MEASURE APPLICATIONS PARTNERSHIP

Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals

FINAL REPORT

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NATIONAL QUALITY FORUM

CONTENTS

EXECUTIVE SUMMARY

There were an estimated 1.6 million new cases of cancer diagnosed in 2011 alone, and an estimated 571,950 deaths.[1] The National Institutes of Health estimates that in 2010, cancer accounted for $263.8 billion in overall costs, divided between direct medical expenditures and indirect morbidity and mortality costs.[2] Though cancer's prevalence and burden on patients and families continues to be great, we are making strides in our national fight against cancer. Specialty cancer hospitals play an important role in this fight, pioneering innovations in care and frequently treating people with the most difficult forms of cancer.

Cancer care in the U.S. is provided in a wide range of settings—community-based hospitals, hospice, home health, comprehensive cancer centers—and by a broad swath of healthcare professionals including surgeons, oncologists, nurses, pain management specialists, home health aides, and hospice workers to name few. In this increasingly diverse sea of settings and caregivers, there are eleven niche hospitals whose singular focus is cancer. These hospitals have been exempt from the Medicare Prospective Payment System (PPS) because their narrow focus on cancer care does not lend itself to the payment program as designed. As a result of this exemption, these hospitals have not been required to participate in quality reporting programs that now apply to most other hospitals, such as the Hospital Inpatient Quality Reporting and Outpatient Quality Reporting Programs.

Recent legislation changes that, establishing the PPS-Exempt Cancer Hospital Quality Reporting Program. Beginning in 2014, the eleven PPS-exempt hospitals must begin publicly reporting quality data, although with no financial penalty or incentive attached to the reporting activity. This shift is part of a broader effort to achieve greater value in healthcare by pushing measurement-driven quality improvement, public reporting, and accountability into every corner of the care delivery system. After all, we can only improve what we can measure and public reporting provides a rich source of information from which to make assessments.

With the creation of this new reporting program, the Department of Health and Human Services (HHS) turned to the Measure Applications Partnership (MAP) to help develop a quality measurement strategy for the eleven PPS-exempt cancer hospitals. MAP is comprised of 60 organizations representing diverse stakeholder interests. It was convened in 2011 by the National Quality Forum (NQF) for the purpose of providing guidance on measures for use in public reporting, performance-based payment, and other performance measurement programs in both the public and private sectors. This is the 6th of a series of performance measurement coordination strategy reports authored by MAP in its advisory capacity to HHS, and the first to focus on a highly specialized care setting that treats patients with a specific, high-impact condition.

MAP's deliberations highlight the inherent complexity and fluidity involved in cancer care.

People with cancer can see many healthcare professionals over the course of their treatment. Rather than be tethered to one hospital, in reality any one patient may toggle between a community-based hospital, an unexpected emergency room visit, a PPS-exempt cancer hospital, a long-term care facility, and hospice. Any measurement strategy developed for PPS-exempt hospitals must be adept at following that patient through their experiences in multiple settings, even beyond the walls of the hospitals under consideration. Often referred to as 'cross-cutting' in this report, MAP accentuates the need to move toward an integrated vision of performance measurement that follows the patient rather than the setting, and full patient experience rather than fragments of it.

In this report, MAP identifies priorities for PPS-exempt hospital quality reporting and presents an initial "core set" of 22 existing measures and priority measure gaps that could be used to help measure the quality of cancer care in this niche setting. Information from these measures would generate data that is far more meaningful to patients and their families making decisions about treatment options and facilities, but are not yet fully captured in available performance measures. It recommends these gaps be addressed for PPS-exempt hospitals, as well as for other facilities and settings where cancer patients receive care. Priority measure gaps include:

- Survival associated with cancer diagnoses, including information broken out by the stage and/or sub-type of cancer – to inform decision making about providers and treatments;
- Experience of care and quality of life, including patients' assessments of their functional status, pain management, and other symptoms;
- Coordination of care and care planning, especially when people transition from one setting of care to another (hospital to nursing home, for example);
- Cost of care, including measures that gauge potential overuse or underuse of treatments; and
- Assessment of palliative and hospice care, emphasizing team-based care coordinated across settings.

MAP recognizes that measuring performance of PPS-exempt cancer hospitals can pose technical problems. Chief among these is that the number of patients with less common forms of cancer may be so small that it can become difficult to draw meaningful conclusions from performance data. To combat this challenge, MAP suggests greater use of cross-cutting measures looking at broader aspects of care such as patient safety, care transitions, and patient-reported experience of care that would apply to any type of cancer in addition to diagnosis-specific measures. MAP also stressed in this report, as in its others, the need for standardized data collection and transmission mechanisms that cross both public- and private sectors. Several private-sector registries have made important inroads toward capturing data but are insufficient across certain data dimensions and their ability to offer real-time reporting. Measurement at present is significantly hampered by this lack of data infrastructure and shared approach.

Given the complexity and cost of cancer care, prevalence of the disease, multiple care "hand-offs" that occur during treatment, and patient preference issues that can arise in treating cancer, PPS-exempt hospitals are ripe for deploying a measurement strategy that may yield information that helps patients, providers, and payers. Such a measurement strategy also represents a valuable opportunity to stir innovations in measure development. Currently, there are many nationally-endorsed measures assessing processes of cancer care, but far fewer measuring patient outcomes and patient- and family-centered care with respect to cancer.[3] Better measures and greater alignment in cancer care quality measurement across all providers offering cancer services will support movement toward achieving national healthcare improvement goals.

BACKGROUND

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for the primary purpose of providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs (Appendix A—MAP Background). The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with a consensus-based entity (i.e., NQF) to "convene multistakeholder groups to provide input on the selection of quality measures" for various uses.[4]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—is designed to provide HHS with thoughtful input on performance measure selection from a broad array of affected stakeholders (Appendix B—Coordinating Committee Roster). Particularly, MAP has been charged with developing a measurement strategy for Medicare Prospective Payment System (PPS)-exempt cancer hospital performance measurement.

Previously, PPS-exempt cancer hospitals (Table 1) had been measuring and reporting on their performance for accreditation purposes, but had not been required to participate in federal quality data reporting programs such as the Hospital Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs. However, ACA established the PPS-Exempt Cancer Hospital Quality Reporting Program, requiring the 11 PPS-exempt cancer hospitals to publicly report quality data. The statute requires that measures of process, structure, outcomes, efficiency, cost of care, and patients' perspectives on care be included in the reporting program. Beginning in FY 2014, these cancer hospitals must report quality data to the Centers for Medicare & Medicaid Services (CMS), with no Medicare payment penalty or incentive indicated by CMS at this time.

TABLE 1. PPS-EXEMPT CANCER HOSPITALS

PPS-Exempt Cancer Hospitals
American Oncologic Hospital (Fox Chase) (Philadelphia, PA)
Arthur G. James Cancer Center Hospital and Research Institute (Columbus, OH)
City of Hope National Medical Center (Duarte, CA)
Dana Farber Cancer Institute (Boston, MA)
Fred Hutchinson Cancer Research Center (Seattle, WA)
H. Lee Moffitt Cancer and Research Institute Hospital, Inc. (Tampa, FL)
Memorial Hospital for Cancer and Allied Disease (New York, NY)
Roswell Park Memorial Institute (Buffalo, NY)
The University of Texas M.D. Anderson Cancer Center (Houston, TX)
University of Miami Hospital and Clinics (Miami, FL)
USC Kenneth Norris Jr. Cancer Hospital (Los Angeles, CA)

PPS-EXEMPT CANCER HOSPITAL SERVICES

PPS-exempt cancer hospitals function as health systems offering comprehensive cancer services. These institutions are dedicated to deepening the understanding of the causes of and cures for cancer, developing new treatments for cancer, and disseminating this knowledge to the provider community at large.[5] While focusing on specialized multidisciplinary inpatient and outpatient cancer treatment, including diagnostic, surgical, medical, chemotherapy, and radiation treatment, they also provide preventive and screening services as well as palliative and end-of-life care.

These hospitals treat common cancers as well as rare cancers that are not treated at other facilities and offer new and experimental treatments through extensive clinical trials programs.[6] The resulting patient population is often medically complex and undergoing extensive treatment regimens, which does not afford these institutions a broad enough mix of patients to allow the PPS system to work.[7,8,9] Consequently, the PPS exemption was created for these cancer hospitals. To qualify for this exemption, a cancer hospital must be:

- Recognized by the National Cancer Institute as a comprehensive cancer center or a clinical cancer research center as of April 20, 1983;
- Recognized by the Health Care Financing Administration (now CMS) as a cancer hospital on or before December 31, 1990; and
- Organized primarily for cancer research or treatment, with at least 50% of total discharges having a principal diagnosis of neoplastic disease.[10]

Beyond cancer-specific treatment, these systems also monitor and treat patients' comorbid conditions to manage the impact of the disease and effects of the cancer treatment. This approach to providing wide-ranging patient care services enables the PPS-exempt cancer hospitals to treat the whole patient, not just cancer diagnoses.

The unique characteristics of these facilities and the patients they serve can also influence methods for measuring performance. For example, special considerations may be necessary for patients participating in clinical trials. In such cases, it might be appropriate to incorporate stratification methodologies or exclusion criteria into performance measures to account for this population.

APPROACH

The MAP Hospital Workgroup advised the Coordinating Committee on developing the performance measurement coordination strategy for PPS-exempt cancer hospitals. The MAP Hospital Workgroup is a 25-member, multistakeholder group (Appendix C—Hospital Workgroup Roster). The agenda and materials for the Hospital Workgroup meeting focused on completion of this task can be found on the **NQF website**. Following MAP's convening activities, a draft version of this report was posted for public comment and responses to comment are reflected throughout the body of the report. The full text of comments received is available in Appendix D—Public Comments Received on Draft Report.

This task involved identifying priorities for PPS-exempt cancer hospital measurement and reviewing available performance measures for cancer care. MAP used this information to construct a core set of measures for quality reporting for those entities. Defining an initial core measure set of existing measures and measure gaps areas serves as a first step toward fostering alignment of measurement efforts across settings to support the assessment of the most meaningful aspects of the quality of care. Building off of NQF's prior work endorsing cancer care measures, NQF staff compiled a table of current NQF-endorsed® measures for cancer care (Appendix E—Endorsed Measures Table) as of October 2011, when the workgroup in-person meeting occurred. The tables included measure attributes such as endorsement status, description, steward, numerator, denominator, data sources, and type, as well as the corresponding settings and programs in which the measure is used. Further, each measure within the table was mapped to the relevant National Quality Strategy (NQS) priorities. MAP also identified opportunities for alignment of measurement efforts as well as for measure development and endorsement needed to fill performance measurement gaps.

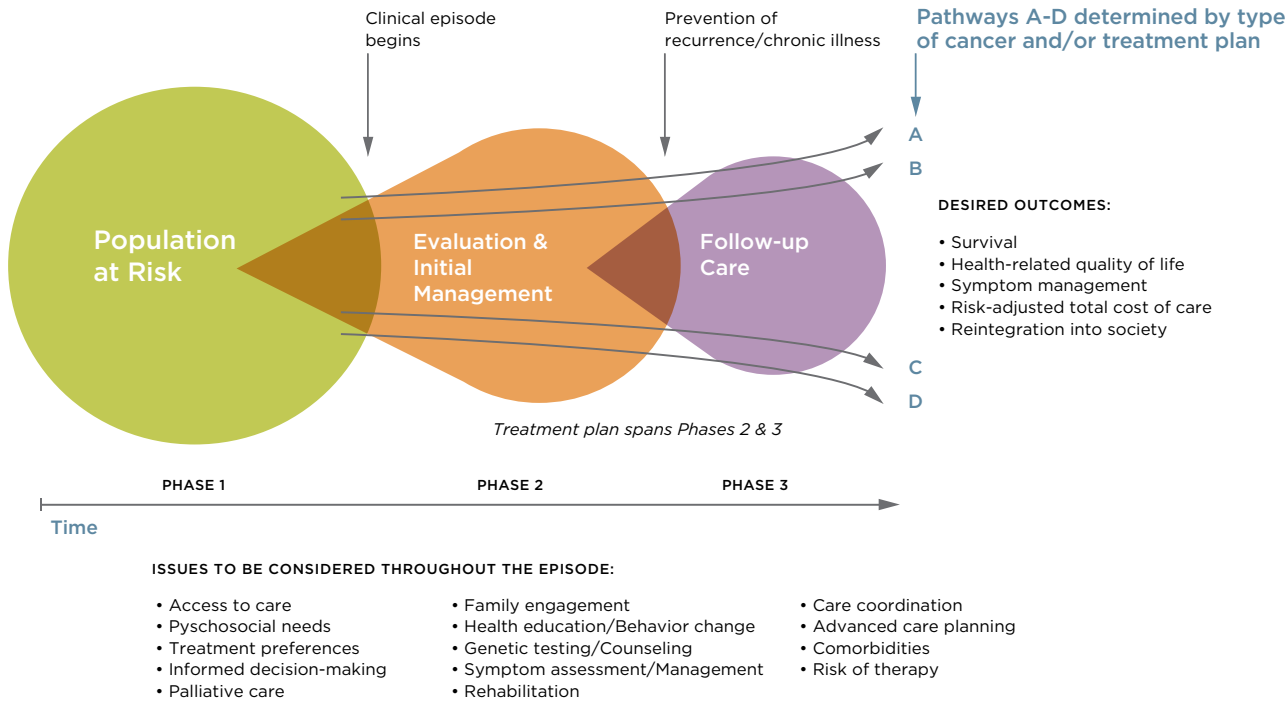
Additionally, MAP built on the data platform principles outlined in a prior report entitled *Coordination Strategy for Clinician Performance Measurement* by adding considerations specific to PPS-exempt cancer hospital measurement. MAP also reviewed and discussed current data sources and data collection efforts, specifically existing cancer registries. In addition, MAP identified two examples of new initiatives showing promise and discussed PPS-exempt cancer hospitals' adoption of health information technology (HIT) as a way to reduce data collection burden.

PATIENT-CENTERED CANCER CARE

MAP stresses the importance of establishing for PPS-exempt cancer hospitals an approach to measurement that is person-centered and aligned across various levels of care. Cancer is a chronic illness that afflicts people of all ages, from very young children to elderly individuals. Cancer care is provided in both acute and outpatient settings within these health systems. Additionally, patients with cancer diagnoses often have comorbid conditions resulting from their cancer or treatment, or entirely unrelated to their cancer. Consequently, the provision of healthcare services in PPS-exempt cancer hospitals is not limited to cancer care. MAP determined that a measurement strategy for PPS-exempt cancer hospitals should address the whole patient across the entire patient episode.

In further developing a strategy for PPS-exempt cancer hospital quality measurement, MAP sought to build on prior NQF work addressing cancer care quality measurement. MAP preferred including NQF-endorsed measures within a PPS-exempt cancer hospital core measure set. In addition, MAP built on recommendations from the Value-Based Episodes of Care project for cancer quality measurement, which applied the NQF-endorsed Patient-Focused Episodes of Care model to cancer care. The major recommendations from this project include taking a person-centered approach to measurement and prioritizing outcomes and cross-cutting issues such as symptom management, clear communication, shared decision making, and end-of-life care. Specific attention was paid to the psychosocial care needs of patients and families. Figure 1 illustrates a trajectory of cancer care from prevention through remission, recurrence, or end-of-life care aligned with corresponding patient-centered issues for consideration. The figure demonstrates key opportunities for performance measurement and quality improvement and identifies desired patient outcomes.[11]

FIGURE 1. PATIENT-FOCUSED EPISODE-OF-CARE MODEL FOR CANCER CARE



The first phase, which includes prevention of and screening for cancer, comes prior to diagnosis. Though this initial phase of care does not usually occur within PPS-exempt cancer hospitals, these systems do offer preventive services. Therefore, preventive services are important to consider when developing a measurement strategy for PPS-exempt cancer hospitals. Once patients receive a cancer diagnosis, there are four typical pathways they may follow, depending on their type of cancer and treatment plan. The patient may move across phases of care from treatment, to maintenance, and on to a surveillance phase once in remission (depicted in Figure 1 as pathways A and B, roughly related to stage I and II respectively). The surveillance phase could include measures looking at late effects of treatment, continued screening, and health-related quality of life. The trajectory for other patients may progress to palliative and end-of-life phases (depicted in Figure 1 as pathways C and D, roughly related to stages III and IV respectively).

Pathways A through D are based on tumor type and are built upon evidence-based guidelines, illustrating the various ways (and corresponding timeframes) by which a patient with cancer navigates diagnosis, evaluation, treatment, and follow-up care. Using colorectal cancer as an example, pathway A could represent a patient undergoing surgical treatment only (Stage I and some Stage II disease) while pathway D could represent a patient with advanced metastatic disease receiving minimal life-prolonging treatments and predominantly palliative care.

MAP noted that the cyclical nature of cancer treatment requires a unique approach to quality measurement. Within the treatment phase, the patient often receives frequently recurring doses of therapy over a discrete period of time. Additionally, patients' health status and care expectations can vary greatly depending on their phase of care. Measurement should reflect changing expectations throughout the course of treatment as patients repeatedly return to their providers for care. This approach also applies to the surveillance phase following remission as many survivors go on to live long, productive lives.

Using the Patient-Focused Episodes of Care model as a guide, MAP began its work to identify priorities for PPS-exempt cancer hospital measurement, establish a set of core measures and measurement gaps, and outline unique data and health IT considerations.

Public Comment

The patient-centered approach taken by MAP was strongly supported by public commenters. Commenters noted that this approach is greatly aligned with the approach to care taken by PPS-exempt cancer hospitals, especially when considering the management of patients' comorbid conditions. Commenters commended MAP for emphasizing the importance of improving the patient experience through an evidence-based and research-driven yet patient-focused approach to cancer-specific patient care.

PRIORITIES FOR PPS-EXEMPT CANCER HOSPITAL MEASUREMENT

MAP continues to use the priorities outlined in the NQS to encourage greater alignment by promoting the use of cross-cutting measures in all aspects of its work. The current cancer care measurement landscape consists of predominantly provider-focused, disease-specific process-of-care measures. While these measures are important for making operational improvements in care, they do not cross various patients and settings to afford a better understanding of healthcare quality. The well-being and experience of patients should be the primary focus of measurement, helping to ensure that patients remain central to measuring and improving the overall quality of care in PPS-exempt cancer hospitals.

The quality measurement priorities for PPS-exempt cancer hospitals are not entirely dissimilar from other settings where cancer care is provided. As noted, these hospitals provide the full range of cancer care services spanning the entire patient-focused episode, as well as treatment for comorbid conditions and complications. However, these hospitals have unique qualities that require a specialized approach to measurement. While PPS-exempt cancer hospitals provide preventive and screening services, the majority of their patients are referred following a diagnosis made elsewhere. Additionally, these facilities focus on specialized cancer care, including the care of rarer cancers, as well as recurrences of more common forms, leading to more specific priorities for measurement. MAP proposes that a measurement strategy for PPS-exempt cancer hospitals, including measurement priorities, a core measure set, and identified gaps, should focus on cross-cutting measures that align with the NQS aims and priorities, as well as disease-specific measures of survival.

MAP identified nine measurement priorities for PPS-exempt cancer hospitals (Table 2), many of which are currently measure gap areas (see measure gaps discussion on pages 16–17).

TABLE 2. PRIORITIES FOR PPS-EXEMPT CANCER HOSPITAL MEASUREMENT

Priority Areas
Survival
Patient-reported outcomes (e.g., experience of care, functional status, quality of life)
Care planning that reflects individualized goals
Shared decision making
Patient and family engagement
Care coordination
Safety
Palliative and end-of-life care
Cost of care

Survival is an important outcome to patients, and as such, patient survivorship measures are a high priority for PPS-exempt cancer hospital measurement. Measurement and public reporting on survival should include cancer type and subtype as well as cancer-specific, stage-for-stage survival curves. Many factors contribute to variation in survival curves by stage; only by measuring by stage can providers begin to define those determinants and establish which ones to target for improvement. Additionally, survival information should be made publically available to help patients and families make informed decisions regarding providers and treatments, as well as gain a better overall understanding of their illness. Members of MAP identified a list of cancer diagnoses that they believed should be addressed in the initial core measure set, expanding slightly

beyond the Medicare High-Impact Conditions,[12] to include breast, colon, lung, prostate, gynecological, and pediatric cancers. MAP suggested that other types of cancers, such as esophageal, pancreatic, multiple myeloma, leukemia, melanoma and other skin cancers, brain, and adrenal, should be included as the measure set continues to evolve and new measures become available. However, it is important to balance the use of cross-cutting measures that may be more feasible to collect in the near term with the development and use of diagnosis-specific measures addressing the many cancer types treated at PPS-exempt cancer hospitals.

A core set should also include patient-reported outcomes, such as experience of care, psychosocial health, and quality of life. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are examples of patient experience-of-care measures currently used within federal programs. These surveys, developed by the Agency for Healthcare Research and Quality (AHRQ), have been adapted for multiple levels of care including hospitals, clinician and group practices, and home health. Further adaptation of these surveys for PPS-exempt cancer hospitals could be considered in addition to other work currently underway to develop cancer-specific measures of patient experience.

Given the stress and emotional aspects of receiving a cancer diagnosis and undergoing treatment, MAP emphasized the importance of measuring a patient's overall quality of life. Following diagnosis and throughout treatment, patients are continually receiving new information related to their illness, treatment regimen, and self-care programs. Further, as a result of their illness and treatment, patients often require additional assistance with such things as transportation, managing work and family life, and financial matters. These factors often cause mental health problems, such as depression and anxiety disorders, requiring additional support for cancer patients to help cope with their illness.[13]

An example of an existing tool that begins to capture patient perspectives is the Functional Assessment of Cancer Therapy-General (FACT-G) questionnaire, part of the Functional Assessment of Chronic Illness Therapy measurement system. The FACT-G is a quality-of-life questionnaire that evaluates a patient's physical, social, emotional, and functional well-being. This is a well-validated tool for assessing an individual patient's experience; however, the tool has not been used to measure the quality of care at the clinician or practice level.[14] MAP suggests that it could be modified for facility-level performance measurement. A standardized, easy-to-use tool for collecting patient-reported information should be implemented across providers to enable comparisons and progress in improving patient experience.

MAP also emphasizes the importance of cross-cutting measures that address shared decision making and patient and family engagement. Painting an overall picture for patients, including diagnosis, survival rates, treatment options, and the experiences of other patients, leads to more informed decision making by patients and families. Coupling this information with patients' values and preferences for their care enables a patient-provider relationship involving true shared decision making. The presence and effectiveness of shared decision making should be monitored as well.

Two additional areas of importance for PPS-exempt cancer hospital measurement are care coordination and patient safety. Navigating the healthcare system and intricate cancer treatment protocols can be overwhelming for patients and caregivers, particularly those who have to travel to a specialized center to receive treatment. Patients need a solid understanding of the risks and side effects of treatment to stay as safe as possible and avoid potentially harmful complications through the course of care. Medication reconciliation is particularly relevant to cancer care. Patients frequently receive chemotherapeutic agents as well as a number of other medications to manage

the side effects of treatment and other chronic conditions, some of which may be affected by the cancer treatment or side effects of that treatment. As patients transition across settings and providers, effective communication and coordination are essential to safe cancer care and a positive patient experience.

MAP's *Performance Measurement Coordination Strategy for Hospice Care*[15] report contains specific information about measures for hospice and palliative care. Considering the continuum of hospice and palliative care, MAP noted that performance measures must be aligned across settings where these types of care are delivered and address a holistic, team-based, and patient- and family-centered approach to care. Patient and family engagement and care coordination are recognized as the highest priorities for measurement in these areas. When reviewing existing measures for this work, MAP determined that a number of measures specified for the cancer population address hospice and palliative care (noted in Appendix E—Endorsed Measures Table). While continuing to refine measurement in both areas, these available measures could be expanded more broadly.

Cost of care is an important consideration for the cancer population, with its often complex and expensive treatment regimens and increased susceptibility to complications. Access to necessary cancer treatment can be very costly and patients may have difficulty obtaining these services based on their ability to pay. Measures of initial diagnosis and treatment should ensure that patients receive the correct diagnosis, including staging, followed by the most appropriate evidence-based treatment in the context of patients' preferences. Cancer care often requires resource-intensive services, particularly at the end of life, which can lead to unwanted treatment if care is misaligned with patients' goals. Monitoring for appropriateness of care, considering under treatment, over treatment (e.g., imaging and chemotherapy), total cost of care by episode, and symptom management, is also a key component to ensuring care is provided in a safe and effective manner.

Public Comment

Public comments expressed strong support for the priority measurement areas identified within this report, with emphasis on survival, patient-reported outcomes, and quality of life. Commenters stressed the need to prioritize cross-cutting measures that are patient-centric, clinically meaningful, and feasible. Commenters noted the need to align measures for PPS-exempt cancer hospitals with those for other institutions where cancer care is provided. However, commenters cautioned that the need for alignment and cross-cutting measures must be balanced with the need for provider-focused, disease-specific process-of-care measures to promote quality improvement.

DEFINING A PPS-EXEMPT CANCER HOSPITAL CORE MEASURE SET

By establishing a core set of measures, MAP emphasizes the importance of taking an aligned, person-centered approach to measurement. This core set of measures for PPS-exempt cancer hospitals includes disease-specific measures and also addresses patient-centered care by incorporating cross-cutting measures. The core set also includes identified gap areas where measures are needed to address the nine priority areas for measurement in PPS-exempt cancer hospitals.

There are currently 47 NQF-endorsed measures (Appendix E—Endorsed Measures Table) related to cancer covering a range of topic areas including breast, colorectal, and blood cancers, as well as symptom management and end-of-life care. NQF is currently conducting an endorsement maintenance review that began in October 2011 during which new measures will be reviewed.

In 2010, CMS contracted with Mathematica and the National Committee for Quality Assurance (NCQA) to identify possible measures for the new PPS-Exempt Cancer Hospital Quality Reporting Program. This contract included conducting an environmental scan that identified cancer-specific and cross-cutting measures—specifically excluding measures of prevention, screening, and diagnosis—followed by the convening of a technical expert panel (TEP) to review and prioritize the measures. The TEP evaluated measures on the basis of relevance to a Medicare population, focusing on the four most common cancers found in that population (lung, breast, colorectal, and prostate), application to both inpatient and outpatient care, and promotion of evidence-based treatment. The TEP favored measures that are NQF-endorsed, already reported or collected by hospitals, available through claims or registry data, and appropriate for reporting by all hospitals that treat cancer patients—not just PPS-exempt cancer hospitals. Based on this analysis, including consultation with the contractor's TEP, CMS' contractor recommended to CMS three chemotherapy/hormone therapy for breast and colon measures developed by the Commission on Cancer and two healthcare-acquired condition (HAC) measures developed by the Centers for Disease Control and Prevention (CDC) (Table 3).

TABLE 3. MEASURE STARTER SET FOR PPS-EXEMPT CANCER HOSPITAL QUALITY REPORTING RECOMMENDED BY CMS' CONTRACTOR

Condition/ Area	Measure Name	NQF Measure Number and Status
Safety	Catheter-associated urinary tract infection	0138 Endorsed
Safety	Central-line-associated bloodstream infection	0139 Endorsed
Breast	Adjuvant hormonal therapy	0220 Endorsed
Breast	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	0559 Endorsed
Colon	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223 Endorsed

These five measures were then proposed for consideration by MAP during its 2012 pre-rulemaking activities as the initial set of measures for the PPS-Exempt Cancer Hospital Quality Reporting Program. In its *Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012 Rulemaking*, MAP supported the inclusion of these measures within the program while recognizing they are a good, albeit limited, starter set. MAP encouraged swift expansion beyond these measures in the coming years for more comprehensive assessment of the quality of care provided in PPS-exempt cancer hospitals. At press time for this report, HHS had included these five measures within the fiscal year (FY) 2013 Inpatient Prospective Payment System (IPPS) proposed rule.

Consistent with other MAP recommendations, MAP supported the use of NQF-endorsed measures within the PPS-Exempt Cancer Hospital Quality Reporting Program. An NQF Endorsement Maintenance Consensus Development Process project was underway when MAP considered the available NQF-endorsed measures and was still ongoing at press time for this report. MAP focused on the cancer types identified as priorities in the list of Medicare High-Impact Conditions[16] and the priorities of the NQS. MAP developed the following list of existing measures and prioritized measure gap areas to serve as an initial PPS-exempt cancer hospital core measure set (Table 4).

TABLE 4. PPS-EXEMPT CANCER HOSPITAL INITIAL CORE SET: EXISTING MEASURES

Condition/Area	Measure Name	NQF Measure Number and Status	Additional Considerations from Public Comment
Patient & Family Engagement	Family evaluation of hospice care	0208 Endorsed	Unclear how this would apply to hospitals without hospice units. Definition of "other inpatient areas" is ambiguous.
Symptom Management	Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	0209 Endorsed	Unclear how this would apply to hospitals without hospice units. Definition of "other inpatient areas" is ambiguous.
Symptom Management	Oncology: plan of care for pain—medical oncology and radiation oncology (paired with 0384)	0383 Endorsed	Measure should be expanded to include patient receiving oral chemotherapy.
Symptom Management	Oncology: pain intensity quantified—medical oncology and radiation oncology (paired with 0383)	0384 Endorsed	Measure should be expanded to include patient receiving oral chemotherapy.
Safety	Catheter-associated urinary tract Infection	0138 Endorsed*	Requires better definition to account for the compromised immune status of cancer patients. The measure involves a significant administrative burden.

Condition/Area	Measure Name	NQF Measure Number and Status	Additional Considerations from Public Comment
Safety	Central-line-associated bloodstream infection	0139 Endorsed*	Protocols and risks vary between temporary and permanent lines. Cancer-specific definitions are needed to differentiate between permanent and temporary lines. Requires better definition to account for the compromised immune status of cancer patients. The measure involves a significant administrative burden.
Safety	Oncology: radiation dose limits to normal tissues	0382 Endorsed	Measure should be rephrased to include the radiation therapy record, rather than the "electronic chart."
Breast	Post breast conserving surgery irradiation	0219 Endorsed	
Breast	Adjuvant hormonal therapy	0220 Endorsed*	
Breast	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	0221 Endorsed	A majority of patients come to PPS-exempt cancer hospitals having already been diagnosed and choice of diagnostic procedure is out of the hospital's control, therefore the measure should be restricted to patients whose cancer was diagnosed in the hospital's screening program.
Breast	Patients with early stage breast cancer who have evaluation of the axilla	0222 Endorsed	A majority of patients come to PPS-exempt cancer hospitals having already been diagnosed and choice of diagnostic procedure is out of the hospital's control, therefore the measure should be restricted to patients whose cancer was diagnosed in the hospital's screening program.
Breast	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	0559 Endorsed*	The term "considered" should be better defined.
Breast, Colon	Oncology: cancer stage documented	0386 Endorsed	

Condition/Area	Measure Name	NQF Measure Number and Status	Additional Considerations from Public Comment
Colon	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223 Endorsed*	
Colon	Completeness of pathology reporting	0224 Endorsed	Numerator exclusion should be updated to reflect that most colonic tumors have no radial margin.
Colon	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	0225 Endorsed	
Colon	Follow up after initial diagnosis and treatment of colorectal cancer: colonoscopy	0572 Endorsed	Stage IV patients be excluded from both the numerator and denominator, since many patients with Stage IV disease undergo resection because of obstruction. Risk adjustment should be considered because of the median age of patients presenting with colon cancer and the comorbidities associated with patient age may affect compliance with the measure. The numerator should include only colonoscopy, in accordance with NCCN guidelines.
Lung	Risk-adjusted morbidity after lobectomy for lung cancer	0459 Endorsed	All NQF-endorsed measures that relate to the diagnosis and treatment of patients with cancer should be included. The measure description does not describe risk adjustment or patient stratification.
Prostate	Prostate cancer: avoidance of overuse measure—isotope bone scan for staging low-risk patients	0389 Endorsed	The measure description should be revised since the PSA measure for low risk patients should read "<= 10"; as opposed to "=10". Patient-specific reasons for ordering a bone scan, such as pain suggestive of bone metastasis, should be included as a specific exclusion or added to the numerator as evidence of compliance.

Condition/Area	Measure Name	NQF Measure Number and Status	Additional Considerations from Public Comment
Prostate	Prostate cancer: adjuvant hormonal therapy for high-risk patients	0390 Endorsed	The measure specification should be expanded to include neoadjuvant and concurrent hormonal therapy as well as adjuvant, since the trials on which the measure is based did not involve adjuvant hormonal therapy exclusively. The wording of the measure should be adjusted to read as follows: "patients who were prescribed hormonal therapy in conjunction with radiation therapy." Finally, a reporting mechanism that permits exclusion of patients refusing ADT, contra-indicated ADT, or post-orchiectomy/already castrate is recommended, so that these patients are either included in the numerator or excluded from the denominator.
Other cancers	Multiple myeloma—treatment with bisphosphonates	0380 Endorsed	Clarification on how this measure would be electronically reported is needed. Commenters support this measure as bisphosphonates have proven beneficial to patients with multiple myeloma with active disease.
Other cancers	Risk-adjusted morbidity and mortality for esophagectomy for cancer	0460 Endorsed	All NQF-endorsed measures that relate to the diagnosis and treatment of patients with cancer should be included. NQF should call for other risk-adjusted mortality and morbidity measures for other cancers using a common methodological approach. The measure description does not describe risk adjustment or patient stratification.

** Measures supported in MAP Pre-rulemaking input on the PPS-Exempt Cancer Hospital Quality Reporting Program*

MAP wrestled with whether to include existing screening measures in the core set, as PPS-exempt cancer hospitals provide those services, but determined that those services, though important, are not core to the specialized function of these systems. Ultimately, MAP recognized that the available measures included in Table 4 are not broad enough to comprehensively assess quality of care.

In addition to these measures, MAP identified priority performance measurement gaps to complete the initial core set. It is necessary to develop, test, endorse, and implement measures in these identified gap areas to create a comprehensive core measure set. The highest priority gap areas identified by MAP, and also noted within the 2012 MAP pre-rulemaking report, are included in Table 5.

TABLE 5. PPS-EXEMPT CANCER HOSPITAL INITIAL CORE SET: MEASURE GAPS

Measure Gap Areas
Patient outcomes, particularly measures of cancer- and stage-specific survival as well as patient-reported measures
Cost and efficiency of care, including measures of total cost, underuse, and overuse
Appropriateness of care, considering the relationship between expected clinical benefit and expected clinical risk
Health and well-being measures addressing quality of life; and social and emotional health
Safety, in particular complications such as febrile neutropenia and surgical site infection
Person- and family-centered care, including shared decision making and patient experience
Care coordination, including transition communication between providers and medication reconciliation
Prevention, such as public outreach and education
Disparities measures, such as risk-stratified process and outcome measures, as well as access measures
Pediatrics measures, including hematologic cancers and transitions to adult care
Treatment of lung, prostate, and gynecological cancers

The initial measure set is not static, but should evolve over time as performance measurement improves and shortfalls in quality of care are identified. The set should be reevaluated periodically to obtain multi-stakeholder input on measures that should be added and removed as new, better measures become available, with an eye toward greater alignment across settings and programs. MAP continues to support minimizing the burden of data collection while maximizing efficiencies in performance measurement among providers.

Public Comment

There were a number of measure-specific public comments received on the initial core measure set which are noted in Table 4. There were some consistent themes across these comments overall. Commenters noted that infection measures should be modified to better account for the immunocompromised status and unique treatment needs of cancer patients. Strong reservations were expressed by some commenters regarding the inclusion of the hospice measures as some of these facilities do not have hospice units. Some commenters questioned the inclusion of measures related to proper diagnostic techniques as these services are often provided at other settings, particularly prior to initial treatment and during the surveillance phase of care. Recognizing the importance of shared accountability across providers, MAP did conclude that measures related to proper diagnostic techniques should be included.

Commenters also suggested additional measures for inclusion in the core set such as palliative care, cancer treatment-related symptom management, team-based care, and risk-adjusted mortality and morbidity measures. These additions should be considered when conducting the first reevaluation of this cancer core measure set in the future.

Finally, commenters expressed strong support for the priority gap areas identified by MAP as part of the core measure set and urged the development of measures to fill these gaps as soon as possible because addressing these issues is vital to provide patient-centered cancer care.

DATA SOURCE AND HEALTH INFORMATION TECHNOLOGY IMPLICATIONS

Unique characteristics of cancer care, such as the various sites and providers of treatment, cyclical nature of treatment, and presence across the lifespan, pose a number of operational challenges for data collection and public reporting. In previous reports discussing **clinician** and **safety** performance measurement coordination strategies, MAP identified a pressing need for common data collection and reporting practices to support performance measurement across the quality measurement enterprise. A common approach would allow for collection of the data needed to efficiently calculate quality measures. Data entered by a single provider at the point of care could flow from electronic health records (EHRs), using common data collection principles and health information exchange (HIE) networks, to be combined with patient data of other providers for aggregation, analysis, reporting, and mining for research. Given the unique characteristics of PPS-exempt cancer hospitals, making this information available to other providers who are jointly involved in patients' care is particularly important.

For this report, MAP reviewed the current collection and reporting processes for several cancer-related registries as a starting place to highlight potential opportunities and concerns for measurement in this area. Particular challenges include difficulty in collecting detailed patient-level data, delays in the availability of performance scores, concerns regarding the impact of small patient sample sizes, and challenges in collecting patient-reported measures. While noting a number of obstacles for measuring PPS-exempt cancer hospitals' performance, MAP did identify promising practices that could demonstrate the feasibility of providing patient-level quality improvement data in a timely manner.

Currently, much of the information captured regarding the quality of cancer care is done through registries such as the American Society of Clinical Oncology's (ASCO's) Quality Oncology Practice Initiative (QOPI)[17] and the American College of Surgeon's (ACS) National Cancer Data Base (NCDB).[18] QOPI provides abstracted medical records data for clinician practices for quality improvement focusing on care processes, and covers steps in care from the initial clinician visit through end of life. The NCDB collects cancer registry data from all Commission on Cancer[19] accredited programs to be used for comparative effectiveness research, retrospective quality monitoring and reporting, and active quality management. Registries such as these are very useful to providers and currently serve as the most common mechanism for cancer performance measurement and reporting. MAP encourages registries to also make this information available for public reporting and development of future educational initiatives.

While registries play an important role in quality measurement and improvement, current cancer databases are limited in their ability to provide specific, cross-cutting, and timely data. The data which are currently being collected lack specificity across the care continuum and are not conducive to providing an overall picture of the patient's care. Existing cancer data registries face challenges tracking unique patients across healthcare providers, leading to missing data and insufficient detail about specific therapies. Additionally, more patient-level detail is needed for identifying disparities in care while implementing controls to ensure data is captured in a uniform manner. It will be important to ensure that patient privacy is maintained while collecting this additional information. The greater use of EHRs by providers

could increase standardization in data collection and documentation and lead to greater sharing of information across the continuum. However, challenges to the widespread adoption of EHRs still exist, including the cost of implementation and variation between systems developed by different vendors.

Another major concern about registries is timely availability of data. MAP recognizes that providers need performance information as close to real time as possible to support better care decisions. When information is funneled through a registry, the delay in accessibility can range from 4 weeks to 2-to-3 years. A long lapse in time between the provision of care and the availability of performance scores can decrease provider accountability for the quality of their care. However, the development of new systems such as the Commission on Cancer Rapid Quality Reporting System[20] could allow for ongoing reporting of quality metrics and more proactive care management. This system allows providers to see performance at the individual patient level and receive alerts if a patient's care is not meeting quality measures, thereby supporting proactive improvement in patient care.

MAP acknowledges that the issue of small sample sizes can be a major measurement challenge in the context of public reporting for PPS-exempt cancer hospitals. As providers try to measure the quality of care for patients with less common forms or more specific types of cancer, the number of appropriate patients to include within the denominator shrinks rapidly. Very small denominators adversely impact the ability of providers to reach meaningful clinical conclusions regarding quality of care. With a small data set, outliers can disproportionately skew results, reflecting an inaccurate representation of a provider's performance. The small numbers problem is particularly applicable to PPS-exempt cancer hospitals as these facilities often provide treatment for the rarest forms of cancers. As this information begins to be publicly reported, it should be used judiciously, with appropriate context, where concerns regarding small sample sizes may exist. Concerns about small denominators could be mitigated by reporting results over a longer timeframe or at health system, state, or regional levels. These concerns also support the need to report cross-cutting and structural measures, as well as clinical quality measures, when assessing the overall quality of care provided within a facility. These types of measures are applicable to the majority, if not all, patients receiving healthcare services, affording more accurate performance scores.

Although necessary to ensuring a person-centered measurement approach, the cyclical nature of cancer treatment can make the collection of patient-reported measures difficult. Accurately capturing the quality of patients' care and their experiences can be challenging when patients are returning repeatedly for treatments. Continually assessing patient experience through surveys and questionnaires poses additional burden on patients who are already working to manage a difficult illness and complex treatment regimen. Additionally, data-gathering processes and mechanisms currently used by providers are not designed to support efficient data collection and measure calculation of patient-reported information. This places additional strains on providers.

Although PPS-exempt cancer hospital quality measurement presents a number of data issues, the United Healthcare Oncology Analysis Program is an example of a promising practice within the private sector that demonstrates the feasibility of quality measurement for cancer care. This database of clinical and claims data creates a record for each patient that compares the care a patient is receiving against the National Comprehensive Cancer Network (NCCN) treatment guidelines. Participating oncologists receive aggregate national results in addition to results on their specific patients, along with guideline data. Another promising advancement in information sharing is an initiative at United

Healthcare working with tumor registries to share data on tumors and treatment. However, issues of privacy around data sharing and the cost of data collection and reporting need to be more fully examined before a wide-scale adoption of a similar system would be possible.

Public Comment

Public comments received were in agreement with the various data challenges laid out above. Commenters noted that once implemented, conversions to ICD-10 codes could facilitate more accurate staging information via claims data and HIT. There was also support for making real-time data more readily available with the caveat that testing must be done in advance to ensure feasibility and validity of data collection.

IMPLICATIONS FOR CANCER CARE BEYOND PPS-EXEMPT CANCER HOSPITALS

Though this specific task focused on a performance measurement strategy for PPS-exempt cancer hospitals, MAP sought a more person-centered view to assess care provided across settings to people at risk for and diagnosed with cancer. As MAP noted in previous performance measurement coordination strategies, setting-specific silos can inhibit effective care coordination and aligned performance measurement. It is important to use consistent measures to ensure that high standards for the quality of cancer care are maintained across all settings and levels of care.

As outlined earlier in this report, cancer care spans the entire continuum, extending upstream and downstream beyond treatment and management received in a hospital setting. Cancer care begins with screening and prevention. There are existing NQF-endorsed measures that address screening for cervical, breast and colorectal cancers as well as surveillance and follow-up for melanoma, breast, and prostate cancers (see Appendix E—NQF-Endorsed Measures Related to Cancer Care). Successful inpatient and outpatient treatment leads to the need for follow-up care and surveillance. These services are typically provided in the ambulatory setting, and related or harmonized measures addressing these concepts should be included in associated measurement programs. Moreover, surveillance and palliative care can extend to post-acute care, long-term care, and hospice settings, so applicable cancer measures should be integrated into those related programs as well. Additional work is needed to promote alignment of cancer care measurement across programs in different settings, particularly exploring opportunities to harmonize existing measures as well as developing measures that span settings and provider types.

Patients with cancer may move back and forth between local community hospitals, ambulatory practices, and PPS-exempt cancer centers throughout their treatment. It is important to have consistent measures across differing acute care facilities. Specifically, MAP advises that cancer care measures should be included within the IQR measure set and that appropriate IQR measures should be applied to PPS-exempt cancer hospitals as a first step toward aligning cancer care quality measurement. Determination of appropriate measures should be done judiciously to ensure only those measures truly applicable to these facilities are included. The initial starter set of measures for the Medicare PPS-Exempt Cancer Hospital Quality Reporting Program (Table 3) begins to address this issue by including two general patient safety measures. During MAP's discussion of these measures, a specific concern was raised regarding appropriate specifications for the central-line-associated bloodstream infection (CLABSI) measure to differentiate between temporary and permanent central lines, the latter commonly found in cancer patients. Evidence-based protocols for the placement and care of permanent central lines differ from those of temporary central lines, particularly for cancer patients who, by the nature of their treatment, may be more prone to infections. As this example illustrates, inclusion of IQR measures within the PPS-Exempt Cancer Hospital Quality Reporting Program requires deliberate measure-by-measure consideration.

Finally, current federal quality measurement programs for both PPS-exempt cancer hospitals and general acute care hospitals focus on Medicare patients. However, cancer care measurement should extend across the lifespan from childhood to older adulthood.

Recognizing the unique needs of pediatric cancer patients, MAP advises that measures focused on this population be considered in a broader performance measurement coordination strategy for cancer care. Transition measures related to the management of care as children grow are especially needed as the effects of cancer and treatment on children can differ greatly from the effects on adults. Inclusion of pediatric measures would encourage alignment across programs, beyond Medicare, to include Medicaid and private-payer programs.

Public Comment

Public comments received stressed the need for alignment of performance measurement efforts across all settings where cancer patients receive care. However, commenters noted that the need for alignment must be balanced with concerns about the applicability of IQR measures for PPS-exempt cancer hospitals. Specifically, commenters raised concerns about measures being appropriately specified, including adequate numerator and denominator coding specificity, risk adjustment, and stratification. There was also request for a clear, defined process for who will determine which measures are appropriate and how those decisions will be made, including a process to contest those decisions.

PATH FORWARD

The core measure set put forth in this report can serve as a fundamental initial list to benchmark cancer care across the 11 PPS-exempt cancer hospitals. MAP suggests that these hospitals could be measured by their results on the core set of measures to inform consumer and purchaser decision making. Moving forward, MAP believes it is important that quality measurement for PPS-exempt cancer hospitals be patient-centered and align with measurement in other settings where patients with cancer receive care. This initial core set aims toward a national core set for measuring cancer care across settings and levels of care.

Although data collection and reporting present a number of challenges to measurement by these hospitals, systems such as the Commission on Cancer Rapid Quality Reporting System and the United Healthcare Oncology Analysis Program show the feasibility and potential of providing quality data at an individual patient level and in real time. Additionally, with the increased use and integration of EHRs by providers, more accurate and timely data will become available, which can be used to uncover opportunities for improvement. While small numbers can make quality measurement for rare cancers difficult, the use of expanded timeframes and geographic populations, as well as cross-cutting and structural measures, can allow for more accurate measurement.

The guidance MAP offers through this report serves as a starting place to better coordinate performance measurement efforts for cancer care. Applying this core measure set for PPS-exempt cancer hospitals and other cancer care providers will promote a more person-centered approach to better prevention and treatment of this disease.

Public Comment

Commenters requested more specific detail around the next steps outlined in the Path Forward section of this report. In particular, they requested that MAP outline a process and timeline for advancing measure development for the priority gap areas. As part of its future work, MAP plans to explore strategies for phasing measures in and out of programs as well as identify pathways for measure development and implementation to fill gaps. Additionally, one commenter recommended that the identification of a small set of measures for cancer care centers of excellence should be used as a model for the future development of measure sets for other specialty areas.

ENDNOTES

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APPENDIX A:
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 programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which 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.[1]

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 ACA-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 alignment of public- and private-sector uses of performance measures to further the National Quality Strategy's (NQS's) three-part aim of creating better, more affordable care, and healthier people.[2] Anticipated outcomes from MAP's work include:

- A more cohesive system of care delivery;
- Better and more information for consumer decision making;
- Heightened accountability for clinicians and providers;
- Higher value for spending by aligning payment with performance;
- Reduced data collection and reporting burden through harmonizing measurement activities across public and private sectors; and
- Improvement in the consistent provision of evidence-based care.

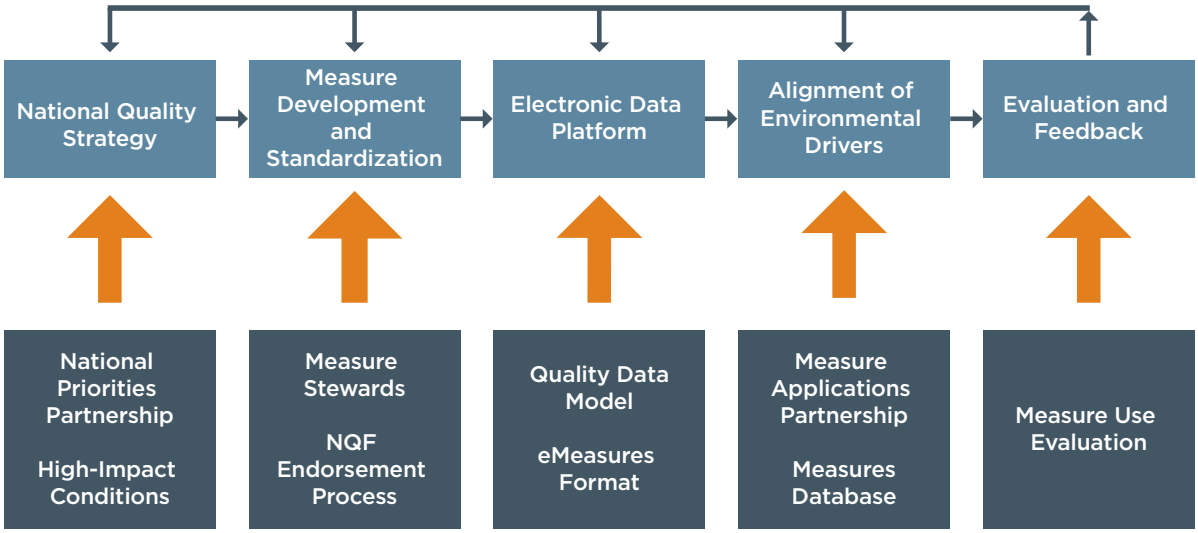
Coordination with Other Quality Efforts

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, aligning payment with value, rewarding providers and professionals for using health information technology (HIT) 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 measurement enterprise" (Figure A-1) that includes:

- Setting priorities and goals for improvement;
- Standardizing performance measures;
- Constructing a common data platform that supports measurement and improvement;
- Applying measures to public reporting, performance-based payment, HIT meaningful use programs, and other areas; and
- Promoting performance improvement in all healthcare settings.

FIGURE A-1. FUNCTIONS OF THE QUALITY MEASUREMENT ENTERPRISE



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.[3] Another NQF-convened group, the Measure Prioritization Advisory Committee, has defined high-impact conditions for the Medicare and child health populations.[4] Cross-cutting priorities and high-impact conditions provide the foundation for all of the subsequent work within the quality measurement enterprise.

Measure development and standardization of measures are necessary to assess the baseline relative to the NQS priorities and goals, determine the current state and opportunities for improvement, and monitor progress. The NQF endorsement process meets certain statutory requirements for setting consensus standards and also provides the resources and expertise necessary to accomplish the task. A platform of data sources, with increasing emphasis on electronic collection and transmission, provides the data needed to calculate measures for use in accountability programs and to provide immediate feedback and clinical decision support to providers for performance improvement.

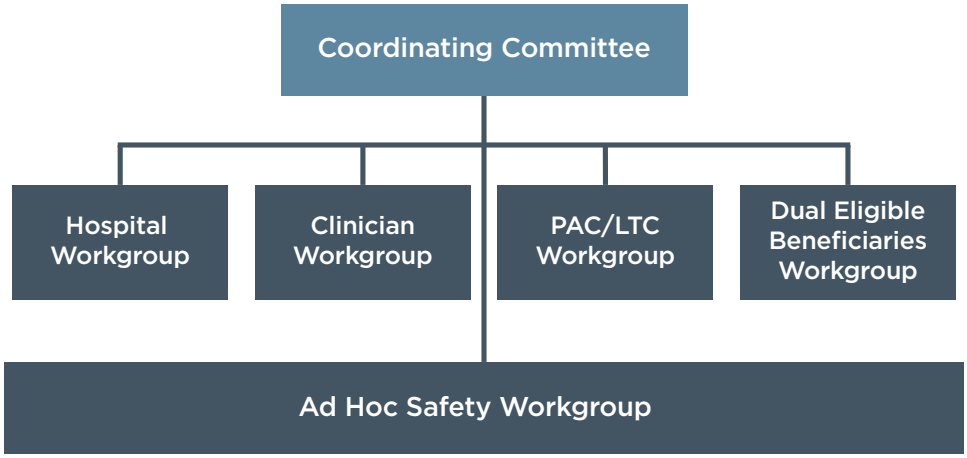
Alignment around environmental drivers, such as public reporting and performance-based payment, is MAP's role in the quality measurement enterprise. By considering and recommending measures for use in specific applications, MAP will facilitate the alignment of public- and private-sector programs and harmonization of measurement efforts under the NQS.

Finally, evaluation and feedback loops for each of the functions of the quality measurement enterprise ensure that each of the various activities is driving desired improvements.[5,6] Further, the evaluation function monitors for potential unintended consequences that may result.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations (Figure A-2). More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented on the Coordinating Committee and workgroups.

FIGURE A-2. MAP 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 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 included 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® Patient-Focused Episodes of Care framework,[7] the HHS Partnership for Patients safety initiative,[8] the HHS Prevention and Health Promotion Strategy,[9] the HHS Disparities Strategy,[10] and the HHS Multiple Chronic Conditions framework.[11] Additionally, the MAP Coordinating Committee has developed measure selection criteria to help guide MAP decision making.

One of MAP's early activities was the development of measure selection criteria. The 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 closely they align with the NQS's priority areas and address the high-impact conditions, and by the extent to which the measure set advances the purpose of the specific program without creating undesirable consequences.

Timeline and Deliverables

MAP's initial work included performance measurement coordination strategies and pre-rulemaking input on the selection of measures for public reporting and performance-based payment programs. Each of the coordination strategies addresses:

- Measures and measurement issues, including measure gaps;
- Data sources and health IT implications, including the need for a common data platform;
- Alignment across settings and across public- and private-sector programs;

- Special considerations for dual eligible beneficiaries; and
- Path forward for improving measure applications.

On October 1, 2011, MAP issued three coordination strategy reports. The report on coordinating readmissions and healthcare-acquired conditions focuses on alignment of measurement, data collection, and other efforts to address these safety issues across public and private payers.[12] The report on coordinating clinician performance measurement identifies the characteristics of an ideal measure set for assessing clinician performance, advances measure selection criteria as a tool, and provides input on a recommended measure set and priority gaps for clinician public reporting and performance-based payment programs.[13] An interim report on performance measurement for dual eligible beneficiaries offers a strategic approach that includes a vision, guiding principles, characteristics of high-need subgroups, and high-leverage opportunities for improvement, all of which informed the content of this final report.[14]

On February 1, 2012, MAP submitted the *Pre-Rulemaking Final Report* and the *Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement Report*. The *Pre-Rulemaking Final Report* provided input on more than 350 performance measures under consideration for use in nearly 20 federal healthcare programs.[15] The report is part of MAP's annual analysis of measures under consideration for use in federal public reporting and performance-based payment programs, in addition to efforts for alignment of measures with those in the private sector. The *Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement* report made recommendations on aligning measurement, promoting common goals for PAC and LTC providers, filling priority measure gaps, and standardizing care planning tools.[16]

Additional coordination strategies for hospice care and dual eligible beneficiaries will be released in June 2012, concurrent with this report.

Endnotes

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APPENDIX B:
Roster for the MAP Coordinating Committee

CHAIR (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	Gerald Shea
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	Doris Peter, PhD
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	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services	Patrick Conway, MD MSc
Health Resources and Services Administration	Ahmed Calvo, MD, MPH
Office of Personnel Management/FEHBP	John O'Brien
Office of the National Coordinator for HIT	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, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

APPENDIX C:
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)
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Health IT	Brandon Savage, MD
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)	Mamatha Pancholi, MS
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Leah Marcotte
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

APPENDIX D:
Public Comments Received on Draft Report

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	American Nurses Association	Maureen Dailey	The American Nurses Association (ANA) supports the comments by the Oncology Nursing Society (ONS) that requests NQF: 1. Encourage and support the development and incorporation of additional team-based measures addressing cancer and cancer-treatment related symptoms beyond pain. 2. Provide specific guidance along with orientation to the proposed two-step consensus development process, in order to be explicit enough to aid measure developers in structuring these kinds of measures. This guidance is necessary to be more conducive to successful endorsement to fill key measure gap areas. The ANA also agrees with ONS's comment supporting the urgent call for less burdensome, more timely methods of data collection (e.g., Meaningful Use), to improve the utility and meaningfulness of these quality measures.
General Comments on the Report	American Society of Clinical Oncology	Thomas Murray	ASCO is the national organization representing more than 30,000 physicians and other health care professionals specializing in cancer research, treatment, diagnosis and prevention. ASCO agrees with the MAP recommendation that priorities outlined in the National Quality Strategy should drive toward measure alignment. ASCO is committed to expanding provider-focused, disease-specific process of care measures to promote quality improvement; however, we also wholeheartedly support MAP's statement of need for more measures that cross patients and settings. Prioritized, cross-cutting measures that are patient-centric, clinically meaningful, and feasible can create a core measure set that can be applied to all institutions providing cancer care. ASCO looks forward to ongoing work to close measure gaps and develop and test this core set. Also, we note that there are several statements related to ASCO's Quality Oncology Practice Initiative (QOPI) that might be misleading as written in the draft. We would be pleased to assist MAP in editing for clarity.
General Comments on the Report	America's Health Insurance Plans	Carmella Bocchino	These 11 PPS-exempt cancer hospitals represent the most expensive care for cancer patients but also the most appropriate for a small set of oncology patients. Health plans have for a number of years used varying sets of data to stratify members appropriate for care in these hospitals. Development of a national set of metrics for gauging these hospitals and their appropriate services lines can lead to a greater degree of standardization of performance in these expensive centers of excellence.
General Comments on the Report	AMGEN Inc.	Sharon Isonaka	References for Amgen's comments are available upon request.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	First, we applaud the focus on measurement as a means of driving change and improving quality as well as the emphasis on the importance of improving the patient experience. We note, however, the singular focus of the MAP on already endorsed cancer measures. The cancer centers treat not only the common cancers, but are also responsible for dealing with many less common malignancies. The single hematologic malignancy addressed in the core measures is multiple myeloma, which in terms of number of patients affected does not reach the significance of patients with lymphoma or leukemia. In addition, patients whose malignancies are best treated by transplant in a specialty center are not addressed in the core measure set at all. The initial core measure set does not include outcomes of vital importance to cancer patients, that is, quality of life and survival. We recommend that development and implementation Of these outcome metrics crucial to our patients be prioritized so that rep0l1ing of these measures is not delayed.
General Comments on the Report	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Second, there appears to be a lack of coordination between the core measures suggested in the MAP report and those endorsed by the NQF Cancer Measure Maintenance Steering Committee (CMMSC). While all the measures included in the MAP report were endorsed by the CMMSC, several endorsed by the CMMSC were omitted by the MAP (0377, 0378, 0379, 0381, 0650). Conversely, the CMMSC endorsed a lung measure which appears more definitive than the measure endorsed by the MAP (1790 versus 0459). Given the fact that the CMMSC has still to consider additional cancer measures in Stage 2 of its deliberations, some clarification of how the measures endorsed by both groups will be harmonized is a priority. Additionally, the difference in recommendations between the MAP report and the CMMSC recommendations arises in the MAP palliative care report as well. Specifically, the CMMSC did not endorse measure 0214, while this measure was endorsed by the MAP.
General Comments on the Report	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Third, we would appreciate clarification of the core measure set endorsed by MAP in terms of expectations for measurement and reporting for the exempt hospitals. The report does not specify when the measurement period is to begin, or whether the core measure set is expected to be phased in over time. The scope of measures included in the core set will make them difficult to implement in a relatively short time frame. Since most of the current proposed measures are not yet available in an electronic record, the specification of the core measure implementation time frame and reporting expectations becomes even more important in order to assess institutional prioritization for reporting purposes.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Fourth, the various measures as specified seem to be insufficiently defined to ensure that all PPS-exempt cancer centers will be measuring them in the same way for comparison purposes. Examples of the variability follow. Some of the measures (0138, 0139, 0389, 0390) reference a part of a document or definitions which are not available for review, making it difficult to assess the core measure. The documentation of measures on the NQF website is variable. Several measures specify whether the measure is intended for use for accountability, reporting or internal improvement purposes; many do not. At least one of the measures uses length of stay as an outcome for mortality (0460), but limits mortality following esophagectomy to those deaths occurring only after 14 days of stay. The reason for this limitation is not specified in the document available for review on the NQF website.
General Comments on the Report	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Finally, we strongly support the recognition by MAP that the inclusion of IQR measures to the PPS-exempt cancer hospital patient population must be discriminating and that each measure must be considered on a case by case basis. MAP mentions the difference between permanent and temporary central lines to exemplify the need for case by case measure determination. An additional example would be the IQR measure specifying immunization, which would pose risks for an immuno-suppressed cancer patient population.
General Comments on the Report	National Patient Advocate Foundation	Nancy Davenport-Ennis	The National Patient Advocate Foundation (NPAF) appreciates the opportunity to comment on the draft performance measurement coordination strategy the Measure Applications Partnership (MAP) has developed to assist CMS as it plans for implementation of a PPS-Exempt Cancer Hospital Quality Reporting Program. Pursuant to the requirements of Section 3005 of the Patient Protection and Affordable Care Act, cancer hospitals are to begin quality reporting in 2014. The draft strategy discusses the technical challenges associated with measuring quality in PPS-exempt cancer hospitals, identifies priorities for establishing a patient-centric cancer care quality measurement program, and presents an initial core set of 22 existing, validated measures that could be used effectively in 2014. Perhaps just as importantly, the report also details a multiplicity of critical concerns for cancer patients and their families that are not yet fully captured in available quality measures.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	National Patient Advocate Foundation	Nancy Davenport-Ennis	NPAF is a non-profit organization dedicated to improving patient access to healthcare services through both federal and state policy reform. Its mission is to be the voice for patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. NPAF has a fifteen year history of serving as the trusted voice of the patient community it represents. Importantly, the advocacy activities of NPAF are grounded in the experience of patients who receive direct, sustained case management services from our companion non-profit organization, Patient Advocate Foundation (PAF). NPAF's comments on the draft strategy are informed by the collective experience of patients who have contacted PAF for assistance with healthcare access issues including insurance issues, medical debt crisis and job retention problems. Those experiences have been quantified annually in the PAF Patient Data Analysis Report (PDAR), which currently illustrates data collected across 260 variables by PAF senior case managers. In 2011, PAF handled over 100,000 patient cases and received more than five million additional inquires from patients nationwide. Most requests were from patients needing assistance with accessing healthcare – either because they could not afford the care recommended by their physicians, could not obtain services within reasonable proximity to their homes, or were denied coverage for prescribed services and treatments by their health insurance plans. By far the most prevalent health condition confronted by patients seeking assistance from PAF was cancer; in fact, 69% of the patients served by PAF in 2011 reported having some form of cancer. Moreover, approximately a quarter of the patients served by PAF were Medicare beneficiaries and requests for assistance from Medicare beneficiaries outnumbered requests from the uninsured for the first time since PAF's founding in 1997. PAF's experience assisting patients confronting a wide spectrum of challenges enables NPAF to competently speak to patients' concerns.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	National Patient Advocate Foundation	Nancy Davenport-Ennis	NPAF's comments are also informed by PAF's considerable experience in assisting cancer patients, particularly low-income cancer patients. As the chart below illustrates, over 63% of cancer patients served by PAF in 2011 had incomes of less than $23,000. NPAF's comments assure that the performance measurement coordination efforts consider the special challenges low-income cancer patients face. NPAF applauds MAP's desire to drive the PPS-Exempt Cancer Hospital Quality Reporting Program toward the use of cross-cutting measures to ensure that the well-being and experience of patients is central to benchmarking and improving the overall quality of care received by a cancer hospital's patients. We understand the need to anchor a quality reporting program in measures that have been thoroughly tested. We recognize too that the current cancer care measurement landscape consists predominantly of provider-focused disease-specific process-of-care measures, and even those are limited to a few of the more common cancer types. We are pleased that the inclusion in the core measures set of disease-specific measures focused on breast, colon, lung and prostate cancer comports with the disease prevalence data reported for patients seeking assistance from PAF in the latest PDAR. Please see the chart on the next page from the PDAR which identifies the top 10 diagnoses of cancer patients seeking assistance from PAF in 2011. Our data also supports the recommendation to expand the focus of disease-specific quality measures to other cancer types as the quality measurement program matures. Although a quality reporting program based on such measures will allow PPS-exempt cancer hospitals to make operational improvements in care processes important to a significant number of cancer patients, a quality system based solely on such measures likely will not improve the effectiveness of shared decision-making, facilitate patients' assessment of quality-of-life issues or inform patients and their families about survival statistics and other outcomes relevant to their selection of a cancer hospital. More cross-cutting measures will be needed to accomplish these objectives.
General Comments on the Report	National Patient Advocate Foundation	Nancy Davenport-Ennis	We agree with the priority that MAP places on patient-centered cancer care and its conclusion that the recommended core set of measures detailed in the draft strategy should serve only as a starting point that will be supplemented over time with the addition of new more cross-cutting measures. We appreciate the suggestion presented in the draft strategy for adapting Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for PPS-exempt cancer hospitals to develop more reliable cancer-specific measures of patient experience. Similarly, we agree with working towards modifications of the Functional Assessment of Cancer Therapy—General (FACT-G) questionnaire to permit the assessment of quality-of-life outcomes at the clinician and/or facility level rather than merely the patient level. We know all too well the barrier posed by poor care coordination between the many sites of service frequented by cancer patients during the course of treatment and survivorship, so we support the recommendations to use common data collection and reporting practices across the quality measurement enterprise where appropriate and to encourage the development and sharing of quality information across sites of service through the use of health information technology.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	National Patient Advocate Foundation	Nancy Davenport-Ennis	We urge MAP, however, to do more to promote the rapid development of the types of measures needed to convert the PPS-Exempt Cancer Hospital Quality Reporting Program into the type of patient-centric model espoused by the draft strategy. Specifically, we recommend including in the draft strategy a detailed timeline for the development, validation and addition of measures to the quality reporting program to address the identified priority measure gaps, all of which we agree deserve attention. Based on the cases handled by PAF, we believe developing and incorporating measures in the cancer hospital quality program that assess the cost of care associated with different cancer diagnoses, including information broken out by stage and/or sub-type, should be addressed expeditiously. We also would like to see survival rates by cancer type and stage publicized on a subsection of the CMS Hospital Compare website devoted to the assessment of PPS-exempt cancer hospitals as soon as possible after the Cancer Hospital Quality Reporting Program goes live. NPAF encourages MAP to seek out ways to gather more input from the patient community early on if it takes on additional projects focused on the development of patient-centric quality of care measures, either to supplement existing quality reporting programs or to define new programs for providers and suppliers not yet subject to robust quality reporting requirements. We see such reporting as essential to the transition to value based purchasing in Medicare and in the commercial insurance arena and we regard such an approach to payment as a key patient-centric change in payer practices. NPAF stands ready to contribute to the understanding of the patient perspective by future MAP or National Quality Forum working groups. Please do not hesitate to contact me should you have further questions or wish to discuss how PAF's experience in assisting patients may inform your efforts on this or other draft strategies for appropriately measuring performance and patient-centric quality of care.
General Comments on the Report	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	1 of 5 Table 4. PPS-Exempt Cancer Hospital Initial Core Measures List The ADCC supports a core measure set for cancer care and the ultimate application of that measure set to all cancer care providers. We appreciate that the MAP supports using measure currently endorsed by the NQF as these measures have been vetted for reliability, usability, feasibility, and scientific acceptability. However, the MAP notes significant gaps in the NQF-endorsed measures applicable to cancer care. Thus, the measures included in Table 4 exclude outcomes of vital importance to cancer patients, including survival and quality of life. We strongly encourage the MAP to revise Table 4 to include measure concepts, such as those outlined in the Priorities for PPS-Exempt Cancer Hospital Measurement section of the report (pg. 6), as the basis for a core measure set for cancer.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	2 of 5 Table 4. PPS-Exempt Cancer Hospital Initial Core Measures List Additionally, we note that the report is silent as to how the cancer-specific core measure reporting would be implemented. For example, we understand that the ADCC members will be required to report five of the measures included in the core measure list beginning in 2014. Is the MAP recommending that we report the other seventeen measures in 2014 as well? Is there a mechanism for "retiring" measures where there are no meaningful differences in reporting across providers (such as when a measure assesses care that is now a standard practice)? Does the MAP recommend stratifying results based on cancer type and stage as well as other cancer-specific risk factors? Specific comments and concerns regarding individual measures are listed below. Measures 0208 and 0209: Family evaluation of hospice care; and, Comfortable dying: Pain brought to a comfortable level within 48 hours of initial assessment We respectfully request clarification of these measures. While the measure descriptions specify that the measures are intended as quality measures for hospice care, their inclusion in the PPS-Exempt Cancer Hospital Core Measure Set implies that they will be used to assess patient care at the hospital level. For those hospitals without hospice units, the use of this measure to assess quality of care at the individual hospital level is unclear.
General Comments on the Report	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	3 of 5 Table 4. PPS-Exempt Cancer Hospital Initial Core Measures List 0138 and 0139: Catheter-associated urinary tract infection; Central line-associated bloodstream infection: As the MAP report notes, central lines placed for cancer treatment are often permanent; evidence-based protocols for the placement and care of such lines differ from those for lines placed for temporary purposes. The risks and outcomes for permanent line placement also differ. We recommend development of cancer-specific definitions for CLABSI and clarification within the measure to differentiate between permanent and temporary lines, in recognition of the fact that the cancer patient population with lines in place differs significantly from a general hospital population, whether in the ICU or elsewhere. 0221 and 0222: Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection; Patients with early stage breast cancer who have evaluation of the axilla: Both measures are appropriate breast quality measures and are readily ascertained. However, the vast majority of patients with breast cancer come to ADCC member institutions having already been diagnosed, whether by needle biopsy or surgical excision. The choice of diagnostic procedure is not under the ADCC's control in such instances. Quality of care at our institutions could be ascertained by these measures only if the measure were restricted to patients whose breast cancer was diagnosed in our screening program.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	4 of 5 Table 4. PPS-Exempt Cancer Hospital Initial Core Measures List Measure 0390: Prostate Cancer: Adjuvant hormonal therapy for high-risk patients In general, we support this measure, which is based on strong evidence. We recommend that the measure specification be expanded to include neoadjuvant and concurrent hormonal therapy as well as adjuvant, since the trials on which the measure is based did not involve adjuvant hormonal therapy exclusively. The optimal timing of radiation therapy and hormones is still a matter of some controversy. We recommend, therefore, that the wording of the measure be adjusted to read as follows: "patients who were prescribed hormonal therapy in conjunction with radiation therapy." We note that the original clinical trials on which this measure is based did not define high risk as the criterion state and that the definition of a high-risk patient is still a matter of debate. Finally, we recommend a reporting mechanism that permits exclusion of patients refusing ADT, contra-indicated ADT, or post-orchiectomy/ already castrate, so that these patients are either included in the numerator or excluded from the denominator.'
General Comments on the Report	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	5 of 5 0459,0460: Risk-adjusted morbidity after lobectomy for lung cancer; Risk-adjusted morbidity and mortality for esophagectomy for cancer: The importance of risk adjustment for these outcome measures is evident. The measure description does not describe the adjustment or any patient stratification into risk categories. 0572: Follow up after initial diagnosis and treatment of colorectal cancer: colonoscopy: With regard to measurement, we recommend that Stage IV patients be excluded from both the numerator and denominator, since many patients with Stage IV disease undergo resection because of obstruction. Risk adjustment should be considered because of the median age of patients presenting with colon cancer. The co-morbidities associated with patient age may affect compliance with the measure. Finally, the numerator includes proctoscopy, sigmoidoscopy or colonoscopy. Given the known increase in metachronous polyp/cancer formation in patients with colon cancer, we would suggest that the numerator include only colonoscopy, in accordance with NCCN guidelines. Of note, at some PPS-exempt cancer centers, the majority of patients is referred for and receives surveillance colonoscopy at outside centers. This is therefore not a useful measure for assessing compliance with care at these centers without a chart audit. We would suggest that the measure be limited to order/ prescription for colonoscopy rather than performance of the procedure at a single institution.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	Comment 1 of 2 Inpatient Quality Reporting (IQR) Program We agree that consistency of measures across care facilities is important. Ultimately, measure alignment will support meaningful comparison of outcomes across providers. However, the ADCC strongly opposes the MAP's recommendation that the measures included in the Inpatient Quality Reporting (IQR) program be applied to the PPS-exempt cancer centers "as a first step to aligning cancer care quality measurement," as indicated on pg. 15 of the report. We appreciate the MAP's recommendation that "appropriate" IQR measures be applied to the PPS-exempt cancer centers. Similarly, the MAP acknowledges on pg. 15 of the report that "inclusion of IQR measures within the PPS-Exempt Cancer Hospital Quality Reporting Program requires deliberate measure-by-measure consideration." Notwithstanding these acknowledgements, the MAP provides no clear direction or mechanism for determining the appropriateness of IQR measures on a case-by-case basis. Who will make this determination? Is there a process for resolving disputes regarding the appropriateness of measures?
General Comments on the Report	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	Comment 2 of 2 Inpatient Quality Reporting (IQR) Program Moreover, the IQR program lacks coding specificity for oncology, and risk adjustment methods appropriate to cancer, which would permit legitimate benchmarking, have not yet been developed. Likewise, applying relevant patient stratification (such as by cancer type and stage and co-morbidity) to patient populations likely would lead to small sample sizes for many providers. These factors would serve to inhibit or disrupt comparison of outcomes across providers, which appears to be the driving force behind this recommendation. Thus, we consider the MAP's recommendation to be too broad and subjective to contribute to meaningful alignment of cancer care quality measurement. We urge measure alignment based on the ongoing development of cancer-focused measures, rather than the application of existing broad-based measures to a cancer population.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	In summary, the ADCC supports many of the recommendations contained in the MAP's Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals. The priority measure gaps outlined in the report reflect the view of the ADCC, and the ADCC would welcome discussions to partner with the NQF and the MAP to develop and pilot measures to fill these measure gaps. As noted above, we strongly disagree with the recommendation that the IQR measures should be applied to the PPS-exempt cancer centers. We urge the MAP to carefully consider removing this recommendation from the report. We believe that recommendation is too broad to accomplish its end goal to align quality measures across cancer care providers. Instead, we are concerned that certain inappropriate measures would be applied to our cancer centers. We thank you in advance for your consideration of our comments and trust that the MAP will give serious consideration to revising the report based on our comments. If you have any questions or would like to discuss these comments with us, please do not hesitate to contact the Chair of our Quality and Value Committee, Dr. Ron Walters.'
General Comments on the Report	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	The ADCC appreciates the extensive work, careful thought, and patient-centered approach reflected in this report. It is evident that, while seeking to address national priorities for cancer care (such as those outlined in the National Quality Strategy), the MAP based its strategy on a clear understanding of the care delivered at the PPS-exempt cancer centers. In particular, we appreciate the comprehensive overview of the PPS-exempt cancer centers and the complexity of care delivered at these institutions beginning on pg. 3 of the report. This report reflects a primary focus on measuring care from the patient's perspective using measures that are evidence-based and research-driven. The episode of care-based approach to quality measurement outlined in the Patient-Centered Cancer Care section of the report harmonizes with the ADCC members' patient-centered approach to care, particularly in accounting for and managing co-morbid conditions that have a profound impact on patient quality of life and the outcomes of cancer care.
Priorities for PPS-Exempt Cancer Hospital Measurement	American Society of Clinical Oncology	Thomas Murray	ASCO agrees that MAP's proposed measurement strategy should include cross-cutting measures that are aligned with NQS aims and priorities. Specifically, ASCO agrees that the priority list proposed by the MAP is a strong starting point that builds off of the past work of NQF and others. Additional measure development and testing are needed to build a measure set that addresses these priority areas. Along with the need for cross-cutting measures, ASCO advocates for the ongoing development and implementation of provider-focused and disease-specific measures to promote quality improvement. ASCO believes that there should be shared priorities and measures for all organizations that treat cancer patients; however, special attention is needed to ensure that there is an adequate patient denominator in each type of center that would be measured.

Comment Category	Commenter Organization	Commenter Name	Comment
Priorities for PPS-Exempt Cancer Hospital Measurement	America's Health Insurance Plans	Carmella Bocchino	We support the priorities articulated in the report and recommend adding to this list measurement of avoidable complications. While some measures of avoidable complications are included in the Starter Measure Set (Table 3) the list could be expanded to be consistent with the Partnership for Patients list of measures.
Priorities for PPS-Exempt Cancer Hospital Measurement	AMGEN Inc.	Sharon Isonaka	Amgen appreciates the efforts of the NQF MAP for developing a quality measures strategy for PPS-exempt cancer hospitals, as well as for other facilities and settings where cancer patients receive care. Having appropriate measures for public reporting and pay for performance are fundamental to ensuring that cancer patients and survivors have access to the highest quality care. It is with this interest in mind that we offer specific comments on the Priority Performance Measure Gaps listed on Page 12 of the Draft Report (See Amgen comment in Defining the Measure Set and Path Forward comment fields).
Priorities for PPS-Exempt Cancer Hospital Measurement	City of Hope National Medical Center	Bernard Tegtmeier	The City of Hope National Medical Center commends the MAP for their thoughtful analysis of the endorsed measures and their identification of measurement priorities and gap areas. However, we believe that there a number of important concerns which were not addressed in the report. As noted in the MAP report, the PPS-Exempt Cancer Hospitals (PECH), as a condition of their exemption, are "organized primarily for cancer research or treatment." Since the maintenance of an infrastructure capable of supporting a robust clinical trials program adds additional costs to cancer care provided at PECH, it seems important to develop metrics for clinical trial participation. In addition, clinical trial participation has the potential for adversely effecting performance if measures do not address clinical trial participation. In reviewing the proposed Measure Starter Set, there is no mention of clinical trial participation in any of the measures. Another area of concern is how metric performance will be controlled for severity of illness and the presence of comorbidities. As tertiary referral centers for cancer patients, PECH see patients who may have already been offered the "best practice" therapies and are sicker and have multiple comorbidities that may not be as prevalent in general acute care hospitals.

Comment Category	Commenter Organization	Commenter Name	Comment
Priorities for PPS-Exempt Cancer Hospital Measurement	OSUCCC-James Cancer Hospital	Charles Borden	Arthur G. James Cancer Hospital and Richard J. Solve Research Institute is supportive of MAP's efforts to establish quality indicators for PPS-exempt cancer hospitals that are patient-centered and reflective of quality care. Further, The James agrees with the priority areas set forth by MAP. However, the feasibility of accurately collecting data for the measures is still unclear. Better defining the measures in the proposed core measure set will reduce ambiguity and alleviate some concern. Several terms such as "considered" in NQF 0559, the definition of hospice in NQF 0208 and 0209 and the definition of "other inpatient areas" for NQF 0208 and 0209 are ambiguous and as a result, subject to differing interpretations, which have the potential for skewing benchmarking results. Clarification is needed on which of the 22 core measures are scheduled for reporting in 2014. The scope of CCCs includes both clinical trials and screening/care provided by clinicians not associated with our institutions. Questions have been raised about how those scenarios will be treated in the core measure set; will these cases be included or excluded? The issue of following such patients is a challenging one and we look forward to additional clarification on the role and responsibilities of the cancer centers. Thank you for your time and consideration.
Priorities for PPS-Exempt Cancer Hospital Measurement	Roswell Park Cancer Institute	Dana Jenkins	On behalf of the Consortium of Comprehensive Cancer Centers for Quality Improvement (C4QI), we appreciate the opportunity to comment on the MAP Performance Measurement Coordination Strategy for PPS Exempt Cancer Hospitals. C4QI is a voluntary organization, formed in 1998 in response to the Joint Commission's ORYX benchmarking initiative. The organization focuses on sharing data and best practice in order to improve cancer care. Currently, there are 18 C4QI member institutions, including all the PPS exempt cancer centers. Our comments on the measures follow. To begin, we commend the MAP members for their thoughtful approach to improving the quality of care for cancer patients. As mentioned above, that has been the primary focus of our group for the 12 years of its existence. We agree that care must be measured in order to improve and that eventually, the measures must be applicable to all areas where cancer care is delivered. We also whole-heartedly agree with the patient-centered approach. C4QI has been participating as a group in a Press Ganey patient satisfaction oncology survey for more than a decade. The results of those surveys, both inpatient and ambulatory have been shared among our membership at our twice-yearly meetings and those institutions with the best scores have been generous in sharing best practices so that others of us can learn.

Comment Category	Commenter Organization	Commenter Name	Comment
Priorities for PPS-Exempt Cancer Hospital Measurement	Roswell Park Cancer Institute	Dana Jenkins	Roswell Park Cancer Institute thanks the MAP for taking a step forward on the difficult journey toward developing reliable measures designed to improve the care provided to those diagnosed with cancer. In the spirit we offer the following comments: * Re: the "starter set" measures for CLABSI and CAUTI: Better definitions, to account for the immunocompromised population we serve, are required. A significant administrative burden is required to a.) get denominator days for these measures, b.) enter them into the cumbersome NHSN database. * Re: the proposed "core measure set": - measure 0208 and 0209: many PPS exempt centers don't have inpt hospice and therefore this would be n/a. If the indicator is intended to measure the family experience with referrals to hospice we don't think this measure should be on the PPS list - measure 0380- valuable measure but unclear how this would be electronically reported - measure 0455- recommend that mandatory performance status documentation before surgery should be 4 weeks to better synchronize with consent form timing - measure 0460- the ALOS for esophagectomy is typically much longer than that for lobectomy given 50% complication rate, need for bowel recovery, diet restart etc. We advocate that this be adjusted.
Priorities for PPS-Exempt Cancer Hospital Measurement	Roswell Park Cancer Institute	Dana Jenkins	continuing... We think it is extremely important to better define the measures in the proposed core measure set. Several terms such as "considered" in NQF 0559 , the definition of hospice in NQF 0208 and 0209 and the definition of "other inpatient areas for NQF 0208 and 0209 are ambiguous and as a result, subject to differing interpretations which have the potential for skewing benchmarking results. We would also appreciate clarification of what constitutes a core measure set and when that measure set will be implemented for reporting purposes. Five of the measures on the core measure set are scheduled for reporting in 2014. Is that the case for all the core measures? Will our members be expected to choose several core measures from among the set of 22? In addition, given the expectation that most measures be used for internal improvement purposes, we would stress the importance of timely and accurate data. Current data such as those from NCCN or ASCO have issues regarding either timeliness or comprehensiveness of the data sets included, which present challenges n calculating concordance. We would question whether cancer registries can staff appropriately to meet additional reporting requirements. In addition, many of our members still rely on paper patient records and the timeline and prioritization of movement to electronic health records must be considered when decisions about implementation of cancer core measures are made.

Comment Category	Commenter Organization	Commenter Name	Comment
Priorities for PPS-Exempt Cancer Hospital Measurement	Roswell Park Cancer Institute	Dana Jenkins	continuing... Many of our centers conduct clinical trials and we would appreciate clarification of how such patients would be treated in terms of the core measure set. Would they be included? Stratified? Excluded from cost/survival measures? Finally, many of our patients are screened for preventive services in areas not associated with our member institutions. The issue of following such patients is a challenging one and we look forward to additional clarification of the role and responsibilities of the cancer centers in compliance. Again, we thank you in advance for your consideration of these comments.
Priorities for PPS-Exempt Cancer Hospital Measurement	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	The ADCC fully supports the measurement development priorities outlined in the section of the report, particularly survival, patient-reported outcomes, and quality of life. We agree that a core measure set for cancer should focus on the measure priorities and on the cancer diseases described therein.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	American Society of Clinical Oncology	Thomas Murray	ASCO emphasizes the need for comprehensive cancer quality measurement, including cross-cutting measures. We encourage quality improvement activities that involve more than the three cancer-specific and two general quality measures included in Starter Set. Therefore, we strongly support MAP's recommendation to encourage "swift expansion beyond these measures in the coming years for more comprehensive assessment of the quality of care provided in PPS-exempt cancer hospitals." The proposed core measure list is a reasonable start; however, the feasibility and validity of the proposed measures may require additional testing prior to 2014, depending on the mechanism(s) for data collection (see comments on the following section). The measure set for PPS-exempt cancer hospitals and for other institutions where cancer care is provided should be completely aligned. ASCO is uniquely positioned to assist in identifying and implementing additional evidence-based quality measures for oncology that are both actionable and relevant at the point of patient care. MAP notes the highest priority gap areas. ASCO has developed measures or is engaged in measure development in many of these areas, and looks forward to ongoing work with MAP, HHS, and others to fill these gaps.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	America's Health Insurance Plans	Carmella Bocchino	NQF Measure #0460 is the only risk-adjusted morbidity and mortality measure included and it is for a less common cancer i.e. esophagus. We encourage NQF to call for other risk-adjusted mortality and morbidity measures for other cancers using a common methodological approach. We would, however, strongly urge that the measure list include all endorsed NQF measures that relate to the diagnosis and treatment of patients with cancer so that the quality of care at PPS-Exempt Cancer Hospitals can be compared effectively with the quality of care of all other cancer providers across the country. Examples of additional measures that could be included are as follows: 210, 211, 213, 215, 216, 0457, 0459, 0460, 1790, and 1822.

Comment Category	Commenter Organization	Commenter Name	Comment
Defining a PPS-Exempt Cancer Hospital Core Measure Set	AMGEN Inc.	Sharon Isonaka	Amgen strongly agrees that febrile neutropenia (FN) should be identified as a priority measure gap (Page 12). Some of the serious and frequent side effects following myelosuppressive chemotherapy are neutropenia, FN and infections which can lead to hospitalization, disruptions in chemotherapy, and significant morbidity and mortality. In 2009 over 300,000 cancer patients were admitted for the management of infectious complications during their cancer treatment. An analysis of the AHRQ HCUP NIS database indicated the mortality rate among those admitted for neutropenic complications was 5.4 percent in 2007. Given the significant number of patients who may require treatment for FN related complications in the hospital setting, this is a major opportunity to institute measurement-driven quality improvement care for people with cancer. Quality measurement for FN would complement other ongoing efforts to reduce infection in cancer patients, such as the CDC's Preventing Infections in Cancer Patients program. We also support "appropriateness of care" and "under and over utilization" as priority measure gaps, and are pleased that the MAP did not focus exclusively on overuse of treatment. We suggest that the MAP clarify the focus of these gap areas for measure developers to ensure measures are predicated on clinical evidence and not exclusively focused on cost considerations.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Eisai, Inc.	Charles Hampsey	Eisai generally supports the core measurement set that the MAP has identified for PPS-Exempt Cancer Hospitals. We note that "Plan of Care for Pain" and "Pain Intensity Quantified" (0383 and 0384) are designated by CMS for registry reporting in the PQRS program. These measures target patients receiving IV chemotherapy or radiation therapy. If, however, a patient is prescribed oral chemotherapy they are excluded because the current measure specifications require a CPT code for IV drug administration as an inclusion criterion. The steward, ASCO/PCPI, is now developing an EHR reporting option for 0383, 0384 and other measures. Registry reporting and EHRs both allow oral and IV chemotherapy data to be collected. Eisai encourages the MAP to urge the steward to revise these measures to include all treatment modalities such that patients who are receiving oral cancer therapy are also included in this evaluation of their care. Broadening 0383 and 0384 is this way would also increase the potential volume of applicable cases for reporting.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measures 0138, 0139: Catheter-associated urinary tract infection; Central line-associated bloodstream infection As the MAP report itself notes, central lines placed for cancer treatment are often permanent; evidence-based protocols for the placement and care of such lines differ from those for lines placed for temporary purposes. The risks and outcomes for permanent line placement also differ. We recommend development of cancer-specific definitions for CLABSI and clarification within the measure to differentiate between permanent and temporary lines, in recognition of the fact that the cancer patient population with lines in place differs significantly from a general hospital population, whether in the ICU or elsewhere.

Comment Category	Commenter Organization	Commenter Name	Comment
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measures 0208, 0209: Family evaluation of hospice care; Comfortable dying; Pain brought to a comfortable level within 48 hours of initial assessment We respectfully request clarification of these measures. While the measure descriptions specify that the measures are intended as a quality measure for hospice care, their inclusion in the PPS-Exempt Cancer Hospital Core Measure Set implies that they will be used to assess patient care at the hospital level. For those hospitals without hospice units, the use of this measure to assess quality of care at the individual hospital level is unclear.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measures 0221, 0222 Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection; Patients with early stage breast cancer who have evaluation of the axilla: Both measures are appropriate breast quality measures and are readily ascertained. However, the vast majority of patients with breast cancer come to MSKCC having already been diagnosed, whether by needle biopsy or surgical excision. The choice of diagnostic procedure is not under MSKCC's control in such instances. Quality of care at our institution could be ascertained by this measure only if the measure were restricted to patients whose breast cancer was diagnosed in our screening program.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measure 0224: Cancer Stage documented This is an appropriate pathology quality measure. With regard to margin status, most colonic tumors have no radial margin; we would suggest adjusting the numerator exclusion to reflect this. In addition, while adding a positive statement for the absence of a result is possible, for example, "small vessel invasion negative" "large vessel invasion negative" as opposed to "no vascular invasion," we are concerned that adding additional information on negative results to a report may lead to the unintended consequence of obscuring positive findings.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measure 0380: Multiple myeloma-treatment with bisphosphonates Bisphosphonates have proven beneficial to patients with multiple myeloma with active disease. Pamidronate or zoledronic acid is acceptable. The measure will quantify the percentage of patients with multiple myeloma not in remission and who are treated with bisphosphonates. We support this measure.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measure 0382: Radiation dose limits to normal tissues (esophageal, lung and pancreatic cancer) We support this measure. At MSKCC all such patients have normal organ dose constraints displayed as part of the treatment plan. The plan is not approved until the treating physician is satisfied. Since the information is not yet retrievable electronically, we suggest that the measure be rephrased to include the Radiation Therapy record, rather than the "electronic chart."

Comment Category	Commenter Organization	Commenter Name	Comment
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measure 0389: Avoidance of overuse-isotope bone scan for staging low risk patients This is a good measure of overuse, consistent with ASCO's recent recommendation not to stage with bone scan in low-risk, early stage prostate cancer. A minor edit in the measure description is recommended, since the PSA measure for low risk patients should read "< = 10"; as opposed to "=10". In addition, we recommend that patient-specific reasons for ordering a bone scan, such as pain suggestive of bone metastasis should be included as a specific exclusion or added to the numerator as evidence of compliance.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measure 0390: Adjuvant hormonal therapy for high-risk prostate cancer patients In general, we support this measure, which is based on strong evidence. We recommend that the measure specification be expanded to include neoadjuvant and concurrent hormonal therapy as well as adjuvant, since the trials on which the measure is based did not involve adjuvant hormonal therapy exclusively. The optimal timing of RT and hormones is still a matter of some controversy. We recommend, therefore, that the wording of the measure be adjusted to read as follows: "patients who were prescribed hormonal therapy in conjunction with radiation therapy." We note that the original clinical trials on which this measure is based did not define high risk as the criterion state and that the definition of a high-risk patient is still a matter of debate. Finally, we recommend a reporting mechanism that permits exclusion of patients refusing ADT, contra-indicated ADT or post-orchiectomy/already castrate, so that these patients are either included in the numerator or excluded from the denominator.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measures 0459, 0460: Risk-adjusted morbidity after lobectomy for lung cancer; Risk-adjusted morbidity and mortality for esophagectomy for cancer The importance of risk adjustment for these outcome measures is evident. The measure description does not describe the adjustment or any patient stratification into risk categories.

Comment Category	Commenter Organization	Commenter Name	Comment
Defining a PPS-Exempt Cancer Hospital Core Measure Set	Memorial Sloan-Kettering Cancer Center	David Pfister Jeremy Miransky	Measure 0572 : Follow up after initial diagnosis and treatment of colorectal cancer: colonoscopy This is a very important measure. The effectiveness of postoperative colonic screening has been shown to identify new polyps/cancer as well as local recurrence. The identification of local recurrence has been shown to improve overall survival with level 1 evidence. The measure is also in keeping with the NCCN guidelines. With regard to measurement, we recommend that Stage IV patients be excluded from both the numerator and denominator, since approximately 25% of patients present to MSK with Stage IV disease and the majority undergoes resection because of obstruction. Risk adjustment should be considered because of the median age of patients presenting with colon cancer. The co morbidities associated with patient age may affect compliance with the measure. Finally, the numerator includes proctoscopy, sigmoidoscopy or colonoscopy. Given the known increase in metachronous polyp/cancer formation in patients with colon cancer, we would suggest that the numerator include only colonoscopy, in accordance with NCCN guidelines. Implementation: At MSK, the majority of patients is referred for and receives surveillance colonoscopy at outside centers. This is therefore not a useful measure for assessing compliance with care at MSK without a chart audit. We would suggest that the measure be limited to order/prescription for colonoscopy rather than performance of the procedure at a single institution.
Defining a PPS-Exempt Cancer Hospital Core Measure Set	WellPoint	Lisa Latts	We are very supportive of the proposed expanded list of Performance Measures for PPS-Exempt Cancer Hospitals. We would, however, strongly urge that the measure list include all endorsed NQF measures that relate to the diagnose and treatment of patients with cancer so that the quality of care at PPS-Exempt Cancer Hospitals can be compared effectively with the quality of care of all other cancer providers across the country. Consistency of measurement across the spectrum of care is critical. Information from the PPS Exempt cancer hospitals is key information for the Longitudinal Patient Record. Specifically, we would believe the following measures should be included in the PPS--Exempt Cancer Hospitals measurement set: 1790 Prostate and Lung Measures - Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer (New Measure) 210 Palliative Measures - Proportion receiving chemotherapy in the last 14 days of life (Maintenance) 211 Palliative Measures - Proportion with more than one emergency room visit in the last days of life (Maintenance) 213 Palliative Measures - Proportion admitted to the ICU in the last 30 days of life (Maintenance) 215 Palliative Measures - Proportion not admitted to hospice for less than 3 days (Maintenance) 216 Palliative Measures - Proportion admitted to hospice for less than 3 days 1822 Palliative Measures - External Beam Radiotherapy for Bone Metastases (New Measure)

Comment Category	Commenter Organization	Commenter Name	Comment
Data Source and Health Information Technology Implications	American Society of Clinical Oncology	Thomas Murray	In selecting the PPS-exempt cancer hospital measures, the MAP thoughtfully discusses the challenges of data collection. ASCO agrees that issues related to privacy around data sharing and the cost of data collection and reporting need to be more fully examined before widespread adoption of data systems. MAP advocates for real-time tracking of quality. To date, CMS quality reporting programs have not included this type of data collection. Moreover, the specifications for the NQF-endorsed measures included in this list were generally not developed or tested for real-time tracking. ASCO supports the concept of real-time quality monitoring; however, the feasibility and validity of data collected using such an approach should be tested prior to implementation in a federal program.
Data Source and Health Information Technology Implications	America's Health Insurance Plans	Carmella Bocchino	We agree with the discussion in the MAP report on data sources, and encourage adoption of measures that incorporate ICD-10 codes, once these codes are fully implemented. Such an approach will facilitate more accurate staging information via HIT and claims data.
Data Source and Health Information Technology Implications	The Alliance of Dedicated Cancer Centers	Ron Walters, MD	This section of the report outlines the unique challenges; particularly timely availability of data and small sample sizes; faced by the ADCC members in their efforts to measure and report internally on meaningful measures of quality cancer care. It also recommends adjustment of existing data registries to accommodate more timely reporting of patient-level quality data.
Path Forward	American Society of Clinical Oncology	Thomas Murray	ASCO agrees with the MAP that quality measurement for PPS-exempt cancer hospitals should be patient-centered and aligned with measurement in other settings in which cancer patients receive care to better coordinate performance measurement efforts for cancer care.
Path Forward	America's Health Insurance Plans	Carmella Bocchino	The path forward in developing a model for a small set of cancer care centers of excellence will become the template for the future development of measures for other centers of excellence across the medical community e.g. hip/knee replacement COE, cardiac COE, etc. In cancer management it has been clear that concentration of high level resources in a small number of hospitals leads to the ability to stratify the patients in need so that those with more complex or unusual disorders receive care in such cancer COEs as these 11 hospitals. This should be our model for other conditions and this report provides that initial guidepost.
Path Forward	AMGEN Inc.	Sharon Isonaka	Amgen supports the priority performance measure gaps areas outlined on Page 12 of report. We commend the focus on patient centered cancer care and we believe the measure gaps pertaining to: patient outcomes; health and well-being; safety and complications including febrile neutropenia; shared patient and family decision-making; care coordination; and disparities are particularly important measure gaps to address. We urge the MAP to facilitate timely development of quality measures in these areas. It is unclear from the draft report what the next steps are to advance measure development in these priority gap areas. In the final report the NQF MAP should outline the process and timeline for advancing measure development for the priority gap areas.

APPENDIX E:
NQF-Endorsed® Measures Related to Cancer Care

Measure Name	NQF Measure Number and Status	Description
Breast cancer screening	0031 Endorsed†	Percentage of eligible women 40-69 who receive a mammogram in a two year period
Cervical cancer screening	0032 Endorsed†	Percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer
Colorectal cancer screening	0034 Endorsed†	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer
Family evaluation of hospice care	0208 Endorsed	Composite Score: Derived from responses to 17 items on the Family Evaluation of Hospice Care (FEHC) survey presented as a single score ranging from 0 to 100. Global Score: Percentage of best possible response (Excellent) to the overall rating question on the FEHC survey Target Population: The FEHC survey is an after-death survey administered to bereaved family caregivers of individuals who died while enrolled in hospice. Timeframe: The survey measures family members' perceptions of the quality of hospice care for the entire enrollment period, regardless of length of service
Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	0209 Endorsed	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours
Proportion receiving chemotherapy in the last 14 days of life	0210 Endorsed	Patients who died from cancer and received chemotherapy in the last 14 days of life
Proportion with more than one emergency room visit in the last days of life	0211 Endorsed*	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life
Proportion with more than one hospitalization in the last 30 days of life	0212 Endorsed*	Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life
Proportion admitted to the ICU in the last 30 days of life	0213 Endorsed*	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life
Proportion dying from cancer in an acute care setting	0214 Endorsed*	Percentage of patients who died from cancer dying in an acute care setting
Proportion not admitted to hospice	0215 Endorsed*	Percentage of patients who died from cancer not admitted to hospice

Measure Name	NQF Measure Number and Status	Description
Proportion admitted to hospice for less than 3 days	0216 Endorsed*	Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there
Post breast conserving surgery irradiation	0219 Endorsed	Percentage of female patients, age 18-69, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, receiving breast conserving surgery who receive radiation therapy within 1 year (365 days) of diagnosis
Adjuvant hormonal therapy	0220 Endorsed	Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, who's primary tumor is progesterone or estrogen-receptor positive recommended for tamoxifen or third generation aromatase inhibitor (considered or administered) within 1 year (365 days) of diagnosis
Needle biopsy to establish diagnosis of cancer precedes surgical excision/ resection	0221 Endorsed	Percentage of patients presenting with AJCC Stage Group 0, I, II, or III disease, who undergo surgical excision/resection of a primary breast tumor who undergo a needle biopsy to establish diagnosis of cancer preceding surgical excision/ resection
Patients with early stage breast cancer who have evaluation of the axilla	0222 Endorsed	Percentage of women with Stage I-IIb breast cancer who received either axillary node dissection or Sentinel Lymph Node Biopsy (SLNB) at the time of surgery (lumpectomy or mastectomy)
Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223 Endorsed	Percentage of patients under the age of 80 with AJCC III (lymph node positive) colon cancer for whom adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery
Completeness of pathology reporting	0224 Endorsed	Percentage of patients with audited colorectal cancer resection pathology complete reports
At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	0225 Endorsed	Percentage of patients >18yrs of age, who have primary colon tumors (epithelial malignancies only), experiencing their first diagnosis, at AJCC stage I, II, or III who have at least 12 regional lymph nodes removed and pathologically examined for resected colon cancer
Myelodysplastic syndrome (MDS) and acute leukemias—baseline cytogenetic testing performed on bone marrow	0377 Endorsed	Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenic testing performed on bone marrow

Measure Name	NQF Measure Number and Status	Description
Documentation of iron stores in patients receiving erythropoietin therapy	0378 Endorsed	Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy
Chronic lymphocytic leukemia (CLL) – baseline flow cytometry	0379 Endorsed	Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed
Multiple myeloma—treatment with bisphosphonates	0380 Endorsed	Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonates within the 12-month reporting period
Oncology: treatment summary documented and communicated—radiation oncology	0381 Endorsed	Percentage of patients with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care within one month of completing treatment
Oncology: radiation dose limits to normal tissues	0382 Endorsed	Percentage of patients with a diagnosis of cancer receiving 3D conformal radiation therapy with documentation in medical record that normal tissue dose constraints were established within five treatment days for a minimum of one tissue
Oncology: plan of care for pain—medical oncology and radiation oncology (paired with 0384)	0383 Endorsed	Percentage of visits for patients with a diagnosis of cancer currently receiving intravenous chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain
Oncology: pain intensity quantified—medical oncology and radiation oncology (paired with 0383)	0384 Endorsed	Percentage of visits for patients with a diagnosis of cancer currently receiving intravenous chemotherapy or radiation therapy in which pain intensity is quantified
Oncology: chemotherapy for stage IIIA through IIIC colon cancer patients	0385 Endorsed	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are prescribed or who have received adjuvant chemotherapy within the 12-month reporting period
Oncology: cancer stage documented	0386 Endorsed	Percentage of patients with a diagnosis of breast, colon, or rectal cancer seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12-month reporting period
Oncology: hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer	0387 Endorsed	Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) within the 12-month reporting period

Measure Name	NQF Measure Number and Status	Description
Prostate cancer: three-dimensional radiotherapy	0388 Endorsed	Percentage of patients with prostate cancer receiving external beam radiotherapy to the prostate only who receive 3D-CRT (three-dimensional conformal radiotherapy) or IMRT (intensity modulated radiation therapy)
Prostate cancer: avoidance of overuse measure—isotope bone scan for staging low-risk patients	0389 Endorsed	Percentage of patients with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer
Prostate cancer: adjuvant hormonal therapy for high-risk patients	0390 Endorsed	Percentage of patients with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)
Breast cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	0391 Endorsed	Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade
Colorectal cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	0392 Endorsed	Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade
Recording of clinical stage for lung cancer and esophageal cancer resection	0455 Endorsed	Percentage of all surgical patients undergoing treatment procedures for lung or esophageal cancer that have clinical TNM staging provided
Recording of performance status (Zubrod, Karnofsky, WHO, or ECOG Performance Status) prior to lung or esophageal cancer resection	0457 Endorsed	Percentage of patients undergoing resection of a lung or esophageal cancer who had their performance status recorded within two weeks of the surgery date
Risk-adjusted morbidity after lobectomy for lung cancer	0459 Endorsed	Percentage of patients undergoing elective lobectomy for lung cancer that have a prolonged length of stay (>14 days)
Risk-adjusted morbidity and mortality for esophagectomy for cancer	0460 Endorsed	The percentage of patients undergoing elective esophagectomy for cancer that had a prolonged length of stay (>14 days)

Measure Name	NQF Measure Number and Status	Description
Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	0559 Endorsed	Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, whose primary tumor is progesterone and estrogen receptor negative recommended for multiagent chemotherapy (considered or administered) within 4 months (120 days) of diagnosis
Melanoma coordination of care	0561 Endorsed	Percentage of patients seen with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis
Over-utilization of imaging studies in stage 0-IA melanoma	0562 Endorsed	Percentage of patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies were ordered
Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	0572 Endorsed	To ensure that all eligible members who have been newly diagnosed and resected with colorectal cancer receive a follow-up colonoscopy within 15 months of resection
Annual cervical cancer screening for high-risk patients	0579 Endorsed†	This measure identifies women age 12 to 65 diagnosed with cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS prior to the measurement year, and who still have a cervix, who had a cervical CA screen during the measurement year
Breast cancer—cancer surveillance	0623 Endorsed†	Percentage of female patients with breast cancer who had breast cancer surveillance in the past 12 months
Prostate cancer—cancer surveillance	0625 Endorsed†	Percentage of males with prostate cancer that have had their PSA monitored in the past 12 months
Melanoma continuity of care—recall system	0650 Endorsed†	Percentage of patients with a current diagnosis of melanoma or a history of melanoma who were entered into a recall system with the date for the next complete physical skin exam specified, at least once within the 12 month reporting period

** NQF-endorsed hospice and palliative care measures specified for the cancer population*

† NQF-endorsed screening and surveillance measures specified for the cancer population

NATIONAL QUALITY FORUM

1030 15TH STREET, NW, SUITE 800

WASHINGTON, DC 20005

www.qualityforum.org