa Keefe

Appendix to Report Needed: The timeline for responding to CMS's request for input on nearly 500 measures is a daunting task. In order to meet the deadlines, CHA recognizes that not every discussion can be fully captured and memorialized in the report. However, CHA urges the MAP to develop an Appendix for future release that provides additional narrative regarding the context of the workgroup and coordinating committee discussion, the agreement or disagreement between the



workgroups and the coordinating committee and differing perspectives expressed by members regarding the appropriateness of measures. Some of the discussion regarding measures appropriate for payment programs took several hours for consensus to be reached – yet the richness of that discussion is not adequately captured in this report. In our view, this additional narrative provides support and documentation of the recommendations and also assists the public and CMS staff not present in the room with an understanding the recommendation rational. Finally, the workgroups operate very differently, with the hospital workgroup voting on nearly every measure, some measures moving forward with a margin of less than three votes as opposed to the post-acute care workgroup that operates at a much higher level. CHA urges the NQF to find a way to capture this information and incorporate it into a report that can be made publicly available.

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### **Children’s Hospital Association**

#### **Ellen Schwalenstocker**

On behalf of over 220 member hospitals committed to advancing child health through innovation in the quality, cost and delivery of health care, the Children’s Hospital Association appreciates the opportunity to comment on the MAP Pre-rulemaking Report Draft. The Association is appreciative of the vast effort that went into developing the draft report and the thoughtful deliberation of the MAP Workgroups and Coordinating Committee. We offer the following general comments.

It would be helpful to consistently list the reason measures were not supported. Reasons are usually listed, but not always. As the “enterprise” continues to evolve, it will be important to maintain an accurate history of deliberations.

At times, there appears to be inconsistency in the tables. For example, for measure M2448 (p. 56), the table states the measure is not NQF endorsed, but the MAP conclusion and rationale states “supports – NQF endorsed measure.” M2762, 2763, and 2764 (p. 87) are additional examples.

Medicaid should be included under the description of care settings included in the Medicare and Medicaid

EHR Incentive Program (p. 114).

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### **Consumer-Purchaser Disclosure Project**

#### **Tanya Alters**

In the Executive Summary, CPDP has a number of comments on the Executive Summary discussion of themes. First, when discussing system-level measurement as a catalyst for patient-centered approaches to measurement, we ask that MAP clarify what system-level measurement means, and also clarify that while the goal is certainly to have patient-centered measures (as opposed to our silo’d/condition- and/or procedure-specific measures of today), the reality is that we are using those non-patient-centered measures to measure ACO and other system-level quality currently. We suggest putting a call out specifically for patient-centered measures, in order to make this theme into something more actionable.

On the next theme re: performance measure rigor to match increasing accountability, we note that 1) it is actually increasing incentives that are driving this accountability, and 2) the MAP did not come to consensus on this notion. In the section following the bulleted themes, we want to applaud the MAP and NQF for their intention to play an activist role in filling measure gaps. We are very pleased to see them taking on this responsibility hope to be able to help and collaborate on this. Later in the Executive Summary in the section on Alignment with the National Quality Strategy, we would suggest that in the language under Figure 1 where the report first discusses the recommendation categories of “support” or “support direction,” MAP clarify that “support direction” is actually conditional support. We understand that this is discussed in more detail much later in the report but we believe it would be very helpful to all readers to make that point clear from the beginning, and then reference where in the report this is discussed more thoroughly, in the “next steps” section in particular.

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### **Dartmouth College**

#### **Jon Skinner**

My comments relate to general issues surrounding risk adjustment for any performance measure. Here’s

the problem - standard risk adjustment methods, for example the Hierarchical Condition Categories (HCCs) tend to bias quality measures to reward more intensive healthcare systems. Doctors often need a diagnosis to bill Medicare. Hence patients who live in regions with intensive systems of healthcare tend to see more doctors, and as a consequence tend to be diagnosed with more disease -- even if they are no sicker than those in less intensive regions.

The net result of this risk-adjustment bias is to make the most expensive and intensive healthcare systems look as if they provide better “risk-adjusted” quality. In one study (Song et al, NEJM, July 1 2010), we showed that Medicare enrollees who moved to intensive regions experienced a 19% higher HCC score, and as a consequence a 15% lower risk-adjusted mortality rate. Once systems are rewarded for better risk-adjusted spending and outcomes, these biases will become even worse.

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## Federation of American Hospitals

### Samantha Burch

The FAH applauds the MAP for making real progress in the second year of pre-rulemaking review, building on last year’s efforts, including the development of “families of measures.” We also appreciate the focus on creating greater coordination across programs and believe the identification of guiding principles was helpful in facilitating the discussion and honing in on key program differences. We encourage the MAP moving forward to place more emphasis on executing the MAP Strategic Plan’s goals and objectives.

In general, the FAH supports the development of valid, reliable and useful cost and resource use measures. However, we believe it is critical that these measures not be looked at in a vacuum, but be tightly linked to quality of care. The cost-quality equation must be balanced in order to provide useful data for the end user.

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## HANYS Quality Institute

### Kathleen Ciccone

HANYS strongly supports the MAP’s work, which aims to improve our nation’s health care system by gathering stakeholder input to inform the selection of

quality measures for federal reporting and payment programs. This past year, the MAP has made considerable progress in fostering stronger alignment between quality reporting and payment across programs by focusing on consistent priority areas and principles. In the future, HANYS urges the MAP to take additional steps to more concretely enhance the alignment of quality measurement reporting and payment efforts. Developing a standard set of measures not only will help providers enhance quality of care, but will also reduce the data collection burden on hospitals.

HANYS continues to work with the American Hospital Association (AHA) to promote alignment of quality measures across federal programs and supports the recommendations put forth by the AHA. In particular, HANYS urges the MAP to consider the following suggestions:

- Measures under consideration for Centers for Medicare & Medicaid Services (CMS) programs should be chosen to ensure a focus on the issues that patients, providers, and other stakeholders consider the most important.
- Measures used in reporting and payment programs should be consistent with the purpose and goals of each program. Inclusion of each measure should support improvement in the safety, quality, and efficiency of care.
- The MAP should only recommend measures that have been endorsed by the National Quality Forum (NQF).
  - Measures that are not NQF-endorsed, but are already finalized in programs should be submitted for NQF review. If a measure does not receive endorsement, it should be removed from the program;
  - Measures that lose their NQF endorsement also should be removed from the programs;
- NQF-endorsed measures used in federal programs must be applied in a manner consistent with how the measures are specified and tested when endorsed. If CMS intends to use a given measure differently in a program, the measure should not be implemented until testing results for this new measure demonstrates a comparable level of reliability and validity as when it was initially

reviewed by the NQF.

- The MAP should be stringent in its selection of measures to ensure that providers are focusing on critical aspects of care that need improvement. Taking a more focused approach will also help consumers find helpful information about health care quality.
- The same measure should not be used in more than one pay-for-performance (payment penalty) program. Inconsistencies in the programs' goals, reporting methods, and performance benchmarks can lead to confusion about the true state of organizational performance.
- The MAP should explicitly call for consideration of socioeconomic adjustments in readmission measures and other measures that span the health care continuum.
- The MAP should include additional categories or more detailed rationales for committee decisions on measures beyond the established criteria of Support Direction, Phased Removal, Do Not Support, or Insufficient Information. More detailed information is useful to providers, associations, and CMS in understanding the position of the MAP for each specific measure.
- The MAP should request additional information from NQF related to measurement burden, including:
  - The types of labor involved in each type of data collection, including abstracted, survey reported, structural, and claims-based data collection;
  - The time involved for providers to learn about and implement the measures as they change
  - The time involved for providers to collect and report the data;
  - The costs for technology and vendor assistance;
  - The barriers that exist to successfully implementing quality measures.

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## Intermountain Healthcare

### Jan A. Orton

We spent significant time reviewing measures including the MAP measures for federal consideration.

From our review this year, I would like to offer some suggestions that might make it easier for hospitals

and healthcare systems to review the report.

1. My preference would be to see the measures in an excel format. In this way, one could filter by the types of measures that are important to a particular organization.

2. I would recommend that you have a column that identifies if this is a new measure, an updated measure, or a previous measure without change.

3. If you cannot provide an excel file, I would recommend that, when creating the PDF file, that you use the feature to NOT BREAK across pages.

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## Medical Imaging & Technology Alliance

### Gail Rodriguez

The Medical Imaging and Technology Alliance (MITA) is pleased to submit comments on the Measures Application Partnership (MAP) 2013 Draft Pre-Rulemaking Report ("draft report") published for public comment in January 2013 which includes 501 measures for consideration to comply with Section 1890A of the Social Security Act. As the leading trade association representing medical imaging, radiotherapy, and radiopharmaceutical manufacturers, we have in-depth knowledge of the significant benefits to the health of Medicare beneficiaries that medical imaging and radiotherapy provide. The comments below reflect a subset of our full comments which were submitted to MAP via email as directed by NQF staff.

Our comments on the 2013 draft report reference our position that HHS should only use measures that are National Quality Forum (NQF) endorsed. MITA supports the inclusion of measures that support use of the right imaging services at the right time. However, without the public transparency and deliberation of the NQF endorsement process, we lack the information to support measures lacking NQF endorsement and are concerned that they may not achieve their stated goals. We encourage HHS to consider measures only after they have received the consideration and approval of the NQF.

We also encourage MAP to use caution in endorsing efficiency measures for diagnostic services. In this regard, the draft report states:

The priority area related to improving the

affordability of care is a target for increasing the use of relevant measures. MAP supported or supported in direction 78 percent of the measures under consideration for affordability, the highest level of any of the priorities.

We understand and concur with MAP's determination that increased focus should be placed on measures that relate to the affordability of care; however, in the case of medical imaging, we urge MAP to view with caution measures that relate solely to the volume of diagnostic tests performed. Diagnostic imaging efficiency measures should take into account unnecessary procedures averted through performance of the test at issue. This comprehensive approach is substantially more likely to result in enhanced value for patients.

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### Medical Imaging & Technology Alliance

#### Gail Rodriguez

Our comments on the 2013 draft report reference our position that HHS should only use measures that are National Quality Forum (NQF) endorsed. MITA supports the inclusion of measures that support use of the right imaging services at the right time. However, without the public transparency and deliberation of the NQF endorsement process, we lack the information to support measures lacking NQF endorsement and are concerned that they may not achieve their stated goals. We encourage HHS to consider measures only after they have received the consideration and approval of the NQF. We also encourage MAP to use caution in endorsing efficiency measures for diagnostic services. In this regard, the draft report states: The priority area related to improving the affordability of care is a target for increasing the use of relevant measures. MAP supported or supported in direction 78 percent of the measures under consideration for affordability, the highest level of any of the priorities. We applaud MAP's recommendation to remove four imaging outpatient measures that lacked NQF endorsement in its 2012 Final Pre-Rulemaking Report:

Mammography Follow Up Rates (OP-9),

Abdomen CT: Use of Contrast Material (OP-10),

Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT) (OP-14), and

Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache (OP-15).<sup>3</sup>

MAP stated support for the direction of these measures from the Hospital Outpatient Quality Reporting (OQR) program, but noted that they require further development before inclusion in Centers for Medicare and Medicaid Services (CMS) programs. We commend MAP on this and believe that measures lacking NQF endorsement included in the 2013 draft report should be similarly removed from CMS programs.

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### National Bone Health Alliance

#### Beatriz Duque Long

NBHA believes that performance measures around post-fracture care and osteoporosis should be a priority, given the lack of attention by clinicians and patients to fractures and osteoporosis and clear evidence that better diagnosis, treatment and patient support after a fracture will lead to decreases in the incidence of subsequent fractures, reduced healthcare costs and improved health outcomes. Process and outcomes measures, and measure alignment across programs, can improve post-fracture care while also reducing the reporting burden and thus encouraging adoption and reporting of the measures.

NBHA will continue to work towards developing greater clinicians awareness and appreciation for proactive post-fracture patient management, which includes not only developing the tools and resources needed for improving post-fracture care, but also supporting efforts to identify and address coordination of care gaps, as well as supporting wider use and alignment of osteoporosis quality measures that can yield immediate economic savings to the Medicare system and greatly enhance the quality of life for fracture patients.

NBHA appreciates the opportunity to comment on the performance measures under consideration by HHS for potential use in federal rulemaking in 2013, via the public comment period conducted by MAP as part of the development of the MAP Pre-Rulemaking Report. NBHA is pleased to support activities around osteoporosis quality management and looks

forward to working with MAP, CMS, HHS and other stakeholders to improve clinician awareness of and participation in osteoporosis quality measurement that better meet the needs of patients, clinicians, MAP and HHS in the years ahead.

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### **National Coalition for Hospice and Palliative Care**

#### **Timothy Quill**

The Coalition also asks you to take note of a supplementary file submitted separately by the American Academy of Hospice and Palliative Medicine (AAHPM). This file shows a crosswalk AAHPM developed between the MAP measurement framework for hospice and palliative care and the recommended measures endorsed by MAP. This crosswalk clearly shows that there are no or few measures of palliative care domains for hospitals, long-term care hospitals, or ESRD - all settings caring for people with serious illness. The current discussion of measure gaps does not sufficiently highlight the complete absence of palliative care measures for hospitals. We note that ASCO is currently conducting a project to develop new measures for PPS-exempt Cancer Hospitals. Many of the measures to be developed fit palliative care domains. With additional testing and modification, these new measures may form the basis for a palliative care measure set for acute hospitals. We urge MAP to make development of a palliative care measure family applicable across settings the highest priority. While we have noted the urgent need to develop measures for the hospital setting, we also note that there are many missed opportunities to improve the quality and continuity of care across the illness trajectory, including home-based care. The palliative care measure family should ideally be cross-cutting across the entire illness trajectory and all sites of care. Most patients prefer to be home if possible, and our care setting and measure system should support and reflect this.

\*Note on language: the Gap report refers to Advanced Illness Care. The National Coalition for Hospice and Palliative Care prefers to use the term Serious Illness. The concern is that if one waits until an illness is "advanced"--an unspecific time that many providers may not recognize--you may miss the opportunity to provide quality symptom management and comfort when it is needed.

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### **Outpatient Ophthalmic Surgery Society; Am Soc of Cataract and Refractive Surgery**

#### **Michael Romansky**

General Comment on MAPS Process for Selection of Measures

ASCRS and OOSS support the goal of harmonizing the quality measures applied to the various surgical environments - where appropriate. However, the MAPS recommendation that two Physician Quality Reporting System (PQRS) cataract-specific measures be adopted for ASCs reflects a fundamental misunderstanding of the operation of the surgery center. Simply stated, the ASC is ill-equipped to evaluate potential cataract outcomes because the facility is not involved in the baseline events preceding surgery against which outcomes are measured or the post-surgical events that encompass the healing process. Under the Medicare program, an ASC operates "exclusively" for the purpose of furnishing ambulatory surgical services to patients. Although the governing regulations permit the surgical facility to exist adjacent to a physician's office under certain circumstances, Medicare ASC Conditions for Coverage state very clearly that the two entities must be physically, administratively, and financially separate from one another. Among the operative requirements: medical recordkeeping must always be maintained separately and exclusively from other operations. In other words, even though a physician in the clinic may perform surgery in the ASC next door, the medical records of one entity are never readily accessible by the other. As a practical matter, the ASC is staffed by registered nurses, operating room technicians, and clerical staff who are neither qualified to evaluate surgical outcomes nor located in the physician's office where pre-operative and post-operative care might be efficiently and accurately evaluated. Physician-level measures such as those incorporated within PQRS were formulated to assess quality within the physician's office. ASC-level measures should relate to episodes that occur within the ASC, encompass data that is available within the ASC chart, be collectable by ASC staff, and generate conclusions that are actionable by the facility. Our organizations look forward to collaborating with CMS, the ASCQC and others in developing appropriate ophthalmic ASC-level measures.

Comment on ASC Representation on the MAP

ASCRS and OOSS share the concern submitted in comments by the ASC Quality Collaboration that the MAP must incorporate representation of experts from within the ASC community. The ASC industry is composed of over five thousand providers that perform 40 percent of the surgery procedures in the United States. ASCs are highly regulated and, effective in 2012, subject to quality reporting requirements. There exists an impressive commitment to and infrastructure for quality reporting in the ASC community; indeed, the ASC Quality Collaboration has developed six facility-level quality measures that have been endorsed by the NQF and adopted by CMS, enhancing the ability of surgery centers to report health outcomes and processes in a standardized manner to governments, insurers, accreditation entities, the public and others. The MAP should immediately act to ameliorate this gap content matter expertise by expanding ASC representation on relevant MAP entities.

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## Pfizer

### Eleanor Perfetto

Pfizer encourages MAP to review all recommended measure titles and specifications to ensure they reflect the latest evidence-based information. This will be critical as the Department of Health and Human Services reviews the report and considers whether individual measures should be included in various programs. Stakeholders look to MAP and HHS to guide their decision-making; thus, currency and timeliness of measures is critical.

An example of an outdated measure title in the current document is “Pneumococcal Immunization (PPV 23)” (NQF #1653). This measure is recommended for inclusion in the Hospital Value-Based Purchasing program (supported) and End Stage Renal Disease Quality Improvement program (direction supported). However, per the 2012 update by the Centers for Medicare & Medicaid Services and the Joint Commission, this measure should be entitled “Pneumococcal Immunization”.

[1] Recommendations from the Advisory Committee on Immunization Practices (ACIP) indicate the varying clinical circumstances under which the polysaccharide or conjugate pneumonia vaccines

should be administered.<sup>2</sup> Therefore, it important the measure supports appropriate application of the ACIP recommendations. Failure to update measures per the latest evidence-based recommendations could result in confusion regarding appropriate therapy recommendations and care processes.

[1] QualityNet. “Specifications Manual, Version 4.2b.” p. 40. <http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTieR4&cid=1228772433589>. Accessed 23 January 2013.

[2] Pillshvilli, Tamara. “Recommendations for Pneumococcal Vaccine use Among Immunocompromised Adults.” A presentation to the Advisory Committee on Immunization Practices. June 20, 2012. Atlanta, GA.

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## PhRMA

### Jennifer Van Meter

PhRMA commends the MAP for supporting measures for use in federal programs that are well-grounded in current best evidence and have attained stakeholder consensus endorsement, such as those that have achieved NQF-endorsement. PhRMA has a long-held position that measures used in federal programs should have attained multi-stakeholder consensus endorsement, and we appreciate that the MAP, a multi-stakeholder private-public partnership, largely agrees. We encourage the MAP to continue to recommend use of up-to-date, evidence-based consensus measures that can improve longer-term outcomes. PhRMA commends the MAP for suggesting that measures be specified and tested at the reporting level at which they will be implemented. In other words, we agree that measures that have been specified at the population-level should not be applied at the individual clinician-level without modifying the specifications and testing the measures, as appropriate. Misapplication of measures could provide misleading or inaccurate results.

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## Renal Physicians Association

### Robert Blaser

RPA appreciates that the MAP has increased its categories to describe potential measure categories. MAP pre-rulemaking report, however, primarily uses the “support” or “do not support” categories when

reviewing and making recommendations regarding measures. Further, some measures assigned to the “do not support” category contain no explanation for not supporting the measure, while other measures categorized as “do no support” have a specific explanation concerning why the measure should not be supported, or the measure is categorized as “insufficient information” with an explanation of what additional information is needed to move forward with the measure. For example, measures 2524, 2525, 2526 and 2530 provide no information about why they were not supported.

To clear up this confusion and provide more accurate information, the RPA urges the MAP to make greater use of the “insufficient information” and “phased removal” categories. Also, the RPA recommends that the MAP take steps to ensure a more consistent and standardized approach in categorizing measures and describing why a measure is categorized in a certain manner. For example, the MAP Workgroup Chairs could meet prior to making recommendations to the MAP to develop a strategy for increased use and greater standardization of these categories.

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## **Takeda Pharmaceuticals**

### **Deborah Walter**

Takeda Pharmaceuticals America, Inc. and Lundbeck LLC are pleased to submit comments on the Measure Applications Partnership’s “List of Measures under Consideration” for potential use in programs within the Department of Health and Human Services (HHS). As leading global research organizations, we have expertise in developing therapies to treat a variety of chronic and life-threatening diseases. We recognize the importance of the work that NQF and MAP do to ensure appropriate measure development and use.

We believe that key measures will help improve the quality of care that depression patients receive and strongly support additional measurement efforts to increase patient education and engagement, care coordination, monitoring of functional status and productivity, and evaluation of residual symptoms.

One measure in particular, M2509 “Adult MDD: Coordination of Care of Patients with Comorbid Conditions,” begins to address an important measure

gap. Takeda and Lundbeck support the inclusion of this measure in the Physician Quality Reporting System (PQRS) and agree that this measure should be submitted for NQF endorsement. Both the American Psychiatric Association (APA) and the Veterans Affairs/Department of Defense (VA/DoD) guidelines discuss the importance of properly identifying and monitoring existing or emerging medical conditions in depression patients.[1][2] As specified in the measure numerator, communication is defined as “transmission of relevant clinical information which specifies that the patient has major depressive disorder AND request for return communication.”[3]

We appreciate MAP’s willingness to consider our comments and look forward to continued engagement in MAP’s future efforts. Please feel free to contact me if you have any questions on these comments.

[1] American Psychiatric Association. (2010). Practice guideline for the treatment of patients with major depressive disorder: Third edition.

[2] Veterans Affairs and Department of Defense. (2009). VA/DoD clinical practice guideline for management of major depressive disorder (MDD).

[3] American Medical Association-convened Physician Consortium for Performance Improvement. (2012). Measure #7: Coordination of Care of Patients with Specific Comorbid Conditions. Adult Major Depressive Disorder Performance Measurement Set. Available at <http://www.ama-assn.org/resources/doc/cqi/no-index/adult-mdd-measures-specifications-vote.pdf>.

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## **The Joint Commission**

### **Margaret VanAmringe**

MAP Review Process

While The Joint Commission acknowledges that the MAP takes on a daunting task in evaluating hundreds of potential measures for inclusion in multiple programs, we are concerned that the time pressures and processes for this review can take away from the credibility of its results. There continues to be a very limited amount of time for the MAP and other stakeholders to review measures and priorities

before making recommendations to the Department of Health and Human Services (DHHS). It is nearly impossible to perform a sufficiently thorough assessment and discussion for the more than 500 measures presented for consideration by DHHS by the imposed deadlines. We strongly urge the MAP to request that CMS provide their list of measures much earlier in the process.

The Joint Commission also has concerns over the delineated MAP Decision Categories and the use of their associated rationales. First, there was some confusion during the MAP deliberations as to the full meaning of the “Support Direction” category. Some questioned whether there is meant to be a defined end-point for a measure assigned to this status -- that is, should direction be supported with an articulated expectation as to when the measure should be ready for use in a program? Others placed measures in this category for very different reasons. Therefore we recommend a more specified definition of what this category means and a consensus from the MAP as to its use. Further adding to the perplexity of the Decision Categories is the occasional disconnect between the MAP’s Conclusion and the noted Rationale. There are several instances where measures have been designated as being supported by the group; however, the recommendation to CMS is contingent on gaining NQF endorsement. By virtue of the standardized rationales set forth by the MAP, the measure should not have the designation of “Support”, but rather bear the “Support Direction” designation. The Joint Commission believes that the MAP must achieve greater clarity and/or instruction to the MAP to appropriately assign recommendations to the measures per the pre-determined decision categories and rationales. In addition, in the forthcoming MAP rulemaking cycles there should be information and details provided as to whether any specific actions were eventually taken on measures categorized at some point by the MAP as “Support Direction.”

#### Measure Criteria

Achieving gains in quality improvement is dependent on having tested, scientific and credible measures likely to result in improved health and health outcomes for patients. The Joint Commission encourages the MAP to revisit the area of measure

selection criteria. The absence of good measure criteria -- at the measure level -- also limits the usefulness of advice to CMS on why a measure was not selected by the MAP for recommendation. The Joint Commission has developed measure criteria for its programs to assess the strength of both clinical process and outcome measures, removing from its programs those measures that do not meet scientific and clinical credibility tests.

#### Potential for Burden

There is an inherent tension between the dual goals of measure parsimony and “filling in the gaps” for the many areas where there are not sufficient measures to assess the myriad of types of care and services. The Joint Commission encourages the MAP to remain cognizant of the need to only have high value measures in quality improvement programs. Utilizing measures that have not shown to promote better patient outcomes serve only to create additional burden, and lessen achievement toward the goal of parsimony. At the same time, it may not be feasible to measure all that one would like to through federal programs, given constraints of the direct and indirect costs associated with federal measurement programs. It may be worth considering priorities for measurement that address the most important areas for patients and patient care.

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#### Tri-Society (Gastroenterology)

##### Ronald Vender, Loren Laine, Thomas Deas

We recognize that reviewing more than 500 measures on the Department of Health and Human Services’ (HHS) list of measures under consideration for 20 federal programs is an immense undertaking. We appreciate the MAP’s efforts to make its recommendations more meaningful during its second cycle by employing measure-selection criteria and workgroup guiding principles to its decision-making process. Our societies participated in the recent two-day MAP meeting. We are also hopeful that further refinement of this process will result in less emphasis on past precedent (i.e. NQF endorsement) in making recommendations to the Centers for Medicare and Medicaid Services (CMS), and greater focus on increased specialty-specific expert review of measures under consideration, stakeholder participation and input during the meetings and



review process, and use of historical knowledge about current and past measures involved in the NQF endorsement process.

Our societies offer comments on the pre-rulemaking report in the following areas:

1. Gastroenterology Measures under Consideration for the PQRS
2. MAP Decision Categories and Rationale for Measures under Consideration
3. Clinician Workgroup Program Recommendations
4. Hospital Outpatient and the Ambulatory Surgery Center (ASC) Quality Reporting Program

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