## Measure Applications PartnershipCoordinating Committee Discussion Guide

*Notes for Measure Deliberations*

*Version Number*: 6.6
*Meeting Date:* January 24-25, 2017

## Full Agenda

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| **Day 1: January 24, 2017**   |  |
|  |  |
| 8:30 AM   | Breakfast |
|  |  |
| 9:00 AM   | **Welcome Remarks**  |
|  | Kate Goodrich, Director and CMS Chief Medical Officer, Center for Clinical Standards and Quality, CMS  |
| 9:15 AM   | **Review of Meeting Objectives**  |
|  | Harold Pincus, MAP Coordinating Committee Co-ChairChip Kahn, MAP Coordinating Committee Co-Chair  |
| 9:30 AM   | **MAP Pre-Rulemaking Approach**  |
|  | Erin O’Rourke, Senior Director, NQFHarold Pincus * Review the 2016-2017 MAP Pre-Rulemaking Approach
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| 9:45 AM   | **NQF Strategic Plan** |
|  | Helen Burstin, Chief Scientific Officer, NQFChip Kahn  |
| 10:00 AM   | *Opportunity for Public Comment on Hospital Programs* |
|  |  |
| 10:15 AM   | **Pre-Rulemaking Recommendations for Hospital Programs** |
|  | Cristie Upshaw Travis, MAP Hospital Workgroup Co-ChairRon Walters, MAP Hospital Workgroup Co-Chair Melissa Mariñelarena, Senior Director, NQFHarold Pincus * Discuss key themes from the Hospital Workgroup meeting
* Review and finalize broader guidance about programmatic issues
* Review and discuss input from the MAP Dual Eligible Beneficiaries Workgroup
* Review and finalize workgroup measure recommendations
 |
|  | *Finalizing Workgroup Recommendations for All Hospital Programs* |
|  | This section of the meeting finalizes the remaining workgroup recommendations for: * [Ambulatory Surgical Center Quality Reporting Program](#MeasureListASCQ)
* [End-Stage Renal Disease Quality Incentive Program](#MeasureListESRD)
* [Hospital Acquired Condition Reduction Program](#MeasureListHACR)
* [Hospital Inpatient Quality Reporting and EHR Incentive Program](#MeasureListHIQR)
* [Hospital Outpatient Quality Reporting Program](#MeasureListHOQR)
* [Hospital Value-Based Purchasing Program](#MeasureListHVBP)
* [Inpatient Psychiatric Facility Quality Reporting Program](#MeasureListIPFQ)
* [Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program](#MeasureListPCHQ)
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|  | Reactors: Rhonda Anderson, Leah Binder, Carole Flamm  |
|  | *Measures Requiring a Vote on MAP's Preliminary Recommendation* |
|  | This section of the meeting includes debate and voting on measures pulled by MAP Coordinating Committee members. |
|  | Reactors:  |
|  | 1. **Ambulatory Breast Procedure Surgical Site Infection (SSI) Outcome Measure** (MUC ID: MUC16-155)
	* *Description:* This measure is for the risk-adjusted Standardized Infection Ratio (SIR) for all Surgical Site Infections (SSIs) following breast procedures conducted at ambulatory surgery centers (ASCs) among adult patients (ages 18 - 108 years) and reported to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). The measure compares the reported number of surgical site infections observed at an ASC with a predicted value based on nationally aggregated data. The measure was developed collaboratively by the CDC, the Ambulatory Surgery Center Quality Collaboration (ASC QC), and the Colorado Department of Public Health and Environment. CDC is the measure steward.
	* *Programs under consideration:* Ambulatory Surgical Center Quality Reporting Program
	* *Workgroup Rationale:* The Workgroup supported this measure for rulemaking on the condition that 1) the measure receive NQF endorsement and 2) additional testing and monitoring is conducted before the measure is used in a value-based purchasing (VBP) program.
	* *Workgroup Recommendation:* Conditional Support for Rulemaking
	* *Notes:*
2. **Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures** (MUC ID: MUC16-152)
	* *Description:* \*\*As of 12/2 testing for this measure has been completed\*\*\*\* The measure score is an ASC-level rate of unplanned hospital visits within 7 days of an orthopedic procedure performed at an ASC.
	* *Programs under consideration:* Ambulatory Surgical Center Quality Reporting Program
	* *Workgroup Rationale:* The Workgroup recommended that this measure be refined and resubmitted prior to rulemaking because it is currently undergoing field testing. The Workgroup agreed that testing results should demonstrate reliability and validity at the facility level in the ambulatory surgical setting. The Workgroup also recommended that this measure be submitted to NQF for review and endorsement.
	* *Workgroup Recommendation:* Refine and Resubmit Prior to Rulemaking
	* *Notes:*
3. **Hospital Visits after Urology Ambulatory Surgical Center Procedures** (MUC ID: MUC16-153)
	* *Description:* \*\*As of 12/2 testing for this measure has been completed\*\*\*\* The measure score is an ASC-level rate of unplanned hospital visits within 7 days of a urology procedure performed at an ASC.
	* *Programs under consideration:* Ambulatory Surgical Center Quality Reporting Program
	* *Workgroup Rationale:* The Workgroup recommended that this measure be refined and resubmitted prior to rulemaking because it is currently undergoing field testing. The Workgroup agreed that testing results should demonstrate reliability and validity at the facility level in the ambulatory surgical setting. The Workgroup also recommended that this measure be submitted to NQF for review and endorsement.
	* *Workgroup Recommendation:* Refine and Resubmit Prior to Rulemaking
	* *Notes:*
4. **Hemodialysis Vascular Access: Long-term Catheter Rate** (MUC ID: MUC16-309)
	* *Description:* Percentage of adult hemodialysis patient-months using a catheter continuously for three months or longer for vascular access.
	* *Programs under consideration:* End-Stage Renal Disease Quality Incentive Program
	* *Workgroup Rationale:* The Workgroup supported this measure for rulemaking because it is intended to replace the existing dialysis catheter access measure in the ESRD QIP. This measure has been recommended for NQF endorsement by the Renal Standing Committee and ratified by the Executive Committee.
	* *Workgroup Recommendation:* Support for Rulemaking
	* *Notes:*
5. **Standardized Transfusion Ratio for Dialysis Facilities** (MUC ID: MUC16-305)
	* *Description:* The risk adjusted facility level transfusion ratio “STrR” is specified for all adult dialysis patients. It is a ratio of the number of eligible red blood cell transfusion events observed in patients dialyzing at a facility, to the number of eligible transfusion events that would be expected under a national norm, after accounting for the patient characteristics within each facility. Eligible transfusions are those that do not have any claims pertaining to the comorbidities identified for exclusion, in the one year look back period prior to each observation window.
	* *Programs under consideration:* End-Stage Renal Disease Quality Incentive Program
	* *Workgroup Rationale:* The Workgroup recommended that this measure be refined and resubmitted prior to rulemaking because dialysis facilities do not make decisions about administering blood transfusions to patients. The Workgroup noted that, in general, clinicians in hospitals make the decisions about blood transfusions. The Workgroup also discussed the variability in blood transfusion coding practices that could inadvertently affect a dialysis facility's performance on this measure.
	* *Workgroup Recommendation:* Refine and Resubmit Prior to Rulemaking
	* *Notes:*
6. **Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol & Other Drug Use Disorder Treatment at Discharge** (MUC ID: MUC16-180)
	* *Description:* The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment.
	* *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program
	* *Workgroup Rationale:* The Workgroup did not support this measure for rulemaking because no scientific evidence was provided demonstrating that patients who received a prescription at discharge for the treatment of alcohol or drug use disorder or a referral for addictions treatment received treatment after discharge.
	* *Workgroup Recommendation:* Do Not Support for Rulemaking
	* *Notes:*
7. **Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention** (MUC ID: MUC16-178)
	* *Description:* The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included. These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge [temporarily suspended]).
	* *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program
	* *Workgroup Rationale:* The Workgroup did not support this measure for rulemaking because there was no evidence demonstrating the impact of brief interventions on alchohol use. The Worgroup also noted that a large amount of effort is required manual chart abstraction needed to implement this measure and the potential benefit was not clearly established.
	* *Workgroup Recommendation:* Do Not Support for Rulemaking
	* *Notes:*
8. **Communication about Pain During the Hospital Stay** (MUC ID: MUC16-263)
	* *Description:* The following questions (or a subset of questions) would replace the current Pain Management measure in the HCAHPS Survey with a new measure(s). The following items were tested in early 2016. CMS is currently analyzing the results, as well as discussing these potential new pain management items with focus groups and hospital staff. Multi-item measure (composite): HP1: “During this hospital stay, did you have any pain?” HP2: “During this hospital stay, how often did hospital staff talk with you about how much pain you had?” HP3: “During this hospital stay, how often did hospital staff talk with you about how to treat your pain?” HP4: “During this hospital stay, did you get medicine for pain?” HP5: “Before giving you pain medicine, did hospital staff describe possible side effects in a way you could understand?”
	* *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program
	* *Workgroup Rationale:* The Workgroup recommended that this composite measure (HP1, HP2 and HP3) be revised and resubmitted prior to rulemaking because the measure has undergone field testing and is intended to replace the Pain Management composite measure in the HCAHPS Survey. The Workgroup emphasized the need to include non-pharmacological options used to treat pain. The Workgroup recommended that the testing results demonstrate reliability and validity for the Inpatient Quality Reporting (IQR) program. The Workgroup also recommended that the measure be submitted to NQF for review and endorsement.
	* *Workgroup Recommendation:* Refine and Resubmit Prior to Rulemaking
	* *Notes:*
9. **Completion of a Malnutrition Screening within 24 Hours of Admission** (MUC ID: MUC16-294)
	* *Description:* Completion of a malnutrition screening using a validated screening tool to determine if a patient is at-risk for malnutrition, within 24 hours of admission to the hospital.
	* *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program
	* *Workgroup Rationale:* The Workgroup recommended that this measure be revised and resubmitted prior to rulemaking because NQF’s Health and Well-Being Standing Committee recently reviewed the measure and did not reach consensus on the evidence provided to support it. The measure must pass the Evidence criterion and receive NQF endorsement. The Workgroup also encouraged the measure developer to test the individual malnutrition measures as a composite in an effort to balance the number of measures in the IQR yet fill the gap on malnutrition.
	* *Workgroup Recommendation:* Refine and Resubmit Prior to Rulemaking
	* *Notes:*
10. **Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 Hours of a Malnutrition Screening** (MUC ID: MUC16-296)
	* *Description:* Patients age 65 years and older identified as at-risk for malnutrition based on a malnutrition screening who have a nutrition assessment documented in the medical record within 24 hours of the most recent malnutrition screening.
	* *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program
	* *Workgroup Rationale:* The Workgroup supported this measure for rulemaking with the condition that NQF's Health and Well-Being Standing Committee agrees that the evidence supporting this measure meets the Evidence criterion and the measure receives NQF endorsement. The Workgroup also encouraged the measure developer to test the individual malnutrition measures as a composite in an effort to balance the number of measures in the IQR yet fill the gap on malnutrition.
	* *Workgroup Recommendation:* Conditional Support for Rulemaking
	* *Notes:*
11. **Measure of Quality of Informed Consent Documents for Hospital-Performed, Elective Procedures** (MUC ID: MUC16-262)
	* *Description:* The measure estimates the hospital-level quality of informed consent documents for elective procedures for fee-for-service (FFS) Medicare patients. The outcome is defined as the quality of the informed consent document, as evaluated using an instrument developed for this purpose, the Abstraction Tool. A sample of hospitals’ informed consent documents are evaluated and hospital-level performance will be derived by aggregating these individual informed consent document quality scores. The measure is broadly applicable to a range of procedures, including elective cardiac, orthopedic, and urological procedures, that are performed in the hospital.
	* *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program
	* *Workgroup Rationale:* The Workgroup recommended that this measure be revised and resubmitted prior to rulemaking because it is the first step towards improving the practice of informed consent through quality measurement, and may compliment or serve as a platform for other measures of high-quality, patient-centered decision making. The Workgroup cautioned CMS about the potential data collection burden associated with this measure and the complexity of existing guidelines, regulations and state laws related to informed consent. The Workgroup recommended that the measure demonstrate reliability and validity at the facility level in the hospital setting. The Workgroup also recommended that the measure be submitted to NQF for review and endorsement.
	* *Workgroup Recommendation:* Refine and Resubmit Prior to Rulemaking
	* *Notes:*
12. **Medication Reconciliation at Admission** (MUC ID: MUC16-049)
	* *Description:* \*\*As of 12/2 testing for this measure has been completed\*\*\*\* \*\*\*\*Changed from requiring reconciliation within 24 hours to requiring reconciliation within 48 hours as of 12/1/16\*\*\*\* This measure assesses the average completeness of medication reconciliations conducted within 24 hours of admission to an inpatient facility.
	* *Programs under consideration:* Inpatient Psychiatric Facility Quality Reporting Program
	* *Workgroup Rationale:* The Workgroup recommended that this measure be refined and resubmitted prior to rulemaking because it is currently undergoing field testing. The Workgroup agreed that testing results should demonstrate reliability and validity at the facility level in the hospital setting. The Workgroup had a lengthy discussion about the intent of the measure (i.e., timeliness vs. accuracy of medication reconciliation) and chart abstraction burden. The Workgroup recommended that this measure be submitted to NQF for review and endorsement.
	* *Workgroup Recommendation:* Refine and Resubmit Prior to Rulemaking
	* *Notes:*
13. **Proportion of patients who died from cancer admitted to hospice for less than 3 days** (MUC ID: MUC16-274)
	* *Description:* Proportion of patients who died from cancer admitted to hospice for less than 3 days
	* *Programs under consideration:* Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
	* *Workgroup Rationale:* The Workgroup supported this measure for rulemaking because enrolling cancer patients in hospice increases survival times and reduces resource use such as aggressive end of life care and hospital admissions. This measure was previously tested and NQF endorsed at the facility level in the hospital setting during the 2012 maintenance review. The Workgroup suggested that MUC16-274 and MUC16-275 be paired to encourage appropriate referral practices.
	* *Workgroup Recommendation:* Support for Rulemaking
	* *Notes:*
14. **Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life** (MUC ID: MUC16-273)
	* *Description:* Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life
	* *Programs under consideration:* Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
	* *Workgroup Rationale:* The Workgroup supported this measure for rulemaking because a higher quality of life has been predicted in patients who avoid aggressive measures such as ICU stays in the last week of life. This measure was previously tested and NQF endorsed at the facility level in the hospital setting during the 2012 maintenance review.
	* *Workgroup Recommendation:* Support for Rulemaking
	* *Notes:*
15. **Proportion of patients who died from cancer not admitted to hospice** (MUC ID: MUC16-275)
	* *Description:* Proportion of patients who died from cancer not admitted to hospice
	* *Programs under consideration:* Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
	* *Workgroup Rationale:* The Workgroup supported this measure for rulemaking because enrolling cancer patients in hospice increases survival times and reduces resource use such as aggressive end of life care and hospital admissions. This measure was previously tested and NQF endorsed at the facility level in the hospital setting during the 2012 maintenance review. The Workgroup suggested that MUC16-274 and MUC16-275 be paired to encourage appropriate referral practices.
	* *Workgroup Recommendation:* Support for Rulemaking
	* *Notes:*
16. **Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life** (MUC ID: MUC16-271)
	* *Description:* Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life
	* *Programs under consideration:* Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
	* *Workgroup Rationale:* The Workgroup supported this measure for rulemaking because it can reduce unnecessary treatment cancer patients receive at the end of life, which can negatively impact the patient and caregiver experience. This measure was previously tested and NQF endorsed at the facility level in the hospital setting during the 2012 maintenance review.
	* *Workgroup Recommendation:* Support for Rulemaking
	* *Notes:*
17. **Safe Use of Opioids – Concurrent Prescribing** (MUC ID: MUC16-167)
	* *Description:* Patients age 18 years and older with active, concurrent prescriptions for opioids at discharge, or patients with active, concurrent prescriptions for an opioid and benzodiazepine at discharge from a hospital-based encounter (inpatient, ED, outpatient)
	* *Programs under consideration:* Hospital Inpatient Quality Reporting and EHR Incentive Program
	* *Workgroup Rationale:* The Workgroup did not support this measure for rulemaking because there are many clinical conditions where concurrent prescriptions of opioids and benzodiazepines are appropriate. The Workgroup was also concerned that patients may unintentionally suffer withdrawal symptoms if previously prescribed opioids and/or benzodiazepines are reduced and/or stopped prior to discharge. The Workgroup also noted that the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain is not evidence-based.
	* *Workgroup Recommendation:* Do Not Support for Rulemaking
	* *Notes:*
18. **Safe Use of Opioids – Concurrent Prescribing** (MUC ID: MUC16-167)
	* *Description:* Patients age 18 years and older with active, concurrent prescriptions for opioids at discharge, or patients with active, concurrent prescriptions for an opioid and benzodiazepine at discharge from a hospital-based encounter (inpatient, ED, outpatient)
	* *Programs under consideration:* Hospital Outpatient Quality Reporting Program
	* *Workgroup Rationale:* The Workgroup did not support this measure for rulemaking because there are many clinical conditions where concurrent prescriptions of opioids and benzodiazepines are appropriate. The Workgroup was also concerned that patients may unintentionally suffer withdrawal symptoms if previously prescribed opioids and/or benzodiazepines are reduced and/or stopped prior to discharge. The Workgroup also noted that the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain is not evidence-based.
	* *Workgroup Recommendation:* Do Not Support for Rulemaking
	* *Notes:*
 |
| 12:00 PM   | Lunch |
|  |  |
| 12:30 AM   | *Opportunity for Public Comment on PAC/LTC Programs* |
|  |  |
| 12:45 PM   | **Pre-Rulemaking Recommendations for PAC/LTC Programs** |
|  | Deb Saliba, MAP PAC/LTC Workgroup Co-ChairJean-Luc Tilly, Project Manager, NQFHarold Pincus * Discuss key themes from the PAC/LTC Workgroup meeting
* Review and finalize broader guidance about programmatic issues
* Review and discuss input from the MAP Dual Eligible Beneficiaries Workgroup
* Review and finalize workgroup measure recommendations
 |
|  | *Finalizing Workgroup Recommendations for All PAC/LTC Programs* |
|  | This section of the meeting finalizes the remaining workgroup recommendations for: * [Home Health Quality Reporting Program](#MeasureListHH_Q)
* [Hospice Quality Reporting Program](#MeasureListHQRP)
* [Inpatient Rehabilitation Facility Quality Reporting Program](#MeasureListIRF)
* [Long-Term Care Hospital Quality Reporting Program](#MeasureListLTCH)
* [Skilled Nursing Facility Quality Reporting System](#MeasureListSNF)
 |
|  | Reactors: David Gifford, Ari Robicsek |
|  | *Measures Requiring a Vote on MAP's Preliminary Recommendation* |
|  | This section of the meeting includes debate and voting on measures pulled by MAP Coordinating Committee members. |
|  | Reactors:  |
|  | 1. **The Percent of Residents or Home Health Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)** (MUC ID: MUC16-145)
	* *Description:* This quality measure reports the percent of Home Health patient episodes with Stage 2-4 or unstageable pressure ulcers that are new or worsened since Start of Care (SOC) or Resumption of Care (ROC). (The endorsed measure specifications are: This quality measure reports the percent of patients or short-stay residents with Stage 2-4 pressure ulcer(s) that are new or worsened since admission. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments ofSkilled Nursing Facility (SNF) / nursing home (NH) residents, the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set for LTCH patients and the the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for Inpatient Rehabilitation Facility (IRF) patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For residents in a SNF/NH, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage since admission. For patients in LTCHs and IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage on admission.Of note, data collection and measure calculation for this measure is conducted and reported separately for each of the three provider settings and will not be combined across settings. For SNF/NH residents, this measure is restricted to the short-stay population defined as those who have accumulated 100 or fewer days in the SNF/NH as of the end of the measure time window. In IRFs, this measure is restricted to IRF Medicare (Part A and Part C) patients. In LTCHs, this measure includes all patients.)
	* *Programs under consideration:* Home Health Quality Reporting Program
	* *Workgroup Rationale:* MAP supported the measure of new or worsened pressure ulcers. MAP cited the severity of pressure ulcers and their effect on quality of life and pain, and the fact that they are largely preventable, as compelling reasons to implement a performance measure. MAP also noted the measure is endorsed (NQF#678), material changes to the measure improve the specifications and it is currently implemented in the SNF QRP, LTCH QRP, and IRF QRP programs.
	* *Workgroup Recommendation:* Support
	* *Notes:*
2. **Application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)** (MUC ID: MUC16-143)
	* *Description:* This quality measure reports the percent of IRF patient stays with Stage 2-4 or unstageable pressure ulcers that are new or worsened since admission (The endorsed measure specifications are: This quality measure reports the percent of patients or short-stay residents with Stage 2-4 pressure ulcer(s) that are new or worsened since admission. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments ofSkilled Nursing Facility (SNF) / nursing home (NH) residents, the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set for LTCH patients and the the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for Inpatient Rehabilitation Facility (IRF) patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For residents in a SNF/NH, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage since admission. For patients in LTCHs and IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage on admission.Of note, data collection and measure calculation for this measure is conducted and reported separately for each of the three provider settings and will not be combined across settings. For SNF/NH residents, this measure is restricted to the short-stay population defined as those who have accumulated 100 or fewer days in the SNF/NH as of the end of the measure time window. In IRFs, this measure is restricted to IRF Medicare (Part A and Part C) patients. In LTCHs, this measure includes all patients.)
	* *Programs under consideration:* Inpatient Rehabilitation Facility Quality Reporting Program
	* *Workgroup Rationale:* MAP conditionally supported the measure of new or worsened pressure ulcers. MAP cited the severity of pressure ulcers and their effect on quality of life and pain, and the fact that they are largely preventable, as compelling reasons to implement a performance measure. While MAP noted the measure is endorsed (NQF#678), and is currently implemented in the SNF QRP, LTCH QRP, and IRF QRP programs concerns were raised about the impact of the material revisions to the measure for the IRF setting. MAP considered feedback that suggested that pressure ulcers have very low (approximately 1%) incidence, and that a change in the data calculation method and data source may lead to inconsistent results. MAP suggested the measure be examined to better understand the impact of the measure revisions and relevance in the IRF population.
	* *Workgroup Recommendation:* Conditional Support
	* *Notes:*
 |
| 2:30 PM   | Break |
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| 2:45 PM   | *Opportunity for Public Comment on Clinician Programs* |
|  |  |
| 2:45 PM   | **Pre-Rulemaking Recommendations for Clinician Programs** |
|  | Bruce Bagley, MAP Clinician Workgroup ChairEric Whitacre, MAP Clinician Workgroup ChairJohn Bernot, Senior Director, NQFFChip Kahn* Discuss key themes from the Clinician Workgroup meeting
* Review and finalize broader guidance about programmatic issues
* Review and discuss input from the MAP Dual Eligible Beneficiaries Workgroup
* Review and finalize workgroup measure recommendations
 |
|  | *Finalizing Workgroup Recommendations for All Clinician Programs* |
|  | This section of the meeting finalizes the remaining workgroup recommendations for: * [Merit-Based Incentive Payment System (MIPS)](#MeasureListMIPS)
* [Medicare Shared Savings Program](#MeasureListMSSP)
 |
|  | Reactors: Carl Sirio, Aparna Higgins, Chris Queram  |
|  | *Measures Requiring a Vote on MAP's Preliminary Recommendation* |
|  | This section of the meeting includes debate and voting on measures pulled by MAP Coordinating Committee members. |
|  | Reactors:  |
|  | 1. **HIV Medical Visit Frequency** (MUC ID: MUC16-073)
	* *Description:* Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (The endorsed specifications of the measure are: Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visitsA medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.)
	* *Programs under consideration:* Merit-Based Incentive Payment System
	* *Workgroup Rationale:* This measure addresses an important clinical area. However, it has not been fully tested as an e-CQM. Additionally, the performance data is in the process of being updated from the 2011 data. Since this is a process measure, MAP is interested in whether that test data continues to show variation and room for improvement in the measure. MAP acknowledged that this measure is part of a continuum of care; however, they prefer that outcome measures be used to monitor HIV. MAP recommended that if an outcome measure is not feasible at this time, that the measure be resubmitted after it has been fully tested as an e-CQM with data demonstrating that a performance gap continues to exist.
	* *Workgroup Recommendation:* Refine and resubmit
	* *Notes:*
2. **Prescription of HIV Antiretroviral Therapy** (MUC ID: MUC16-072)
	* *Description:* Percentage of patients, regardless of age, with a diagnosis of HIV prescribed HIV antiretroviral therapy for the treatment of HIV infection during the measurement year. (The endorsed specifications of the measure are: Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement yearA medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.)
	* *Programs under consideration:* Merit-Based Incentive Payment System
	* *Workgroup Rationale:* Though an important clinical area, the measure does not support alignment as CMS has removed the related, paper measure, NQF#2083. Additionally, the performance data is in the process of being updated from the 2011 data. Since this is a process measure, MAP is interested in whether that test data continues to show variation and room for improvement in the measure. MAP acknowledged that this measure is part of a continuum of care; however, they prefer that outcome measures be used to monitor HIV. MAP recommended that if an outcome measure is not feasible at this time, that the measure be resubmitted after it has been fully tested as an e-CQM with data demonstrating that a performance gap continues to exist. Additionally, MAP recommends that the alignment issue be addressed as part of resubmission.
	* *Workgroup Recommendation:* Refine and resubmit
	* *Notes:*
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| 5:00 PM   | Adjourn for the Day |
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| **Day 2: January 25, 2017**   |  |
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| 8:30 AM   | Breakfast |
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| 9:00 AM   | **Day 1 Recap** |
|  | Chip KahnHarold Pincus  |
| 9:15 AM   | **Pre-Rulemaking Cross-Cutting Issues: Attribution**  |
|  | Harold Pincus Taroon Amin, Consultant, NQFErin O’RourkeHelen Burstin* Findings from the Attribution Committeel
* Off-label measure use
* Shared accountability in context of setting-specific programs
 |
| 10:45 AM   | Break |
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| 11:00 AM   | **Refinements to the Medicaid Task Force Processes** |
|  | Debjani Mukherjee, Senior Director, NQF  |
| 11:45PM   | *Opportunity for Public Comment* |
|  |  |
| 12:00 PM   | Lunch |
|  |  |
| 12:30 PM   | **Potential Improvements to the Pre-Rulemaking Process** |
|  | Kim Ibarra, Senior Project Manager, NQF * Round-Robin Plus/Delta
* Input on improving the review of current measure sets
* Feedback loops
 |
| 1:30 PM   | **Pre-Rulemaking Cross-Cutting Issues: Risk Adjustment for Sociodemographic Factors** |
|  | Karen Joynt, Senior Advisor to the Deputy Assistant Secretary for Planning and Evaluation, Office of the Assistant Secretary for Planning and Evaluation (ASPE) Nancy De Lew, Acting Deputy Assistant Secretary, ASPE Kate GoodrichHelen BurstinChip Kahn* Update on 21st Century Cures Act
* Request from CSAC
* Implications of the ASPE Report
 |
| 2:30 PM   | *Opportunity for Public Comment* |
|  |  |
| 2:45 PM   | **Closing Remarks** |
|  | Chip Kahn Harold Pincus  |
| 3:00 PM   | Adjourn |
|  |  |