MEASURE APPLICATIONS PARTNERSHIP

Maximizing the Value of Measurement: MAP 2017 Guidance

FINAL REPORT

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NATIONAL QUALITY FORUM

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The Measure Applications Partnership (MAP) recommends performance measures for use in 16 federal healthcare quality initiative programs. The MAP pre-rulemaking process enables a unique multistakeholder dialogue about the priorities for measurement in these programs. MAP allows stakeholders across the care continuum, including patients, clinicians, providers, purchasers, and payers, the opportunity to identify and recommend the highest-value measures for each program as well as to provide strategic guidance across all programs. Throughout its six years of annual review, MAP has worked toward the goal of lowering costs while improving quality and ensuring that patients and consumers get the information they need to support their healthcare decision making.

In its 2016-2017 pre-rulemaking work, MAP emphasized maximizing the value that measurement brings to healthcare improvement while ensuring a person-centered approach to healthcare delivery. This year MAP also provided guidance on the potential future removal of measures from federal programs to reduce the measurement burden on clinician and providers. In addition, MAP discussed better understanding the impact of measurement as a means of maximizing its value in improving healthcare, assessing how measures perform once implemented, and exploring how best to ensure the use of high-value measures. MAP also emphasized the importance of a person-centered approach to measurement by encouraging shared accountability for a patient's outcomes, developing patient-reported outcome (PRO) based performance measures, and finding ways to increase the information available about healthcare quality to all consumers. Finally, MAP noted the need to ensure that measures used in accountability programs are fair and accurate.

MAP encouraged stakeholders to advance measurement science in areas such as improving models used to attribute patient episodes appropriately to providers and determining the impact of patients' social risk factors on their healthcare outcomes.

BACKGROUND AND CONTEXT

The Patient Protection and Affordable Care Act (ACA) of 2010 required that the U.S. Department of Health and Human Services (HHS) implement an annual, federal pre-rulemaking process to provide private-sector input and consensus on the quality and efficiency measures being considered for federal public-reporting and performance-based payment programs. The National Quality Forum (NQF) first convened MAP in 2011 as a multistakeholder entity to provide recommendations on the measures under consideration for use by HHS.

As detailed in the Process and Approach for MAP Pre-Rulemaking Deliberations, 2016-2017, MAP used a four-step process to analyze and select measures.

1. **Provide program overview.** Using CMS critical program objectives and the MAP Measure Selection Criteria, NQF staff developed a framework for each program in order to organize each program's current measure set.
2. **Review current measures.** MAP used the program measure set frameworks to better understand the current measures in the program, identify important gaps in measurement, and surface other areas of need. MAP reviewed the current measures to help determine how well the measures under consideration might fit into the program.
3. **Evaluate measures under consideration.** MAP used the Measure Selection Criteria and a MAP-approved preliminary analysis algorithm to determine whether the measures under consideration would enhance the program measure sets. Staff performed a preliminary analysis on each measure under consideration using the preliminary analysis algorithm. The MAP workgroups made their recommendations for each measure under consideration during December in-person meetings. The MAP Coordinating Committee finalized the recommendations for all measures under consideration at their January in-person meeting.
4. **Provide feedback on current program measure sets.** MAP reviewed the current measure sets to offer input on how to strengthen them, address gaps, and make recommendations for future removal of measures.

As previously noted in its 2016 guidance, MAP aims to provide guidance on the selection, use, and reduction of performance measures on multiple levels. MAP considers the value that an individual measure under consideration may add to a program by carefully balancing the opportunity for improvement with the potential for negative consequences and the burden on providers to report on the measure. Secondly, MAP evaluates a program's measure set as a whole. MAP also provides guidance on prioritizing gaps for measure endorsement and development. For the current pre-rulemaking cycle, MAP added a new focus: It now identifies measures that potentially could be removed from a program measure set in the future. Finally, MAP looks across the various quality initiative programs to identify ways measurement can drive improvement and maximize value across the healthcare system.

OPPORTUNITIES TO MAXIMIZE VALUE IN HEALTHCARE THROUGH MEASUREMENT

In its 2016-2017 pre-rulemaking deliberations, MAP identified ways to increase the value of measurement to drive improvements in healthcare quality. MAP underscored the need to ensure measures are person-centered and have a meaningful and intended impact as well as the need to improve measurement science as a whole.

Reducing Measurement Burden

Understanding Measure Performance and Impact

MAP emphasized the need to understand better the impact of measures used in the federal quality initiatives. The burden of measurement on providers, including data collection, must be reduced while quality and patient outcomes are improved. To help achieve these goals, MAP called for better feedback from frontline providers to ensure that measures are driving improvement and not causing negative, unintended consequences.

In the 2016-2017 pre-rulemaking process, MAP reviewed the measure sets currently in use in addition to focusing on new measures under consideration to better understand how the measures in the sets would work together. This change in the process allowed MAP members to suggest ways to strengthen the current measure sets, including making recommendations about measures that could potentially be removed in the future. However, MAP recognized that in order for CMS to act on these recommendations, it will likely need to engage in rulemaking as well as consider other programmatic needs not taken into account by the MAP process.

There are currently 634 measures used in the programs that MAP reviews. Overall, MAP recommended the removal of 51 measures from the programs. However, the Merit-Based Incentive Payment System (MIPS) has the largest measure set of any of the programs (273 measures). MAP recognized that clinician programs include a large number of measures across a wide range of specialties, and limited participation in some measures makes it challenging to streamline those sets. Excluding MIPS, MAP reviewed 361 current measures and recommended removal of 14 percent of them.

The main reasons MAP suggested removal of these measures related to overall high levels of performance with limited variation across providers (topped out measures) and lack of evidence that the measures are continuing to drive improvements in care. However, MAP cautioned that the removal of topped-out measures must be balanced with the need to ensure that performance does not slip. MAP also urged removal of measures that failed endorsement or maintenance review.

MAP reiterated the crucial role that NQF endorsement plays in ensuring that measures are evidence-based, reliable and valid, usable, and feasible. MAP stressed that measures used in public-reporting and value-based purchasing programs should be NQF-endorsed. MAP's guidance is that HHS should remove from federal programs the measures that have failed NQF's endorsement review. Additionally, MAP urged submission of measures currently used in federal programs that have not been submitted for endorsement review. MAP frequently has limited information on how a measure performed during testing and depends on the endorsement process to ensure measures are important to measure, scientifically acceptable, feasible, and useful.

Feedback from end-users would significantly enhance these discussions in the future. MAP urged federal programs to strive for a limited set

of high-impact measures to reduce measurement burden on providers while promoting improvements in healthcare quality and providing the most useful information to consumers.

TABLE 1. MAP REMOVAL SUGGESTIONS BY PROGRAM

Program	Number of Measures Suggested for Removal	Total Number of Current Measures
ESRD Quality Incentive Program	4	18
PPS-Exempt Cancer Hospital Quality Reporting Program	4	17
Ambulatory Surgery Center Quality Reporting Program	2	15
Inpatient Psychiatric Facility Quality Reporting Program	7	20
Outpatient Quality Reporting Program	13	29
Inpatient Quality Reporting Program	6	62
Home Health Quality Reporting Program[1]	15	79

MAP identified additional ways to improve the usefulness of measures and reduce the burden of measurement. MAP urged CMS to explore the possibility of implementing composite measures that combine two or more individual measures in a single measure that results in a single score. MAP also encouraged alignment across programs when relevant and possible. MAP recognized that aligning measures can help consumers and purchasers compare healthcare performance across settings, as well as reduce the burden on providers that must report for multiple programs.

MAP acknowledged the need for better data to evaluate the current measures and noted that a focus of NQF's strategic plan is to improve understanding of the impact of NQF-endorsed measures. MAP supported NQF's plan to work with its member organizations to gather feedback on the measures. MAP encouraged organizations affected by measurement to work with NQF to submit better data on the current measures. MAP also encouraged measure users to participate in greater data sharing with CMS so MAP and others can better understand how measures are performing. MAP stressed the need for a systematic, data-driven process that incorporates both qualitative and quantitative feedback from organizations and providers who implement and use measures.

Overall, public comments received were supportive of MAP's recommendation to reduce the burden of measurement. One commenter stated that retiring topped out measures will allow providers to focus on measures that can have a greater impact on the quality of care such as new outcome and efficiency measures. One commenter noted that NQF endorsement is not required for many programs and should not be the sole reason for the removal of a measure.

Develop and Implement High-Value Measures

MAP called for the development and implementation of high-value measures in the federal healthcare quality initiative programs. MAP has defined high-value measures as "measures that will drive the health system to higher performance." To make this guidance more concrete, MAP identified the following measure types as high-value:

- Outcome measures (e.g., mortality, adverse events, functional status, patient safety, complications, or intermediate outcomes)
- Patient-reported outcome measures where patients provide the data about the results of their treatment, level of function, and health status
- Measures addressing patient experience, care coordination, population health, quality of life, or impact on equity

- Appropriateness, overuse, efficiency, and cost-of-care measures
- Composite measures
- Process measures with a strong evidence-based link to patient outcomes

MAP has been encouraged that over the past six years more high-value measures have been submitted for consideration. In its 2016-2017 guidance, MAP emphasized the need to continue to shift the measures used in federal programs to high-value measures. Although the number of outcome measures under consideration was lower than in the 2015-2016 cycle, MAP was encouraged that 32 out of 71 measures under consideration were outcome, intermediate outcome, or patient-reported outcome measures. Table 2 breaks down the measures under consideration by measure type.

TABLE 2. MEASURES UNDER CONSIDERATION (MUC) BY MEASURE TYPE

Measure Type	Number of MUCs
Outcome	17
Intermediate Outcome	4
Patient-Reported Outcome	11
Process	41
Structure	1

While recognizing that process measures are needed, MAP recommended moving to composite measures whenever possible. MAP noted that composite measures could help alleviate the burden on clinicians and providers while ensuring quality improvement on comprehensive processes.

MAP also noted that many measures used in the various programs address a specific clinical condition or care setting. MAP recommended the inclusion of more measures that cut across conditions or settings because this could provide a broader picture of quality while minimizing the reporting burden on providers. MAP emphasized that this approach could be particularly useful for measures of harm and safety and underscored the need for measures that assess all causes of patient harm.

Public commenters agreed with MAP that the federal programs should move to higher value measures and agreed with the measure types MAP noted as high value. One commenter raised concerns that some of the measures under consideration classified as PROs addressed processes rather than outcomes of care. One commenter suggested that the NQF Measure Incubator™ could accelerate the development of higher value measures.

One commenter highlighted the challenge of achieving reliable surgeon-specific outcome measures due to case volume. The commenter cited data from the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP) that demonstrates the needed case volume is too high for most surgeons to be accurately ranked in quality programs, including MIPS, solely by their individual outcomes. The commenter noted that an approach that includes patient-reported outcome measures and high-value process measures could address these challenges.

Other comments were received on specific measures under consideration. Concerns were raised about Communication about Pain During the Hospital Stay (MUC16-263); it was noted that while pain is an important concept, the questions are too open-ended. A comment pointed out that an individual clinician may not be able to influence Adult Local Current Smoking Prevalence (MUC16-69). Finally, a comment provided support for Otitis Media with Effusion: Systemic Antimicrobials – Avoidance of Inappropriate Use (MUC16- 269) as this measure could reduce the use of an inappropriate and ineffective therapy.

Ensure a Person-Centered Approach to Measurement

Encourage Shared Accountability

As new payment and care delivery models incentivize integration across the healthcare system, MAP recognized a need to ensure that measurement approaches promote quality across the care continuum. MAP acknowledged the role that multidisciplinary teams play in ensuring high quality, coordinated, and patient-centered care. MAP reiterated the need to improve cooperation and communication across the healthcare system and underscored the role that performance measurement can play in meeting these goals.

MAP previously noted that performance measures are needed across every site of care to assess the effectiveness of shared accountability.[2] Since MAP issued that guidance, legislation—such as the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)—has expanded quality measurement to additional settings and provider types. MAP emphasized the need to ensure that measures work together across the federal healthcare quality programs and encourage shared accountability for patient outcomes.

Develop Patient-Reported Outcome Measures

Since its inception, MAP has called for greater use of patient-reported outcome based performance measures (PRO-PMs). MAP also has emphasized the need to ensure that public- and private-sector quality initiatives address the outcomes patients find most important. PRO-PMs present a unique opportunity to ensure that the patient's voice is heard. MAP has repeatedly named PRO-PMs as a leading gap area across the federal programs on which it provides input.

During the 2016-2017 pre-rulemaking process, the MAP Clinician, Hospital, and Post-Acute Care/Long Term Care Workgroups discussed the PROMIS® (Patient-Reported Outcomes Measurement Information System). PROMIS® is a set of measures that evaluate and monitor physical, mental, and social health in adults and children. Overall, MAP supported the use of measures from PROMIS and noted that the tool has great potential. MAP members noted that the use of the tool could improve care and increase patient and family engagement.

MAP members did raise implementation concerns for PROMIS® measures and PRO-PMs. First, MAP recognized the potential challenge that facilities with budgetary restrictions could face when implementing these measures. Next, MAP noted the need to use PRO-PMs judiciously to prevent burden on patients responding as well as clinicians trying to incorporate the information into clinical workflow. MAP emphasized the importance of considering the patient's perspective on whether the measure is meaningful, understandable, and achievable. MAP also stressed the potential for cultural and linguistic barriers to the implementation of PRO-PMs and recommended that implementers ensure cultural competency. Finally, MAP expressed some concerns on how PRO-PMs based on PROMIS® would be standardized to allow for comparability and use in federal quality initiatives.

Develop Ways to Increase Information for All Consumers

MAP emphasized that the federal healthcare quality initiatives and the public reporting of the results of these initiatives on CMS websites help consumers to make more informed choices about where to seek healthcare. While progress has been made since MAP began its work six years ago, persistent measure gaps remain. MAP noted the need to provide information to support

the healthcare decisions of all consumers and recommended that CMS continue to include in its federal programs measures that address broader populations. MAP stated its interest in additional measures that address care for younger populations. For example, MAP noted that persistent gaps remain around pediatrics and maternal health and recognized public comments urging the adoption of measures on important quality issues such as rates of caesarian sections.

MAP recognized that data challenges may be responsible for some of these information gaps and that CMS data are often limited to Medicare beneficiaries. However, MAP encouraged CMS and other payers to find ways to progress toward the goal of reporting all-payer data. Such progress would benefit all consumers, including Medicare beneficiaries, by increasing transparency and providing more information to support healthcare decision making.

Public commenters reinforced MAP's recommendation to ensure a person-centered approach to measurement.

Advance Measurement Science

MAP underscored the importance of continuing to improve the science of healthcare performance measurement. MAP noted the need to understand measure results better in the context of care improvements and the need to get better information on how to set performance goals. For example, reducing readmissions is an important quality issue, but setting a reasonable performance goal remains challenging. MAP also pointed out the need to continue to improve attribution models and to improve understanding of how to address social risk factors in value-based payment.

Improve Attribution Models

The U.S. healthcare system continues to pursue value-based purchasing and alternative payment models to reduce healthcare costs while improving quality. Such payment models, which tie a provider's reimbursement to performance on cost and quality measures, require an accurate understanding of who is responsible for a patient's outcomes and costs. Attribution is defined as the methodology used to assign patients, and their quality outcomes, to providers or clinicians. However, this is increasingly challenging in a system moving to team-based care and shared accountability.

MAP discussions have frequently surfaced questions about attribution. MAP strived to recommend measures that will improve care for patients while accurately and fairly assessing a provider or clinician's performance. This balance can be complicated when multiple entities may be involved in a person's care but a measure or program holds only one entity accountable.

NQF, with funding from HHS, **convened a multistakeholder Committee to provide guidance** on selecting and implementing attribution models. MAP reviewed the Committee's guidance and reflected on how it should consider attribution challenges, including those posed by some of the current measures in federal programs.

MAP acknowledged the need to ensure that how a measure is attributed reflects the original intent of the measure and its endorsement. MAP noted that some measures currently used in federal programs are endorsed for a different level of analysis than the level for which they are actually used. For example, MAP raised concerns that NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure is used in MIPS for physician groups. The measure was endorsed for the facility level of analysis but is being used in clinician programs. MAP recommended that CMS submit NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure for NQF review at the clinician group level. MAP also expressed concerns about the accuracy of the attribution methodology used to assign Medicare beneficiaries to clinicians and noted this could affect the reliability and validity of the measure.

MAP pointed out attribution challenges and a need to balance a future state that is moving toward population-based payments with the current fee-for-service environment. MAP recognized that payers and purchasers may be interested in more global strategies to attribute patient outcomes and costs but stressed that much of the current measurement architecture addresses only one care setting. MAP recognized that the clinician or provider must be able to influence the attributed outcomes and that attribution methodologies must support transparency, accountability, and improvement. MAP also noted a need to consider the role of clinicians like pharmacists, nurses, and physician assistants as well as the role of community partners and long-term social supports. Finally, MAP recognized that while greater flexibility in attribution methodologies can help to support innovative measurement, greater standardization could help to alleviate measurement burden on clinicians and providers and that flexibility and standardization need to be balanced.

Understand the Role of Social Risk

There is increasing evidence that social risk factors, such as socioeconomic status (SES), race and ethnicity, and residential and community context, can affect a person's health and can make it harder to help them achieve optimal health outcomes. Simultaneously, the shift to value-based purchasing increasingly ties provider payment to patient outcomes. These factors have led to important conversations about how to reduce healthcare disparities and improve quality for all while ensuring that providers and clinicians caring for the most vulnerable are not unfairly penalized because of the populations they serve.

The question of whether or not measures under consideration should include social risk factors in their risk adjustment models has challenged MAP. While committed to reducing disparities and promoting high-quality care for all Americans, MAP recognized the need to be fair to clinicians and providers and ensure that performance measurement results accurately reflect the quality of care they provide.

MAP received an update on advancements around measuring and accounting for social risk factors. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) presented findings from a study mandated by the IMPACT Act to analyze the impact of SES on quality and resource use in Medicare using existing SES data. ASPE's work had two main findings: (1) that Medicare beneficiaries with social risk factors had worse outcomes on quality measures regardless of the provider they saw and (2) that providers that disproportionately served Medicare beneficiaries with social risk factors tended to perform worse on quality measures, even after adjusting for the proportion of beneficiaries with social risk factors. ASPE reviewed potential policy solutions to account for social risk in Medicare value-based purchasing programs.

In addition, CMS provided MAP with an update on refinements to the Hospital Readmission Reduction Program (HRRP) required by the 21st Century Cures Act. The measures in the HRRP are not currently risk-adjusted for socioeconomic status. The Cures Act updates the payment approach used by the HRRP to compare hospitals of the same type to their peers, rather than all hospitals. Specifically, the Cures Act changes HRRP to stratify hospitals by the proportion of patients who are fully eligible to participate in Medicare and Medicaid with similar proportions of dually eligible patients for the purpose of assessing incentives or penalties for hospital performance. CMS noted that the Act says that CMS also can consider the ASPE recommendations regarding risk adjustment of the measures but that the first step is hospital stratification in terms of assessing penalties.

Finally, NQF shared an update on its trial period for SES risk adjustment. The NQF Board approved the two-year trial period in 2014 to allow for measures to be risk-adjusted for SES as part

of the endorsement evaluation process. The results of the trial period will inform a future NQF decision about permanently changing NQF policy. During the trial period, NQF requires that measure developers show both a conceptual and empirical basis to risk-adjust for SES. The NQF trial period has demonstrated the challenges in getting adequate data on social risk factors. Some measures, including measures of cost and resource use and readmissions, have come forward with a conceptual basis for adjustment, but empirical analyses using available data did not support inclusion of the factors in question.

MAP recognized the need for additional research to understand better the role of social risk factors. MAP noted the need to ensure high-quality care for all and the importance of better support and resources for facilities and clinicians caring for the most vulnerable. MAP looks to the work of the NQF Disparities Standing Committee to help develop a plan for equity measurement and to provide guidance on ensuring that value-based purchasing drives quality improvement for all while not worsening access challenges for people with social risk factors.

Public commenters agreed with MAP's recommendation to improve the science of healthcare performance measurement. Commenters noted the challenges that attribution and social risk can present and recognized the need to improve the ability of measurement to address these issues.

CONCLUSION

Quality measurement and healthcare payment have changed significantly since the inception of MAP six years ago. The healthcare system continues to look to performance measurement to support new payment and care delivery models. In its role, MAP continues to strive to recommend measures that will lower costs while improving the quality of care. At the same time, MAP attempts to reduce the burden of measurement on clinicians and providers by recommending aligned measures across federal programs and by promoting the use of high-value measures. In its 2016-2017 pre-rulemaking work, MAP aimed to maximize the value of measurement to improve healthcare by understanding better the impact of measurement, ensuring a person-centered approach, and improving measurement science.

MAP will continue to improve the pre-rulemaking process to ensure that its recommendations address the most important quality issues while minimizing undue measurement burden. MAP also will continue to build partnerships with CMS and others to understand better how measures are performing and recommend ways that current measure sets used in federal programs could be improved—with a drive toward further reductions in measure burden. Finally, MAP will continue to push for the development and implementation of high-value measures. By carefully considering the impact of each measure in a program and thoughtfully weighing the potential input of a measure under consideration, MAP aims to maximize the value of measurement to improve healthcare.

ENDNOTES

1 MAP provided guidance on the CY 2016 Home Health Quality Initiative measure set. Some measures MAP provided input on may already be slated for removal as CMS has determined they are "topped out" or of limited clinical and quality improvement value.

2 National Quality Forum (NQF). *MAP Families of Measures: Safety, Care Coordination, Cardiovascular Conditions, Diabetes.* Washington, DC: NQF; 2012. Available at http://www.qualityforum.org/Publications/2012/10/MAP_Families_of_Measures.aspx.

APPENDIX A:
Measure Applications Partnership Coordinating Committee

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APPENDIX B:
Measure Applications Partnership Guidance on Future Removal of Measures from Federal Programs

Number	Program	NQF #	Measure Title	NQF Status	Comments
1	HH QRP	518	Depression Assessment Conducted	Endorsed	MAP recommended removing measures where performance may be topped out.
2	HH QRP	N/A	Stabilization in Grooming	Not Endorsed	MAP recommended removing measures where performance may be topped out.
3	HH QRP	N/A	Stabilization in Bed Transferring	Not Endorsed	MAP recommended removing measures where performance may be topped out.
4	HH QRP	N/A	Stabilization in Light Meal Preparation	Not Endorsed	MAP recommended removing measures where performance may be topped out.
5	HH QRP	N/A	Stabilization in Phone Use	Not Endorsed	MAP recommended removing measures where performance may be topped out.
6	HH QRP	N/A	Stabilization in Management of Oral Medications	Not Endorsed	MAP recommended removing measures where performance may be topped out.
7	HH QRP	N/A	Stabilization in Speech and Language	Not Endorsed	MAP recommended removing measures where performance may be topped out.
8	HH QRP	N/A	Stabilization in Cognitive Functioning	Not Endorsed	MAP recommended removing measures where performance may be topped out.
9	HH QRP	N/A	Stabilization in Anxiety Level	Not Endorsed	MAP recommended removing measures where performance may be topped out.
10	HH QRP	N/A	Stabilization in Toilet Transferring	Not Endorsed	MAP recommended removing measures where performance may be topped out.
11	HH QRP	N/A	Stabilization in Toileting Hygiene	Not Endorsed	MAP recommended removing measures where performance may be topped out.
12	HH QRP	N/A	Stabilization in Bed Transferring	Not Endorsed	MAP recommended removing measures where performance may be topped out.
13	HH QRP	519	Diabetic Foot Care and Patient/Caregiver Education Implemented during All Episodes of Care	Endorsed	MAP recommended removing measures where performance may be topped out.

Number	Program	NQF #	Measure Title	NQF Status	Comments
14	HH QRP	N/A	Drug Education On High Risk Medications Provided To Patient/ Caregiver At Start Of Episode	Not Endorsed	MAP recommended removing measures where performance may be topped out.
15	HH QRP	181	Increase in Number of Pressure Ulcers	Endorsement Removed	MAP recommended removing measures which have lost NQF endorsement.
16	ESRD QIP	1454	Proportion of Patients with Hypercalcemia	Endorsed	MAP members noted the small performance gap for this measure. MAP recognized the legislative requirement for a bone and mineral metabolism measure but raised concerns about the clinical impact of this measure.
17	ESRD QIP	0249	Adult Hemodialysis Adequacy	Endorsed	MAP members raised concerns that this measure may be topped out.
18	ESRD QIP	0418	Clinical Depression Screening and Follow-Up Reporting Measure	Endorsed	MAP recommended that CMS move to a patient-reported outcome measure to assess depression.
19	ESRD QIP	0420	Pain Assessment and Follow-up Reporting Measure	Endorsed	MAP recommended that CMS move to a patient-reported outcome measure to assess pain.
20	PCHQR	2936	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Failed Initial Endorsement	MAP recommended that this measure be removed from the program as it failed NQF endorsement.
21	PCHQR	0559	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer	Endorsed	MAP noted universally high performance on this measure and recommended that it could be removed in the future.
22	PCHQR	0220	Adjuvant Hormonal Therapy	Endorsed	MAP noted universally high performance on this measure and recommended that it could be removed in the future.

Number	Program	NQF #	Measure Title	NQF Status	Comments
23	PCHQR	0223	Adjuvant Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer	Endorsed	MAP noted universally high performance on this measure and recommended that it could be removed in the future.
24	ASCQR	0264	Prophylactic Intravenous (IV) Antibiotic Timing	Failed Maintenance Endorsement	MAP recommended that this measure be removed from the program as it failed NQF endorsement.
25	ASCQR	9999	Safe Surgery Checklist Use	Not Endorsed	MAP recommended that this measure be removed given the lack of variation in performance.
26	IPFQR	1661	SUB-1 Alcohol Use Screening	Endorsed	MAP noted the importance of addressing substance abuse but recommended that CMS prioritize measures that will better address the quality of mental health care.
27	IPFQR	1651	TOB-1 Tobacco Use Screening	Endorsed	MAP noted the importance of tobacco cessation but recommended that CMS prioritize measures that will better address the quality of mental health care.
28	IPFQR	1654	TOB-2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	Endorsed	MAP noted the importance of tobacco cessation but recommended that CMS prioritize measures that will better address the quality of mental health care.
29	IPFQR	1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	Endorsed	MAP noted the importance of addressing substance abuse but recommended that CMS prioritize measures that will better address the quality of mental health care.
30	IPFQR	1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Endorsed	MAP noted the importance of tobacco cessation but recommended that CMS prioritize measures that will better address the quality of mental health care.

Number	Program	NQF #	Measure Title	NQF Status	Comments
31	IPFQR	1664	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Endorsed	MAP noted the importance of addressing substance abuse but recommended that CMS prioritize measures that will better address the quality of mental health care.
32	IPFQR	0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Endorsed	MAP recommended that this measure be re-specified for acute care and submitted for NQF endorsement.
33	HOQR	0498	Door to Diagnostic Evaluation by a Qualified Medical Professional	Failed Maintenance Endorsement	MAP recommended the removal of measures that have failed maintenance endorsement.
34	HOQR	0662	Median Time to Pain Management for Long Bone Fracture	Failed Maintenance Endorsement	MAP recommended the removal of measures that have failed maintenance endorsement.
35	HOQR	0496	Median time from ED Arrival to ED Departure for Discharged ED Patients	Endorsed	MAP noted the potential burden in collecting this measure and recommended that it could be removed to allow for the implementation of a higher value measure.
36	HOQR	0499	Left Without Being Seen	Failed Maintenance Endorsement	MAP recommended the removal of measures that have failed maintenance endorsement.
37	HOQR	0289	Median Time to ECG	Failed Maintenance Endorsement	MAP recommended the removal of measures that have failed maintenance endorsement.
38	HOQR	0287	Median Time to Fibrinolysis	Failed Maintenance Endorsement	MAP recommended the removal of measures that have failed maintenance endorsement.
39	HOQR	0288	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Failed Maintenance Endorsement	MAP recommended the removal of measures that have failed maintenance endorsement.
40	HOQR	0286	Aspirin at Arrival	Failed Maintenance Endorsement	MAP recommended the removal of measures that have failed maintenance endorsement.
41	HOQR	9999	Mammography Follow-Up Rates	Failed Initial Endorsement	MAP recommended the removal of measures that failed NQF endorsement.
42	HOQR	9999	Abdomen CT - Use of Contrast Material	Failed Initial Endorsement	MAP recommended the removal of measures that failed NQF endorsement.

Number	Program	NQF #	Measure Title	NQF Status	Comments
43	HOQR	9999	Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	Failed Initial Endorsement	MAP recommended the removal of measures that failed NQF endorsement.
44	HOQR	0489	The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data Elements	Failed Maintenance Endorsement	MAP recommended the removal of measures that have failed maintenance endorsement.
45	HOQR	2936	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Failed Initial Endorsement	MAP recommended that this measure be removed from the program as it failed NQF endorsement.
46	HIQR	0376	Incidence of Potentially Preventable Venous Thromboembolism	Failed Maintenance Endorsement	MAP recommended that measures that failed NQF endorsement be removed from the program.
47	HIQR	3042	Discharged on Antithrombotic Therapy	Failed Initial Endorsement	MAP recommended that measures that failed NQF endorsement be removed from the program.
48	HIQR	3043	Anticoagulation Therapy for Atrial Fibrillation/Flutter	Failed Initial Endorsement	MAP recommended that measures that failed NQF endorsement be removed from the program.
49	HIQR	3045	Antithrombotic Therapy by the End of Hospital Day Two	Failed Initial Endorsement	MAP recommended that measures that failed NQF endorsement be removed from the program.
50	HIQR	3046	Discharged on Statin Medication	Failed Initial Endorsement	MAP recommended that measures that failed NQF endorsement be removed from the program.
51	HIQR	3047	Assessed for Rehabilitation	Failed Initial Endorsement	MAP recommended that measures that failed NQF endorsement be removed from the program.

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