## Measure Applications Partnership Coordinating Committee Discussion Guide

*Notes for Measure Deliberations*

*Version Number*: 3.6  
*Meeting Date:* January 26-27, 2016

## Full Agenda

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| **Day 1: January 26, 2016** |  |
|  |  |
| 9:30 AM | Breakfast |
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| 10:00 AM | **Welcome and Review of Meeting Objectives** |
|  | Beth McGlynn, MAP Coordinating Committee Co-Chair Harold Pincus, MAP Coordinating Committee Co-Chair |
| 10:30 AM | **MAP Pre-Rulemaking Approach Updates** |
|  | Erin O’Rourke, Senior Director, NQF Beth McGlynn   * Review the 2015-2016 MAP Pre-Rulemaking Approach * Discuss the implementation of measures under development pathway * Discuss the process to consider of gap filling measures |
| 11:30 AM | **MAP Pre-Rulemaking Strategic Issues** |
|  | Taroon Amin, NQF Consultant Harold Pincus   * Review the Risk-adjustment of Measures for Socioeconomic Status (SES) Trial Period * Discuss attribution and shared accountability * Discuss the importance of feedback loops |
| 12:30 PM | *Opportunity for Public Comment* |
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| 12:45 PM | Lunch |
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| 1:15 PM | **Pre-Rulemaking Recommendations for PAC/LTC Programs** |
|  | Carol Raphael, Workgroup Co-Chair Sarah Sampsel, Senior Director, NQF Erin O’Rourke Beth McGlynn   * Discuss key themes from the PAC/LTC Workgroup meeting * Review and finalize broader guidance about programmatic issues * Review and discuss input from the MAP Dual Eligible Beneficiaries Workgroup * Review and finalize workgroup measure recommendations |
|  | *Measures Requiring a Vote on MAP's Preliminary Recommendation* |
|  | This section of the meeting includes debate and voting on measures pulled by MAP Coordinating Committee members. |
|  | 1. **Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) (required by PAMA)** (MUC ID: MUC15-1048)    * *Description:* All-condition risk-adjusted potentially preventable hospital readmission rates (required under PAMA)    * *Programs under consideration:* Skilled Nursing Facility Value-Based Purchasing Program    * *Workgroup Rationale:* MAP members raised concerns about potential negative unintended consequences if SNFs are hesitant to transfer patients to the hospital to avoid penalties. Some MAP members noted the limited actionability of this measure and that increased granularity could provide information to improve care. However, other members stated that providers should implement their own systems for tracking and identifying these issues for quality improvement.CMS indicated that this measure would replace the current all-cause readmission as soon as practical.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 2. **Falls risk composite process measure** (MUC ID: MUC15-207)    * *Description:* Percentage of patients who were assessed for falls risk and whose care plan reflects the assessment and was implemented as appropriate.    * *Programs under consideration:* Home Health Quality Reporting Program    * *Workgroup Rationale:* MAP noted that this composite measure addresses falls risk and related clinical intervention assessments, which are considered safety measures and meet the goals of the Home Health QRP.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 3. **Hospice and Palliative Care Composite Process Measure** (MUC ID: MUC15-231)    * *Description:* This measure will assess percentage of hospice patients who received care processes consistent with guidelines at admission. This is a composite measure based on select measures from 7 NQF-endorsed measures: NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617.    * *Programs under consideration:* Hospice Quality Reporting Program    * *Workgroup Rationale:* Although MAP encouraged continued development, members noted the need to balance this measure with what is relevant to the patient, and not limit to only check box quality measures.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 4. **Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)** (MUC ID: MUC15-236)    * *Description:* This quality measure estimates the risk-adjusted mean change in self-care score between admission and discharge among SNF residents. (*The endorsed specifications of the measure are: This measure estimates the risk-adjusted mean change in self-care score between admission and discharge for Inpatient Rehabilitation Facility (IRF) Medicare patients.*)    * *Programs under consideration:* Skilled Nursing Facility Quality Reporting System    * *Workgroup Rationale:* The functional status measures are adaptations of currently endorsed measures for the IRF population. MAP encouraged continued development to ensure alignment across PAC settings, but also noted there should be some caution in interpretation of measure results due to patient differentiation between facilities.MAP also stressed the importance of considering burden on providers when measures are considered for implementation.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 5. **Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Home Health Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1127)    * *Description:* Percentage of stays Inpatient Rehabilitation Facility (IRF), Long Term Care Facility (LTCH), and Skilled Nursing Facility (SNF) or care episodes Home Health (HH) in which a drug regimen review was conducted at the Admission (IRF, LTCH or SNF)/ Start of Care (SOC)/ Resumption of Care (ROC) (HH) and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay (IRF, LTCH, or SNF) or care episode (HH).    * *Programs under consideration:* Home Health Quality Reporting Program    * *Workgroup Rationale:* MAP noted the importance of medication reconciliation but raised concerns and asked for greater clarity about the definition of reconciliation versus drug regimen review. Members also noted the challenge of defining some of the measure components, specifically “a clinically significant issue” given the large number of medications a patient may be taking. MAP stressed that medication reconciliation is a step in a drug regimen review and asked for greater clarity on defining the drug regimen review process. MAP stressed the importance of conducting a complete medication review from all sites of care, including the home. MAP members noted the value of the role of family caregivers in providing this information and the hope that technology can help to minimize the burden of getting this information. MAP members asked for greater emphasis of the inclusion of non-prescription medication (including supplements), noting that this is a particular concern in the PAC/LTC population.MAP members raised some concerns about the feasibility of this measure and noted the need to clarify the roles of the interdisciplinary team. MAP noted the importance of attribution issues for this measure. Additionally, Workgroup members raised concerns about the challenges of competing guidelines and need for greater clarity about when a medication can be withdrawn. MAP stressed that medication reconciliation needs to be an on-going process. MAP also noted that this is a particular concern for dual-eligible beneficiaries.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 6. **Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Inpatient Rehabilitation Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1128)    * *Description:* Percentage of stays Inpatient Rehabilitation Facility (IRF), Long Term Care Facility (LTCH), and Skilled Nursing Facility (SNF) or care episodes Home Health (HH) in which a drug regimen review was conducted at the Admission (IRF, LTCH or SNF)/ Start of Care (SOC)/ Resumption of Care (ROC) (HH) and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay (IRF, LTCH, or SNF) or care episode (HH).    * *Programs under consideration:* Inpatient Rehabilitation Facility Quality Reporting Program    * *Workgroup Rationale:* MAP noted the importance of medication reconciliation but raised concerns and asked for greater clarity about the definition of reconciliation versus drug regimen review. Members also noted the challenge of defining some of the measure components, specifically “a clinically significant issue” given the large number of medications a patient may be taking. MAP stressed that medication reconciliation is a step in a drug regimen review and asked for greater clarity on defining the drug regimen review process. MAP stressed the importance of conducting a complete medication review from all sites of care, including the home. MAP members noted the value of the role of family caregivers in providing this information and the hope that technology can help to minimize the burden of getting this information. MAP members asked for greater emphasis of the inclusion of non-prescription medication (including supplements), noting that this is a particular concern in the PAC/LTC population.MAP members raised some concerns about the feasibility of this measure and noted the need to clarify the roles of the interdisciplinary team. MAP noted the importance of attribution issues for this measure. Additionally, Workgroup members raised concerns about the challenges of competing guidelines and need for greater clarity about when a medication can be withdrawn. MAP stressed that medication reconciliation needs to be an on-going process. MAP also noted that this is a particular concern for dual-eligible beneficiaries.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 7. **Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Long-Term Care Hospital Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1129)    * *Description:* Percentage of stays Inpatient Rehabilitation Facility (IRF), Long Term Care Facility (LTCH), and Skilled Nursing Facility (SNF) or care episodes Home Health (HH) in which a drug regimen review was conducted at the Admission (IRF, LTCH or SNF)/ Start of Care (SOC)/ Resumption of Care (ROC) (HH) and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay (IRF, LTCH, or SNF) or care episode (HH).    * *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program    * *Workgroup Rationale:* MAP noted the importance of medication reconciliation but raised concerns and asked for greater clarity about the definition of reconciliation versus drug regimen review. Members also noted the challenge of defining some of the measure components, specifically “a clinically significant issue” given the large number of medications a patient may be taking. MAP stressed that medication reconciliation is a step in a drug regimen review and asked for greater clarity on defining the drug regimen review process. MAP stressed the importance of conducting a complete medication review from all sites of care, including the home. MAP members noted the value of the role of family caregivers in providing this information and the hope that technology can help to minimize the burden of getting this information. MAP members asked for greater emphasis of the inclusion of non-prescription medication (including supplements), noting that this is a particular concern in the PAC/LTC population.MAP members raised some concerns about the feasibility of this measure and noted the need to clarify the roles of the interdisciplinary team. MAP noted the importance of attribution issues for this measure. Additionally, Workgroup members raised concerns about the challenges of competing guidelines and need for greater clarity about when a medication can be withdrawn. MAP stressed that medication reconciliation needs to be an on-going process. MAP also noted that this is a particular concern for dual-eligible beneficiaries.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 8. **Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1130)    * *Description:* Percentage of stays Inpatient Rehabilitation Facility (IRF), Long Term Care Facility (LTCH), and Skilled Nursing Facility (SNF) or care episodes Home Health (HH) in which a drug regimen review was conducted at the Admission (IRF, LTCH or SNF)/ Start of Care (SOC)/ Resumption of Care (ROC) (HH) and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay (IRF, LTCH, or SNF) or care episode (HH).    * *Programs under consideration:* Skilled Nursing Facility Quality Reporting System    * *Workgroup Rationale:* MAP noted the importance of medication reconciliation but raised concerns and asked for greater clarity about the definition of reconciliation versus drug regimen review. Members also noted the challenge of defining some of the measure components, specifically “a clinically significant issue” given the large number of medications a patient may be taking. MAP stressed that medication reconciliation is a step in a drug regimen review and asked for greater clarity on defining the drug regimen review process. MAP stressed the importance of conducting a complete medication review from all sites of care, including the home. MAP members noted the value of the role of family caregivers in providing this information and the hope that technology can help to minimize the burden of getting this information. MAP members asked for greater emphasis of the inclusion of non-prescription medication (including supplements), noting that this is a particular concern in the PAC/LTC population.MAP members raised some concerns about the feasibility of this measure and noted the need to clarify the roles of the interdisciplinary team. MAP noted the importance of attribution issues for this measure. Additionally, Workgroup members raised concerns about the challenges of competing guidelines and need for greater clarity about when a medication can be withdrawn. MAP stressed that medication reconciliation needs to be an on-going process. MAP also noted that this is a particular concern for dual-eligible beneficiaries.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 9. **Medicare Spending Per Beneficiary-Post Acute Care (PAC) Home Health Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1134)    * *Description:* The MSPB-PAC Measure for HHAs evaluates providers’ efficiency relative to the efficiency of the national median HHA provider. Specifically, the MSPB-PAC Measure assesses the cost to Medicare for services during an episode of care, which consists of a treatment period and an associated services period. The episode is triggered by the initiation of a 60 day HHA service period. The treatment period begins at the trigger and ends on the last day of the service period. The associated services period begins at the trigger and ends 30 days after the end of the treatment period. These periods constitute the episode window during which beneficiaries’ Medicare services are counted toward the episode. The MSPB-PAC episode includes all services during the episode window that are attributable to the HHA provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to HHA responsibilities (e.g., planned care and routine screening).    * *Programs under consideration:* Home Health Quality Reporting Program    * *Workgroup Rationale:* Members noted the importance of balancing cost measures with quality and access. Although the MAP encouraged continued development, they did note concerns about the potential for unintended consequences. In particular, the group raised concerns about issues of premature discharges. The group noted this could put a tremendous burden on family caregivers who may have to care for a patient they are not fully able to support. Members also noted the need to consider risk adjustment for severity and socioeconomic status.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 10. **Medicare Spending per Beneficiary-Post Acute Care (PAC) Inpatient Rehabilitation Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-287)     * *Description:* The MSPB-PAC Measure for IRFs evaluates providers’ efficiency relative to the efficiency of the national median IRF provider. Specifically, the MSPB-PAC Measure assesses the cost to Medicare for services during an episode of care, which consists of a treatment period and an associated services period. The episode is triggered by an admission to an IRF stay. The treatment period begins at the trigger and ends at discharge. The associated services period begins at the trigger and ends 30 days after the end of the treatment period (i.e., discharge). These periods constitute the episode window during which beneficiaries’ Medicare services are counted toward the episode. The MSPB-PAC episode includes all services during the episode window that are attributable to the IRF provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to IRF responsibilities (e.g., planned care and routine screening).     * *Programs under consideration:* Inpatient Rehabilitation Facility Quality Reporting Program     * *Workgroup Rationale:* MAP noted that socioeconomic status is a particular concern for IRFs. Patients need social supports to be able to return to the community with a disability. Additionally, it was suggested that providers who are teaching facilities and serve low income patients may have higher costs than others.     * *Workgroup Recommendation:* Encourage continued development     * *Notes:* 11. **Medicare Spending per Beneficiary-Post Acute Care (PAC) Long-Term Care Hospital Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-289)     * *Description:* The MSPB-PAC Measure for LTCHs evaluates providers’ efficiency relative to the efficiency of the national median LTCH provider. Specifically, the MSPB-PAC Measure assesses the cost to Medicare for services during an episode of care, which consists of a treatment period and an associated services period. The episode is triggered by an admission to an LTCH stay. The treatment period begins at the trigger and ends at discharge. The Measure is constructed differently for cases in which the LTCH stay is paid according to the standard MS-LTC-DRG versus cases in which the LTCH stay is paid a site neutral rate comparable to the IPPS payment rates. The associated services period for standard payment rate cases begins at the trigger and ends 30 days after the end of the treatment period (i.e., discharge). The associated services period for site neutral payment rate cases begins at the close of the treatment period and ends 30 days after, to parallel the MSPB-Hospital measure. For the standard and site neutral cases, these periods constitute the episode window during which beneficiaries’ Medicare services are counted toward the episode. For the standard cases, the MSPB-PAC episode includes all services during the episode window that are attributable to the LTCH provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to LTCH responsibilities (e.g., planned care and routine screening). For the site neutral cases, the MSPB-PAC episode includes all services during the episode window that are attributable to the LTCH provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to LTCH responsibilities (e.g., planned care and routine screening). As discussed above, there is a difference in the construction of the associated services period for these cases, in that it only begins at discharge and ends 30 days after.     * *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program     * *Workgroup Rationale:* Members noted the importance of balancing cost measures with quality and access. Although the MAP encouraged continued development, they did note concerns about the potential for unintended consequences.     * *Workgroup Recommendation:* Encourage continued development     * *Notes:* 12. **Medicare Spending per Beneficiary-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-291)     * *Description:* The MSPB-PAC Measure for SNFs evaluates providers’ efficiency relative to the efficiency of the national median SNF provider. Specifically, the MSPB-PAC Measure assesses the cost to Medicare for services during an episode of care, which consists of a treatment period and an associated services period. The episode is triggered by an admission to a SNF stay. The treatment period begins at the trigger and ends at discharge. The associated services period begins at the trigger and ends 30 days after the end of the treatment period (i.e., discharge). These periods constitute the episode window during which beneficiaries’ Medicare services are counted toward the episode. The MSPB-PAC episode includes all services during the episode window that are attributable to the SNF provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to SNF responsibilities (e.g., planned care and routine screening).     * *Programs under consideration:* Skilled Nursing Facility Quality Reporting System     * *Workgroup Rationale:* Members noted the importance of balancing cost measures with quality and access. Although the MAP encouraged continued development, they did note concerns about the potential for unintended consequences. The group also raised concerns about the impact on rural providers. Additionally, MAP raised concerns that measuring acute and post-acute care separately could discourage innovative partnerships between hospitals and PAC/LTC providers.     * *Workgroup Recommendation:* Encourage continued development     * *Notes:* |
|  | *Measures Identified for Discussion (No Vote Required)* |
|  | This section of the meeting includes discussion on specific measures (no vote required) where MAP Coordinating Committee members would like to add themes to the recommendation rationale or better understand the workgroup deliberations. |
|  | 1. **Discharge to Community-Post Acute Care (PAC) Inpatient Rehabilitation Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-408)    * *Description:* This measure describes the risk-standardized rate of Medicare fee-for-service (FFS) patients/residents/persons who are discharged to the community following a post-acute stay/episode, and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community.    * *Programs under consideration:* Inpatient Rehabilitation Facility Quality Reporting Program    * *Workgroup Rationale:* MAP noted that available discharge codes and coding practices could cause confusion about the results of this measure and could also introduce validity concerns. MAP asked for greater clarity about the intent of these measures, especially how they may impact patients and consumers. MAP members raised concerns about the multiple ways that readmissions are being measured and noted that a provider could potentially be penalized multiple times for the same occurrence. MAP noted the need for excluding patients who are admitted to hospice to prevent discouraging discharges to hospice. MAP also noted that discharge to community can reflect access to social support and the measure may need to reflect this. MAP indicated the need for these measures to be submitted for NQF review and endorsement to address psychometric concerns about the measures.MAP members noted concerns about the risk adjustment of these measures, particularly for the home health setting. MAP specifically noted the need to appropriately risk adjust the measures to avoid unintended consequences.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 2. **Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-414)    * *Description:* This measure describes the risk-standardized rate of Medicare fee-for-service (FFS) patients/residents/persons who are discharged to the community following a post-acute stay/episode, and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community.    * *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program    * *Workgroup Rationale:* MAP noted that available discharge codes and MAP noted that available discharge codes and coding practices could cause confusion about the results of this measure and could also introduce validity concerns. MAP asked for greater clarity about the intent of these measures, especially how they may impact patients and consumers. MAP members raised concerns about the multiple ways that readmissions are being measured and noted that a provider could potentially be penalized multiple times for the same occurrence. MAP noted the need for excluding patients who are admitted to hospice to prevent discouraging discharges to hospice. MAP also noted that discharge to community can reflect access to social support and the measure may need to reflect this. MAP indicated the need for these measures to be submitted for NQF review and endorsement to address psychometric concerns about the measures.MAP members noted concerns about the risk adjustment of these measures, particularly for the home health setting. MAP specifically noted the need to appropriately risk adjust the measures to avoid unintended consequences.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 3. **Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-462)    * *Description:* This measure describes the risk-standardized rate of Medicare fee-for-service (FFS) patients/residents/persons who are discharged to the community following a post-acute stay/episode, and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community.    * *Programs under consideration:* Skilled Nursing Facility Quality Reporting System    * *Workgroup Rationale:* MAP noted that available discharge codes and coding practices could cause confusion about the results of this measure and could also introduce validity concerns. MAP asked for greater clarity about the intent of these measures, especially how they may impact patients and consumers. MAP members raised concerns about the multiple ways that readmissions are being measured and noted that a provider could potentially be penalized multiple times for the same occurrence. MAP noted the need for excluding patients who are admitted to hospice to prevent discouraging discharges to hospice. MAP also noted that discharge to community can reflect access to social support and the measure may need to reflect this. MAP indicated the need for these measures to be submitted for NQF review and endorsement to address psychometric concerns about the measures.MAP members noted concerns about the risk adjustment of these measures, particularly for the home health setting. MAP specifically noted the need to appropriately risk adjust the measures to avoid unintended consequences.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* |
|  | *Finalizing Workgroup Recommendations for All PAC/LTC Programs* |
|  | This section of the meeting finalizes the remaining workgroup recommendations for:   * [Home Health Quality Reporting Program](#MeasureListHH_Q) * [Hospice Quality Reporting Program](#MeasureListHQRP) * [Inpatient Rehabilitation Facility Quality Reporting Program](#MeasureListIRF) * [Long-Term Care Hospital Quality Reporting Program](#MeasureListLTCH) * [Skilled Nursing Facility Quality Reporting System](#MeasureListSNF) * [Skilled Nursing Facility Value-Based Purchasing Program](#MeasureListSVF-) |
| 2:15 PM | *Opportunity for Public Comment* |
|  |  |
| 2:30 PM | **Pre-Rulemaking Recommendations for Clinician Programs** |
|  | Bruce Bagley, Workgroup Chair Eric Whitacre, Workgroup Chair Reva Winkler, Senior Director, NQF Andrew Lyzenga, Senior Director, NQF Harold Pincus   * Discuss key themes from the Clinician Workgroup meeting * Review and finalize broader guidance about programmatic issues * Review and discuss input from the MAP Dual Eligible Beneficiaries Workgroup * Review and finalize workgroup measure recommendations |
|  | *Measures Requiring a Vote on MAP's Preliminary Recommendation* |
|  | This section of the meeting includes debate and voting on measures pulled by MAP Coordinating Committee members. |
|  | 1. **Surveillance colonoscopy for dysplasia in colonic Crohns Disease** (MUC ID: MUC15-212)    * *Description:* Percentage of patients with diagnosis of colonic Crohn’s Disease for 10 years or more that have documented colonoscopy in the measurement period or 1 year prior to measurement period.    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* Crohn's disease is a chronic inflammatory disease of the digestive tract. Symptoms include abdominal pain and diarrhea, sometimes bloody, and weight loss. Crohn’s patients are at higher risk for colon cancer. American Society for Gastrointestinal Endoscopy (ASGE) guidelines recommend that patients with Crohn’s Disease for more than 10 years should have a surveillance colonoscopy every 1-2 years. Although there are no measures that focus on Crohn’s Disease in the current measures set and this measure would complement other colonoscopy measures MAP is concerned that the measure could be better specified to discourage overuse as well as encourage appropriate use of endoscopy. Comments from the American Gastroenterological Association do not support this measure and American Society for Gastrointestinal Endoscopy commented "While ASGE finds the inclusion of surveillance measures in public reporting programs worthy of exploration, this measure, as specified, would not deter overutilization of colonoscopy. The recommendations for surveillance colonoscopy in Crohn’s disease are based on how long the patient has had the disease."    * *Workgroup Recommendation:* Do not encourage further consideration    * *Notes:* 2. **NMSC: Biopsy Reporting Time - Pathologist** (MUC ID: MUC15-216)    * *Description:* Length of time taken from when the pathologist completes the final biopsy report to when s/he sends the final report to the biopsying physician. This measure evaluates the reporting time between pathologist and biopsying clinician.    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* MAP does not encourage further consideration of this measure for accountability programs. This "behind the scenes" measure is appropriate for quality improvement and systems improvement.    * *Workgroup Recommendation:* Do not encourage further consideration    * *Notes:* 3. **Hepatitis C Virus (HCV)- Sustained Virological Response (SVR)** (MUC ID: MUC15-229)    * *Description:* Percentage of Patients aged 18 years and older with a diagnosis of hepatitis C who have completed a full course of antiviral treatment with undetectable hepatitis C virus (HCV) ribonucleic acid (RNA) 11 weeks after cessation of treatment.    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* This is an intermediate outcome that reflects the treatment for Hepatitis C. Recent studies report that combining several oral antivirals—drugs taken in pill form, not as injections—clear the virus from the liver in more than 95% of people in just 12 weeks. The new medications are very expensive though cost-effectiveness studies conclude that treatment is cost-effective in most patients. This measure only captures patients that begin treatment – patient that cannot afford the medications are not included. This is an intermediate outcome measure related to process measure PQRS#087/NQF #0398 Hepatitis C: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks After Initiation of Treatment. MAP encourages continued development but noted that data on current performance would provide a better understanding of gap in care. Public comments on this measure were mixed with some strongly supporting and other not.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 4. **Screening endoscopy for varices in patients with cirrhosis** (MUC ID: MUC15-251)    * *Description:* Percentage of patients with diagnosis of cirrhosis that have documented endoscopy    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* Esophageal varices (dilated veins) are a serious complications of cirrhosis of the liver. Screening for varices allows treatment to prevent variceal hemorrhage. Endoscopy is the standard for diagnosing varices. AASLD guidelines recommend endoscopy at the time of diagnosis when the prevalence of medium/large varices is 15-25% (Class IIa, Level C evidence.) Follow up screening every 1-2 years is recommended depending on the initial findings. If patients have small varices, follow up endoscopy is not necessary. All recommendations are Level C evidence so there is little empirical evidence that screening endoscopy will impact patient outcomes. Endoscopy carries significant costs, so evidence-based indications are needed. MAP does not encourage continued development because while this measure would address a new topic area in the set, the screening recommendation is not based on solid empirical evidence. The submitter did not provide any information on opportunity for improvement. Comments from the American Gastroenterological Association do not support this measure and American Society for Gastrointestinal Endoscopy commented "ASGE does not support advancement of this measure as specified. This measure would not deter overutilization of colonoscopy. Most guidelines suggest screening every 3 years in cirrhotic and within a year if they are decompensated."    * *Workgroup Recommendation:* Do not encourage further consideration    * *Notes:* 5. **Ischemic Vascular Disease All or None Outcome Measure (Optimal Control)** (MUC ID: MUC15-275)    * *Description:* The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) - Using the IVD denominator optimal results include: Most recent blood pressure measurement is less than 140/90 mm Hg -- And Most recent tobacco status is Tobacco Free -- And Daily Aspirin or Other Antiplatelet Unless Contraindicated -- And Statin Use    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* Composite measures of evidence-based processes and intermediate clinical outcomes combine multiple factors important to care and address whether a patients is receiving all the evidence-based care they receive. Most of the atherosclerotic disease measures enjoy high performance individually, but the composite reveals that the results are not uniformly high for individual patients. Opportunity for improvement exists which can further reduce the risks of poor outcomes for patients and represents a measure that promotes high performance. CMS recently removed PQRS #349 (NQF#0076) Optimal Vascular Care - an all-or-none-composite measure - because it is duplicative of the Millions Hearts measures. MAP supports use of both a composite measure as well as the individual measures for the Millions Hearts campaign. This measure, MUC15-275 is a competing measure with PQRS #349 (NQF#0076) – both are all-or-none composite measures for ischemic vascular disease. NQF will be evaluating both measures side-by-side in the upcoming Cardiovascular - Phase 4 project. CONDITION: MAP conditionally supports this measure pending the outcome of the NQF evaluation of both composite measures. MAP supports inclusion of the composite measure that is considered best-in-class by the NQF review.    * *Workgroup Recommendation:* Conditional support    * *Notes:* 6. **Prevention Quality Indicators 92 Prevention Quality Chronic Composite** (MUC ID: MUC15-576)    * *Description:* PQI composite of chronic conditions per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure. (Includes PQIs 1, 3, 5, 7, 8, 13, 14, 15, and 16)    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* This composite measure combines AHRQ's PQI individual measures for admissions for several chronic conditions. This composite measure for population health encourages care coordination and efficient use of healthcare services and is sensitive to dual eligible patients. MAP encourages continued development and testing of this measure with attention to applicability at the clinician level of analysis and the risk-adjustment model under development. MAP suggests considering sociaodemographic factors also. CMS advised MAP that this composite is already used in the Physician Value Modifier Program.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 7. **Prevention Quality Indicators 92 Prevention Quality Chronic Composite** (MUC ID: MUC15-576)    * *Description:* PQI composite of chronic conditions per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure. (Includes PQIs 1, 3, 5, 7, 8, 13, 14, 15, and 16)    * *Programs under consideration:* Medicare Shared Savings Program    * *Workgroup Rationale:* This composite measure combines AHRQ's PQI individual measures for admissions for several chronic conditions. This composite measure for population health encourages care coordination and efficient use of healthcare services and is sensitive to dual eligible patients. MAP encourages continued development and testing of this measure with attention to applicability at the ACO level of analysis and the risk-adjustment model under development. MAP suggests considering sociodemographic factors also. CMS advised MAP that this composite is already used in the Physician Value Modifier Program.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 8. **PQI 91 Prevention Quality Acute Composite** (MUC ID: MUC15-577)    * *Description:* PQI composite of acute conditions per 100,000 population, ages 18 years and older. Includes admissions with a principal diagnosis of one of the following conditions: dehydration, bacterial pneumonia, or urinary tract infection. (Includes PQIs 10, 11, and 12)    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* This composite measure combines AHRQ's PQIs individual measures for three acute conditions. MAP encourages continued development of this composite with testing at the clinician level with the new risk-adjustment model that includes co-morbidities. This composite measure for population health encourages care coordination and efficient use of healthcare services and is sensitive to dual eligible patients. This measure encourages appropriate care of acute conditions in the ambulatory setting to avoid hospitalization which is highly desirable for patients and families. However, MAP raised concerns about the potential for promoting antibiotic overuse such as overtreatment for aspiration pneumonia particularly in patients residing in nursing homes and unnecessary treatment for asymptomatic bactiuria. MAP questioned whether there could be interaction of this measure with the hospital acquired condition(HACs)measures - the developer responded that the present on admission codes used for these measures are excluded for the HACs. CMS advised MAP that this composite is already used in the Physician Value Modifier Program. CMS advised that they are considering attribution and geographical comparisons.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 9. **PQI 91 Prevention Quality Acute Composite** (MUC ID: MUC15-577)    * *Description:* PQI composite of acute conditions per 100,000 population, ages 18 years and older. Includes admissions with a principal diagnosis of one of the following conditions: dehydration, bacterial pneumonia, or urinary tract infection. (Includes PQIs 10, 11, and 12)    * *Programs under consideration:* Medicare Shared Savings Program    * *Workgroup Rationale:* This composite measure combines AHRQ's PQIs individual measures for three acute conditions. MAP encourages continued development of this composite with testing at the ACO level with the new risk-adjustment model that includes co-morbidities. This composite measure for population health encourages care coordination and efficient use of healthcare services and is sensitive to dual eligible patients. This measure encourages appropriate care of acute conditions in the ambulatory setting to avoid hospitalization which is highly desirable for patients and families. However, MAP raised concerns about the potential for promoting antibiotic overuse such as overtreatment for aspiration pneumonia particularly in patients residing in nursing homes and unnecessary treatment for asymptomatic bactiuria. MAP questioned whether there could be interaction of this measure with the hospital acquired condition(HACs)measures - the developer responded that the present on admission codes used for these measures are excluded for the HACs. CMS advised MAP that this composite is already used in the Physician Value Modifier Program.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 10. **Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls** (MUC ID: MUC15-579)     * *Description:* This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future Fall Risk: Percentage of patients aged 65 years of age and older who were screened for future fall risk at least once within 12 months; B) Falls: Risk Assessment: Percentage of patients aged 65 years of age and older with a history of falls who had a risk assessment for falls completed within 12 months; C) Plan of Care for Falls: Percentage of patients aged 65 years of age and older with a history of falls who had a plan of care for falls documented within 12 months.     * *Programs under consideration:* Medicare Shared Savings Program     * *Workgroup Rationale:* Prevention of falls is a cross-cutting, patient safety measure applicable to all Medicare patients. This NQF-endorsed measure is aligned with PQRS.     * *Workgroup Recommendation:* Support     * *Notes:* 11. **Paired Measure: Depression Utilization of the PHQ-9 Tool; Depression Remission at Six Months; Depression Remission at Twelve Months** (MUC ID: MUC15-928)     * *Description:* This three-component paired measure assesses whether the PHQ-9 screening tool was used among patients with a diagnosis of major depression or dysthymia, and using patient reports, whether patients with an initial PHQ score >9 demonstrate remission (i.e., PHQ score >5) at six or 12 months.     * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)     * *Workgroup Rationale:* In 2006 and 2008, an estimated 9.1% of U.S. adults reported symptoms for current depression.1 Persons with a current diagnosis of depression and a lifetime diagnosis of depression or anxiety were significantly more likely than persons without these conditions to have cardiovascular disease, diabetes, asthma and obesity and to be a current smoker, to be physically inactive and to drink heavily. There is an opportunity for improvement for the population captured by this paired measure, which includes two PROs. MAP noted that the clinician set contains measure NQF#710/PQRS#370 Depression Remission at Twelve months and NQF#712 and PQRS#371Depressison Utilization of the PHQ-9. CMS advised that the public-private collaboration ongoing to development core sets of measures to foster better alignment will include measures NQF#710/PQRS#370 and NQF#1895 Assessment of mental status for community-acquired bacterial pneumonia. This NQF-endorsed measure is a patient-reported outcome. This updated three-part measure consolidates two current measures in the PQRS and Meaningful Use programs. MAP was advised that the data collected for the current measures can be used for this measures without additional burden. MAP also notes that this new measure is more aggressive that the current measures and supports this measure with the following CONDITIONS: look at the response rates; consider risk-stratification to minimize adverse selection; consider target rates for different types of providers and consider alignment with the core measures.     * *Workgroup Recommendation:* Conditional Support     * *Notes:* 12. **Screening for Hepatoma in patients with Chronic Hepatitis B** (MUC ID: MUC15-217)     * *Description:* Percentage of patients with a diagnosis of Chronic Hepatitis B that have had a documented abdominal US, CT Scan, or MRI in the measurement period     * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)     * *Workgroup Rationale:* This measure addresses a new topic area of Hepatitis B and is related to PQRS# 401 Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis. A systematic review of Screening for Hepatocellular Carcinoma in Chronic Liver Disease concluded that “There is very-low-strength evidence about the effects of HCC screening on mortality in patients with chronic liver disease. Screening tests can identify early-stage HCC, but whether systematic screening leads to a survival advantage over clinical diagnosis is uncertain.” The frequency of imaging is not specified. MAP does not encourage further consideration because the current evidence indicates that the benefit to patients is uncertain. The costs of screening without evidence of a benefit are not justified. Comments from the American Gastroenterological Association do not support this measure and American Society for Gastrointestinal Endoscopy commented "ASGE does not support advancement of this measure at this time as the measure concept lacks sufficient evidence to show importance to measure and variation in performance."     * *Workgroup Recommendation:* Do not encourage further consideration     * *Notes:* |
|  | *Measures Identified for Discussion (No Vote Required)* |
|  | This section of the meeting includes discussion on specific measures (no vote required) where MAP Coordinating Committee members would like to add themes to the recommendation rationale or better understand the workgroup deliberations. |
|  | 1. **Hepatitis A vaccination for patients with cirrhosis** (MUC ID: MUC15-210)    * *Description:* Percentage of patients with diagnosis of cirrhosis that have documented hepatitis A vaccination    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* The ACIP recommends Hepatitis A vaccination: "Although not at increased risk for Hep A infection, persons with chronic liver disease are at increased risk for fulminant hepatitis A. Death certificate data indicate a higher prevalence of chronic liver disease among persons who died of fulminant hepatitis A compared with persons who died of other causes. Vaccination against viral hepatitis for patients with cirrhosis can improve long term clinical outcomes. (ACIP 2014)MAP encouraged continued development of this measure but strongly recommends this measure be fully harmonized with PQRS#183/NQF#0399 Hepatitis C: Hepatitis vaccination or better yet, consolidate both into a single vaccination measure for patients with chronic liver disease as recommended by ACIP. The measure is duals sensitive. The registry is not specified. Data on current performance would provide a better understanding of the gap in care. Public comments on this measure were mixed with some strongly supporting and other not.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 2. **Hepatitis B vaccination for patients with chronic Hepatitis C** (MUC ID: MUC15-220)    * *Description:* Percentage of patients with diagnosis of chronic Hepatitis C that have documented hepatitis B vaccination    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* CDC recommends that all patients with chronic liver disease are vaccinated for hepatitis B. MAP encourages continued development with strong consideration to consolidating this measure as Hepatitis B vaccination for all patients with chronic liver disease, including hepatitis C as recommended by CDC, i.e., combine this measure with the MUC for Hepatitis B vaccination for patients with cirrhosis. Importantly, the specifications should specify that all doses of the vaccine should be given to get credit for this measure. This measure is duals sensitive. Data on current performance would provide better understanding of the gap in care. The registry is not specified. Public comments on this measure were mixed with some strongly supporting and other not.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 3. **Hepatitis B vaccination for patients with cirrhosis** (MUC ID: MUC15-211)    * *Description:* Percentage of patients with diagnosis of cirrhosis that have documented hepatitis B vaccination    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* The CDC recommendation for Hepatitis B vaccination includes persons with chronic liver disease as a preventive health measure. MAP encourages continued development of this measures with strong consideration to focusing this measure on patients with chronic liver disease, including Hepatitis C, rather than multiple measures. The measure is duals sensitive. The registry is not specified. Data on current performance would provide a better understanding of the gap in care. Public comments on this measure were mixed with some strongly supporting and other not.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 4. **Over-utilization of mesh in the posterior compartment** (MUC ID: MUC15-436)    * *Description:* Percentage of patients undergoing vaginal surgery for pelvic organ prolapse involving the posterior compartment where a synthetic mesh augment is utilized.    * *Programs under consideration:* Merit-Based Incentive Payment System (MIPS)    * *Workgroup Rationale:* Posterior repair with and without mesh have been compared with similar outcomes. Mesh has been shown to have significant complications including expulsion of the mesh in 17%. MAP encourages continued development of this measure that will promote reduced use of mesh and the associated costs (mesh and complications) without affecting patient outcomes. The measure adds an appropriate use measure to the group of measures for pelvic prolapse – a common condition in older women.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* |
|  | *Finalizing Workgroup Recommendations for All Clinician Programs* |
|  | This section of the meeting finalizes the remaining workgroup recommendations for:   * [Merit-Based Incentive Payment System (MIPS)](#MeasureListMIPS) * [Medicare Shared Savings Program](#MeasureListMSSP) |
| 3:30 PM | Break |
|  |  |
| 3:45 PM | *Opportunity for Public Comment* |
|  |  |
| 4:45 PM | *Opportunity for Public Comment* |
|  |  |
| 5:00 PM | Adjourn for the Day |
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| **Day 2: January 27, 2016** |  |
|  |  |
| 9:00 AM | Breakfast |
|  |  |
| 9:15 AM | **Day 1 Recap** |
|  | Beth McGlynn Harold Pincus |
| 9:30 AM | **Pre-Rulemaking Recommendations for Hospital Programs** |
|  | Cristie Upshaw Travis, MAP Hospital Workgroup Co-Chair Ronald Walters, MAP Hospital Workgroup Co-Chair Melissa Mariñelarena, Senior Director, NQF Erin O’Rourke Beth McGlynn   * Discuss key themes from the Hospital Workgroup meeting * Review and finalize broader guidance about programmatic issues * Review and discuss input from the MAP Dual Eligible Beneficiaries Workgroup * Review and finalize workgroup measure recommendations |
|  | *Measures Requiring a Vote on MAP's Preliminary Recommendation* |
|  | This section of the meeting includes debate and voting on measures pulled by MAP Coordinating Committee members. |
|  | 1. **Measurement of Phosphorus Concentration** (MUC ID: MUC15-1136)    * *Description:* Percentage of all peritoneal dialysis and hemodialysis patient months with serum or plasma phosphorus measured at least once within the month.    * *Programs under consideration:* End-Stage Renal Disease Quality Incentive Program    * *Workgroup Rationale:* MAP supported this measure, NQF #0255, because it tracks performance of a precursor process that is consistent with clinical guidelines to mitigate patient morbidity and mortality. The measure has been found to be reliable, valid, and not burdensome to calculate. This updated measure has been broadened to include pediatric patients and permit an alternative measurement mechanism, plasma phosphorous.    * *Workgroup Recommendation:* Support    * *Notes:* 2. **ESRD Vaccination: Full-Season Influenza Vaccination** (MUC ID: MUC15-761)    * *Description:* Percentage of ESRD patients = 6 months of age on October 1 and on chronic dialysis = 30 days in a facility at any point between October 1 and March 31 who either received an influenza vaccination, were offered and declined the vaccination, or were determined to have a medical contraindication.    * *Programs under consideration:* End-Stage Renal Disease Quality Incentive Program    * *Workgroup Rationale:* MAP did not support this measure because there is no discussion of exclusions, and it does not address the inactivated vaccine. Additionally, there is a burden for staff to enter data into the database. MAP encouraged CMS to consider NQF #0226, which is NQF-endorsed, fully aligned, and fully tested.    * *Workgroup Recommendation:* Do not support    * *Notes:* 3. **National Healthcare Safety Network (NHSN) Antimicrobial Use Measure** (MUC ID: MUC15-531)    * *Description:* Assesses antimicrobial use (AU) in hospitals based on medication administration data hospitals collect electronically at the point of care and report via electronic file submissions to NHSN. AU data included in the measure are antibacterial agents administered to adult and pediatric patients in a specified set of hospital ward and intensive care unit locations.    * *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program    * *Workgroup Rationale:* MAP conditionally supported this measure since the measure developer stated that the measure is intended for use in the National Healthcare Safety Network (NHSN) and wishes to gain greater experience and gather more information before using it for reporting or payment. MAP recognized the high importance of antimicrobial stewardship and conditionally support the inclusion of this measure in the IQR program to allow for the opportunity for additional testing to address feasibility issues. However, MAP noted these issues should be addressed before the measure is reported on Hospital Compare.    * *Workgroup Recommendation:* Conditional support, pending the Centers for Disease Control recommendation that the measure is ready for use in public reporting, and pending resubmission to MAP for review of implementation data    * *Notes:* 4. **Excess Days in Acute Care after Hospitalization for Pneumonia** (MUC ID: MUC15-391)    * *Description:* This measure assesses the difference (“excess”) between the average number of risk-adjusted days a hospital’s patients spend in an ED, observation, or readmission in the 30 days following a hospitalization for pneumonia (“predicted”) and the number of days in acute care that they would have been expected to spend if discharged from an average hospital.    * *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program    * *Workgroup Rationale:* MAP conditionally supported this measure pending NQF review and endorsement. MAP also stated that the Standing Committee reviewing this measure should consider SDS factors that examine the true hospital vs. community role in readmissions and consider parsimony with regard to multiple pneumonia readmission measures.    * *Workgroup Recommendation:* Conditional support, pending NQF review and endorsement and examination of SDS factors    * *Notes:* 5. **IQI-22: Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated** (MUC ID: MUC15-1083)    * *Description:* Vaginal births per 1,000 deliveries by patients with previous Cesarean deliveries. Excludes deliveries with complications (abnormal presentation, preterm delivery, fetal death, multiple gestation diagnoses, or breech procedure).    * *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program    * *Workgroup Rationale:* MAP did not support this measure because it adds little value to this measure set since VBAC rates would be calculated using only CMS claims data.    * *Workgroup Recommendation:* Do not support    * *Notes:* 6. **INR Monitoring for Individuals on Warfarin after Hospital Discharge** (MUC ID: MUC15-1015)    * *Description:* Percentage of adult inpatient hospital discharges to home for which the individual was on warfarin and discharged with a non-therapeutic International Normalized Ratio (INR) who had an INR test within 14 days of hospital discharge    * *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program    * *Workgroup Rationale:* MAP conditionally supported this measure an optional eCQM pathway and asked that its performance be monitored. MAP recognized that this is an important patient safety issue, but stated that it should be optional for hospitals because not all vendors may be able to support the implementation of this measure.    * *Workgroup Recommendation:* Conditional support, pending optional eCQM pathway    * *Notes:* 7. **Adult Local Current Smoking Prevalence** (MUC ID: MUC15-1013)    * *Description:* Percentage of adult (age 18 and older) U.S. population that currently smoke, defined as adults who reported having smoked at least 100 cigarettes in their lifetime and currently smoke. (*The endorsed specifications of the measure are: Percentage of adult (age 18 and older) U.S. population that currently smoke.*)    * *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program    * *Workgroup Rationale:* MAP encouraged further development of this measure at the city and/or county level because the group recognized the importance of a community-based approach to decrease smoking. This type of county-based measure indicates the need for hospital collaboration with the surrounding community to work together to provide tobacco cessation.    * *Workgroup Recommendation:* Encourage continued development    * *Notes:* 8. **Spinal Fusion Clinical Episode-Based Payment Measure** (MUC ID: MUC15-837)    * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to a Spinal Fusion IP stay and attributes them to the hospital where the index IP stay occurred.    * *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program    * *Workgroup Rationale:* MAP did not support this measure because although cost is important to measure, data supporting variation in costs for this procedure was not provided. The group also noted that measuring resource use (cost) is different from appropriateness of care; the cost of a service is not indicative of quality care.    * *Workgroup Recommendation:* Do not support    * *Notes:* 9. **Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure** (MUC ID: MUC15-835)    * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to an aortic aneurysm procedure inpatient (IP) stay and attributes them to the hospital where the index IP stay occurred. It includes abdominal aortic aneurysm and thoracic aortic aneurysm subtypes.    * *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program    * *Workgroup Rationale:* MAP did not support this measure because although cost is important to measure, data supporting variation in costs for this procedure was not provided. The group also noted that measuring resource use (cost) is different from appropriateness of care; the cost of a service is not indicative of quality care.    * *Workgroup Recommendation:* Do not support    * *Notes:* 10. **Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure** (MUC ID: MUC15-836)     * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to a Cholecystectomy and Common Duct Exploration IP stay and attributes them to the hospital where the index IP stay occurred.     * *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program     * *Workgroup Rationale:* MAP did not support this measure because although cost is important to measure, data supporting variation in costs for this procedure was not provided. The group also noted that measuring resource use (cost) is different from appropriateness of care; the cost of a service is not indicative of quality care.     * *Workgroup Recommendation:* Do not support     * *Notes:* 11. **Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia Clinical Episode-Based Payment Measure** (MUC ID: MUC15-838)     * *Description:* The measure constructs a clinically coherent group of services to inform providers about resource use and effectiveness. It sums Parts A and B payments related to a TURP IP stay and attributes them to the hospital where the index IP stay occurred.     * *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program     * *Workgroup Rationale:* MAP did not support this measure because although cost is important to measure, data supporting variation in costs for this procedure was not provided. The group also noted that measuring resource use (cost) is different from appropriateness of care; the cost of a service is not indicative of quality care.     * *Workgroup Recommendation:* Do not support     * *Notes:* 12. **Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an Inpatient Psychiatric Facility (IPF)** (MUC ID: MUC15-1082)     * *Description:* The measure estimates a facility-level risk-standardized readmission rate for unplanned, all-cause readmission within 30 days of discharge from an Inpatient Psychiatric Facility of adult Medicare fee-for-service (FFS) patients with a principal diagnosis of a psychiatric disorder. The performance period for the measure is 24 months.     * *Programs under consideration:* Inpatient Psychiatric Facility Quality Reporting Program     * *Workgroup Rationale:* MAP noted the importance of reducing readmissions for mental health conditions but recommended this measure be submitted for NQF review and endorsement. MAP recommended the Admissions and Readmissions Standing Committee pay particular attention to the influence of sociodemographic factors when reviewing this measure as access to community resources and supports can influence a patient's ability to manage mental and behavioral health issues on an outpatient basis.     * *Workgroup Recommendation:* Conditional support, pending NQF review and endorsement and examination of SDS factors.     * *Notes:* 13. **Substance Use Core Measure Set (SUB)-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge** (MUC ID: MUC15-1065)     * *Description:* Overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. (*The endorsed specifications of the measure are: The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).*)     * *Programs under consideration:* Inpatient Psychiatric Facility Quality Reporting Program     * *Workgroup Rationale:* MAP recognized the importance of addressing this critical quality and public health concern. MAP noted that this process measure is a start to addressing the issue but recommended that outcome measures be quickly developed and implemented. MAP recommended that the developer consider expanding this measure to the under 18 population and that this measure be considered for implementation in the IQR program.     * *Workgroup Recommendation:* Support     * *Notes:* |
|  | *Finalizing Workgroup Recommendations for All Hospital Programs* |
|  | This section of the meeting finalizes the remaining workgroup recommendations for:   * [Ambulatory Surgical Center Quality Reporting Program](#MeasureListASCQ) * [End-Stage Renal Disease Quality Incentive Program](#MeasureListESRD) * [Hospital Acquired Condition Reduction Program](#MeasureListHACR) * [Hospital Inpatient Quality Reporting and EHR Incentive Program](#MeasureListHIQR) * [Hospital Outpatient Quality Reporting Program](#MeasureListHOQR) * [Hospital Value-Based Purchasing Program](#MeasureListHVBP) * [Inpatient Psychiatric Facility Quality Reporting Program](#MeasureListIPFQ) * [Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program](#MeasureListPCHQ) |
| 10:30 AM | Break |
|  |  |
| 10:45 AM | **MAP at 5 Years: Vision for the Future** |
|  | Wunmi Isijola, Administrative Director, NQF Harold Pincus Taroon Amin Erin O’Rourke   * Discuss improved CDP/MAP alignment and how MAP can ensure scientific integrity of the measures it recommends * Discuss the impact of the NQF Intended Use project on the pre-rulemaking process |
| 11:45 AM | **Discussion of MAP Core Concepts – Breakout Sessions** |
|  |  |
| 12:00 PM | Lunch |
|  |  |
| 12:30 PM | **Finalization of MAP Core Concepts** |
|  |  |
| 1:30 PM | **Round-Robin Discussion: Improving MAP’s Processes** |
|  | Amber Sterling, Project Manager, NQF |
| 2:00 PM | *Opportunity for Public Comment* |
|  |  |
| 2:15 PM | **Closing Remarks** |
|  | Beth McGlynn Harold Pincus |
| 2:30 PM | Adjourn |
|  |  |