NATIONAL QUALITY FORUM
Driving measurable health improvements together

Measure Applications Partnership (MAP) Hospital Workgroup: 2022 Measure Summary Sheets

June 06, 2022

Last Updated: August 17, 2022

This report is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-T0003, Option Year 3.

Table of Contents

01049-C-ASCQR Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	01049-C-ASCQR
CMS Program(s) for Which Measure is Being Discussed for Removal	Ambulatory Surgical Center Quality Reporting Program
Measure description	Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.
Numerator	Patients 18 years and older who had improvement in visual function achieved within 90 days following cataract surgery, based on completing both a pre-operative and post-operative visual function survey.
Numerator Exclusions	N/A
Denominator	All patients aged 18 years and older who had cataract surgery and completed both a pre-operative and post-operative visual function survey.
Denominator Exclusions	Patients who did not complete both a pre-operative and post-operative survey.
Denominator Exceptions	Patient care survey was not completed by patient
CMS Program(s) in Which Measure is Used	Ambulatory Surgical Center Quality Reporting Program; Merit-Based Incentive Payment System Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Hospital Compare
Measure Steward	American Academy of Ophthalmology

Field Label	Field Description
Data Reporting Begin Date	Ambulatory Surgical Center Quality Reporting Program: 2015-01-01; Hospital Compare: 2020-01-01, Merit-Based Incentive Payment System Program: 2018-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 5
Rationale for Removal Consideration	Rationale for nominations: • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 4. Performance or improvement on the measure does not result in better patient outcomes • Criteria 8. Measure leads to a high level of reporting burden for reporting entities Notes from survey respondents: • This measure is difficult to track, in part because the term "improved" is ambiguous. Would favor a more objective assessment of patient visual acuity. • Despite endorsement having been removed for this measure, it's a voluntary measure and the only PRO-PM so we did not nominate it for removal. • Interested in reasons for endorsement removal

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Endorsement Removed
Consensus-Based Entity Number	1536
History of CBE Endorsement	2012: Initial Endorsement 2018: Endorsement Removed According to NQF's Surgery, Spring 2018 Cycle: CDP [Consensus Development Process] Report, the measure was withdrawn for endorsement consideration due to the developer working on a new instrument to measure visual function.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2012-2013 Recommendation: Support
Rationale for MAP Recommendation	Support: Addresses a high-impact condition not adequately addressed in the program measure set. Addresses a measure type not adequately represented in the program measure set. Additional Findings: Measure should be tested and NQF endorsed for the facility level of analysis. Public comments from American Academy of Ophthalmology (AAO) and American Association of Eye and Ear Centers of Excellence (AAEECE) do not support MAP's conclusions because the measure was not designed or tested for the facility level of analysis.

Section 4: Performance and Reporting Data

Lower averages compared to the median rate indicate some low performers with room for improvement. ASC-11 is voluntarily reported (not required).

National Performance for ASC - 11: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

Year	N Reporting	Average Rate	Median Rate
2020	113	96.14	100
2019	59	92.61	100
2018	169	94.45	100
2017	137	95.63	100
2016	126	95.82	100

Data Source: Hospital Compare files for January 2016, 2017, 2018, 2020, 2022.
N Reporting is the number of facilities reporting a rate plus the number of facilities with too few cases to report

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Proportion
- Measure direction: larger results are better
- Adjustment applied: None
- Trend category: Declining
- Average annual percentage change (AAPC): -1.3
- AAPC 90% confidence interval: [-1.3, -1.2]
- Score (standard deviation) [provider interquartile range]
    - 2016: 95.8 (20.0) [4.2]
    - 2017: 95.6 (20.4) [2.9]
    - 2018: 94.5 (22.9) [2.5]

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	Data elements for this measure come from a survey. The specified data elements are not available electronically in defined fields. A web-based survey instrument could be used and results uploaded into a data registry. Paper survey instruments could be scanned and incorporated into a data registry. The registry could calculate the results and provide these results as feedback to the physicians and as quality measures to the CMS PQRS [Physician Quality Reporting System]. There is a burden upon the office practice to survey patients pre and post cataract surgery. The majority of these patients are elderly, and they may require assistance/prompting in responding to the surveys. This then will entail time taken out by the practice staff. The follow-up survey also requires close attention. Therefore, the measure developer has proposed a minimal sampling size of 30, which will reduce the burden on physicians´ practice and optimize the response rates. The survey would be administered by a third party (a registry for reporting of PQRS measures sponsored by the American Academy of Ophthalmology) to prevent or minimize bias which might be introduced if it is an in-office paper survey with questions asked by the office staff. Options would be provided to the patient, either online survey, mail survey or phone survey, depending on their preferences and abilities, because these patients are elderly and have visual impairment.
Source and Date of Feasibility Data	CBE Measure Submission Form, 2018

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 0
- No (Do Not Support Retaining in Proposed Program) – 6
- Unsure of Retaining in Proposed Program – 0

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

Advisory group members did not have rural health concerns.

MAP Health Equity:

Advisory group members highlighted the PROM-PM (patient reported outcome performance measure) structure of the measure, and its use of a pre/post-surgery survey, noting that the measure may not be equity sensitive because it does not identify who does not complete the survey. Regarding health equity implications, the member noted there may be potential measure design issues.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program with the following conditions: (1) measure developer integrates the new survey instrument and (2) measure aligns to use the same survey version across programs. The workgroup discussed survey burden and reporting burden. The workgroup acknowledged this measure is a PRO-PM and measures patient functioning, not visual acuity. As this measure is used in multiple programs, the workgroup recommended alignment across measures regarding which version of the survey is used.

Public Comments

Marsden Advisors

Do you support retaining this measure in the program? No

MarsdenAdvisors strongly supports the MAP recommending removal of ASC-11. Ophthalmic specialty societies have opposed ASC-11 for years due to the inappropriate nature of these surveys being attributed to the ASC facility rather than to the individual surgeon and the burdensome nature of patient surveys, particularly in this context. Medicare ASC Conditions for Coverage state that the two entities must be physically, administratively, and financially separate from one another. This measure,

however, requires the ASC to report on data that is located in the surgeon's office and, thus inaccessible by the ASC.

Moreover, any improvement in visual function is attributable to the individual surgeon, not to the facility in which the procedure was performed. ASCs are neither licensed nor qualified to evaluate the cataract patient and make these assessments. ASCs should not be involved in the professional decision-making intended by this measure. This measure will not result in improved patient outcomes and is inappropriate for facility measurement as facilities do not contribute to the skill of the cataract surgeon.

With CMS finalizing this measure as mandatory beginning with the 2025 ASCQR reporting year, this issue is even more urgent. We ask the MAP to show CMS the inappropriate nature of this measure by recommending it for removal.

ASC Quality Collaboration

Do you support retaining this measure in the program? No

Thank you for the opportunity to comment. The ASC Quality Collaboration does not support the implementation of this measure, and we submit the same comments that were shared with CMS in 2021. The reporting burden will be extraordinary for the ASCs, and the results will not result in better outcomes delivered by ASCs.

ASC-11 assesses the percentage of patients aged 18 years and older who had cataract surgery and experienced improvement in visual function within 90 days following surgery. The results of the measure are based on patients' completion of both pre-operative and post-operative visual function surveys.

In the CY 2014 OPPS/ASC final rule, CMS finalized the adoption of ASC–11 for inclusion in the ASCQR Program over many objections regarding the implementation burden and concerns regarding the feasibility and actionability of the measure. Shortly after adopting the measure, the agency delayed implementation twice before deciding to make reporting strictly voluntary. Under this voluntary status, ASCs are not obligated to report on the measure in order to be eligible to receive their annual payment update. However, any data submitted to the agency has been subject to public reporting.

CMS states it made ASC-11 voluntary for a few reasons. First, the agency understood it was "operationally difficult for ASCs to collect and report on the measure" because the results of the surveys were collected by clinicians during office visits, "making it difficult for ASCs to have knowledge of the visual function of the patient before and after surgery" (79 FR 66984). As CMS has indicated, ASC-11 relies on data obtained by the clinician and recorded in the clinician's medical records during the patient's pre-operative visit(s) and additional postoperative visit(s). ASCs, as distinct entities that operate in an entirely separate capacity from physician offices (please see 42 CFR §416.2 for the definition of an ASC and the CMS State Operations Manual, Appendix L for detailed guidance on the interpretation of Federal requirements), do not have access to these records.

The agency also acknowledged the collection and reporting burden and subsequently applied a sampling scheme and a low case threshold to address these concerns. The agency now believes all issues are resolved and that the measure is now appropriate as mandatory. The agency further states the measure provides opportunities for care coordination as well as direct patient feedback.

The ASC QC does not support implementing ASC-11 as a mandatory measure. We believe ASC-11 would continue to pose data collection and reporting challenges, notwithstanding the changes CMS has made. While it is true that a small number of ASCs have voluntarily reported the measure, we think it is unlikely that additional ASCs would be able to join their ranks. Implementation of the measure would require

ASCs to obtain the preoperative and postoperative survey data from the ophthalmologists performing the surgery. Additionally, we have shared our concern about the low number of physicians reporting on the measure under the (then) Physicians Quality Reporting System. Specifically, in 2013 only 215 of the more than 7,300 cataract physicians in the US reported on the measure.

Fast forwarding to the present, our research indicates that, as of 2021, the physician measure corresponding to ASC-11 - the Quality ID #303: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure - is still in use under the current Merit-based Incentive Payment System of the Quality Payment Program for clinicians. Under the ophthalmology track for the program, clinicians choose six measures to report. There is no requirement that clinicians choose Quality ID #303 when selecting which measures to report.

We have discovered there are no publicly reported results available in 2021for Quality ID #303: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure from the PY 2019 reporting period. According to the Quality Payment Program support contractor, this is because the standards for publicly reporting the measure were not met. Reporting standards were not met because fewer than 20 reporters submitted data.

In light of this, we think it unlikely that additional ASCs beyond those already reporting voluntarily will be able to get survey results from surgeons because it appears that fewer than 20 are collecting and reporting the survey data ASCs would need. Therefore, we strongly urge CMS set aside the proposal for mandatory reporting and continue with voluntary reporting of the measure.

Covenant Physician Partners

Do you support retaining this measure in the program? Yes

Though this measure continues to pose data collection issues for some of our ASCs, we support the continuation of its use.

Surgical Care Affiliates

Do you support retaining this measure in the program? No

Unreasonable financial and logistical measure for ambulatory surgery centers to manage as ASCs typically are not involved at all with pre-surgical visual function testing or even post-surgical visual function testing as this assessment is not performed within the confines of the ASC and ASCs do not have the expertise and capability to conduct either of these assessment tests. This is primarily the responsibility of the ophthalmologist out of the confines of the ASC. The ASC is only involved with the surgical management of cataract removal and implantation of an intraocular lens all determined by the treating physician.

Public Comments Post-Workgroup Meeting

MarsdenAdvisors

Do you support retaining this measure in the program? No

MarsdenAdvisors urges the MAP to recommend removal of ASC-11. Ophthalmic specialty societies have opposed ASC-11 for years due to the inappropriate nature of these surveys being attributed to the ASC facility rather than to the individual surgeon and the burdensome nature of patient surveys, particularly in the context of Conditions for Coverage requirements. Medicare ASC Conditions for Coverage state that the two entities must be physically, administratively, and financially separate from one another.

This measure, however, requires the ASC to report on data that is located in the surgeon's office and, thus inaccessible by the ASC.

Moreover, any improvement in visual function is attributable to the individual surgeon, not to the facility in which the procedure was performed. ASCs are neither licensed nor qualified to evaluate the cataract patient and make these assessments. ASCs should not be involved in the professional decision-making intended by this measure. This measure will not result in improved patient outcomes and is inappropriate for facility measurement as facilities do not contribute to the skill of the cataract surgeon.

ASC-11 has had problems before it was even implemented, with the ASCA, ASCRS, and the AAO strongly advocating against its use from its inception. This measure has ill-defined logic as an evaluation of individual physicians, as well as a high burden to facilities to complete. While the 2023 ASC proposed rule delays the implementation of this measure as mandatory due to the COVID-19 pandemic, CMS states that it anticipates proposing mandatory reporting in the future.

We ask the MAP to show CMS the inappropriate nature of this measure by recommending it for removal.

02936-C-ASCQR Normothermia Outcome

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	02936-C-ASCQR
CMS Program(s) for Which Measure is Being Discussed for Removal	Ambulatory Surgical Center Quality Reporting Program
Measure description	The percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the post-anesthesia care unit (PACU).
Numerator	The numerator is the number of surgery patients with a body temperature equal to or greater than 96.8 degrees Fahrenheit/36 degrees Celsius recorded within 15 minutes of arrival in the PACU.
Numerator Exclusions	N/A
Denominator	The denominator is all patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes in duration.
Denominator Exclusions	The measure excludes: Patients who did not have general or neuraxial anesthesia; patients whose length of anesthesia was less than 60 minutes; and patients with physician/advanced practice nurse/physician assistant documentation of intentional hypothermia for the procedure performed.
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Ambulatory Surgical Center Quality Reporting Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	N/A
Measure Steward	ASC Quality Collaboration
Data Reporting Begin Date	Ambulatory Surgical Center Quality Reporting Program: 2018-01-01

Field Label	Field Description
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 6
Rationale for Removal Consideration	Rationale for nominations: • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 8. Measure leads to a high level of reporting burden for reporting entities Notes from survey respondents: • Lost endorsement. Important but is a standard of care and I think was topped out. • Revise to match hospital standard. • Selected criteria #8 if data source truly is paper medical records (as opposed to EHRs). • Interested in learning if the measure has been submitted for endorsement and if so if it failed endorsement and why. If not been submitted, then why has it not been submitted.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed; this measure has not been submitted to the CBE for endorsement.
Consensus-Based Entity Number	9999
History of CBE Endorsement	N/A

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2014-2015 Recommendation: Conditional Support

Field Label	Field Description
Rationale for MAP Recommendation	Conditional support pending the completion of reliability testing and NQF endorsement. MAP supported this measure conditional on completion of reliability testing, and review and endorsement by NQF. The MAP agreed that this measure is highly impactful and meaningful to patients. Anesthetic-induced thermoregulatory impairment may cause perioperative hypothermia, which is associated with adverse outcomes including significant morbidity (decrease in tissue metabolic rate, myocardial ischemia, surgical site infections, bleeding diatheses, prolongation of drug effects) and mortality. As an intermediate outcome measure, this workgroup agreed that this measure moves towards an outcome measure that fills the workgroup identified gap of anesthesia-related complications.

Section 4: Performance and Reporting Data

National Performance for ASC - 13: Normothermia

Year	N Reporting	Average Rate	Median Rate
2020	2,145	95.11	100
2019	1,172	95.75	100
2018	2,149	85.53	100

Data Source: Hospital Compare files for January 2020, 2022.
N Reporting is the number of facilities reporting a rate plus the number of facilities with too few cases to report

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Proportion
- Measure direction: larger results are better
- Adjustment applied: None
- Trend category: N/A
- Average annual percentage change (AAPC): N/A
- AAPC 90% confidence interval: N/A
- Score (standard deviation) [provider interquartile range]
    - 2018: 85.6 (35.1) [5.6]

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	At this time, NQF has no information on feasibility for this measure.
Source and Date of Feasibility Data	N/A

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 0
- No (Do Not Support Retaining in Proposed Program) – 6
- Unsure of Retaining in Proposed Program – 1

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns.

MAP Health Equity:

The advisory group members did not have health equity concerns.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program. The workgroup noted this measure has overall high performance, but there are outliers and room for improvement. The workgroup questioned whether the measure data could be captured by something other than manual review.

Public Comments

No public comments received.

Public Comments Post-Workgroup Meeting

No public comments received.

00140-C-HOQR Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	00140-C-HOQR
CMS Program(s) for Which Measure is Being Discussed for Removal	Hospital Outpatient Quality Reporting
Measure description	This measure evaluates the percentage of magnetic resonance imaging (MRI) of the lumbar spine studies for patients with low back pain performed in the outpatient setting where antecedent conservative therapy was not attempted prior to the MRI. *Antecedent conservative therapy* may include claim(s) for physical therapy in the 60 days preceding the lumbar spine MRI, claim(s) for chiropractic evaluation and manipulative treatment in the 60 days preceding the lumbar spine MRI, and/or claim(s) for evaluation and management at least 28 days but no later than 60 days preceding the lumbar spine MRI. The measure is calculated based on a one-year window of Medicare claims. The measure has been publicly reported, annually, by the measure steward, the Centers for Medicare & Medicaid Services (CMS), since 2009, as a component of its Hospital Outpatient Quality Reporting (HOQR) Program.
Numerator	Of cases in the denominator, the numerator contains those MRI of the lumbar spine studies with a diagnosis of low back pain (from the denominator) for which the patient did NOT have claims-based evidence of antecedent conservative therapy prior to imaging.
Numerator Exclusions	N/A
Denominator	The denominator contains any Medicare beneficiary (not excluded from the initial patient population because of a diagnosis for which the imaging may be appropriate) who underwent an MRI of the lumbar spine (which had documentation of low back pain on the imaging claim), performed at a hospital outpatient department within a one-year window of claims.

Field Label	Field Description
Denominator Exclusions	Indications for measure exclusion include any beneficiaries with the following diagnoses (look-back periods listed following each exclusion): lumbar spine surgery (look back of 90 days prior to the MRI), infectious conditions (look back of 1 year), treatment fields for radiation therapy (look back of 5 years), trauma (look back of 45 days), unspecified immune deficiencies (look back within 12 months), cancer (look back within 12 months), spinal vascular malformations and/or the cause of occult subarachnoid hemorrhage (look back within 5 years), spinal abnormalities associated with scoliosis (look back within 5 years), IV drug abuse (look back within 12 months), intraspinal abscess (on the MRI claim), congenital spine and spinal cord malformations (look back within 5 years), spinal cord infarctions (look back within 12 months), syringohydromyelia (look back within 5 years), neurologic impairment (look back within 12 months), inflammatory and autoimmune disorders (look back within 5 years), neoplastic abnormalities (look back within 5 years), postoperative fluid collections and soft tissue changes (look back within 12 months), or HIV (look back within 12 months).
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Hospital Outpatient Quality Reporting Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Hospital Compare
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Data Reporting Begin Date	Hospital Outpatient Quality Reporting: 2008-01-01; Hospital Compare: 2009-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 7

Field Label	Field Description
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 4. Performance or improvement on the measure does not result in better patient outcomes • Criteria 7. Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation • Criteria 8. Measure leads to a high level of reporting burden for reporting entities Notes from survey respondents: • This measure has a good intent but without revision this measure may not function as intended. Could lead to long wait times for patients. Favors cost savings over patient care. • Interested in understanding why endorsement was removed.

Section 2: Consensus-Based Entity (CBE) Endorsement History

CBE Endorsement Status

Endorsement Removed

Consensus-Based Entity Number

0514

History of CBE Endorsement

2008: Initial Endorsement

2014: Endorsement Maintenance

CMS submitted OP-8 to NQF for endorsement maintenance review by the Musculoskeletal Project's Standing Committee in May 2014. The Committee originally did not recommend the measure for endorsement based on it failing the validity criterion. Comments made by the Committee included concern about application of evidence from ACR Appropriateness Criteria® and guidelines related to the initial patient population's age (i.e., there was not consensus if older adults should be excluded from the measure) and exclusions (e.g., concerns about look-back periods for some exclusions, such as lumbar spine surgery or cancer, and the conditions used to document low back pain). Votes for validity were: 0 High, 4 Moderate, 15 Low, and 3 Insufficient.

During CSAC review of the Musculoskeletal Project's Standing Committee votes, members expressed concern about how the Committee evaluated the measure's exclusions, noting that the NQF criteria for assessing threats to validity and exclusions may not have been applied correctly.

Endorsement maintenance was deferred to a future cycle (in 2016–2017) to allow the developer to perform additional testing and resubmit the Measure Submission Form, addressing concerns from the Committee.

2016-2017 Endorsement Removed during Musculoskeletal Off-Cycle Measure Review

The Musculoskeletal Committee conducted an off-cycle review of this measure in 2016-2017. The Committee did not recommend the measure for endorsement based on the measure failing the validity criterion.

For validity, votes were: 0 High, 3 Moderate, 9 Low, and 1 Insufficient.

The Committee again expressed concerns with the exclusions and the continued inclusion of "elderly" patients in the measure. The Committee also continued to have concerns with using administrative claims data to identify use of antecedent conservative therapies. The Committee rated the measure as "low" on the validity subcriterion and thus the measure did not pass scientific acceptability.

During the member and public commenting period, the developer submitted a request for reconsideration of the validity subcriterion. The developer stated that the "measure specifications are aligned with the most updated clinical practice guidelines and have strong face validity; additionally, measure testing confirms that threats to validity have been addressed by the exclusion of red-flag conditions." On the post-draft report comment call, the Committee reviewed the reconsideration request. Ultimately, the Committee agreed to reconsider the measure for endorsement. After a thorough review and discussion, the Committee re-voted and did not pass the measure on the validity subcriterion. The Committee did not recommend the measure for continued endorsement.

Votes following consideration of public and member comments for validity were: 0 High, 3 Moderate, 8 Low, and 2 Insufficient.

The Consensus Standards Approval Committee then voted to uphold the Standing Committee's recommendation not to endorse the measure. The vote was 16 to uphold the recommendation and 0 to overturn the Standing Committee's recommendation and endorse the measure.

The Consensus Standards Advisory Committee (CSAC) acknowledged that determination of the validity of a measure includes consideration of potential threats to validity. The CSAC concluded that the Standing Committee appropriately applied NQF's evaluation criteria related to measure exclusions and upheld the Committee's recommendation to not endorse the measure.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2017-2018 Recommendation: Do Not Support for Rulemaking

Field Label	Field Description
Rationale for MAP Recommendation	MAP did not support for the HOQR program. MAP noted that this measure was not recommended for continued endorsement by the NQF Musculoskeletal Standing Committee in 2017. When reviewing this measure for endorsement maintenance, the Standing Committee agreed that it did not meet the validity sub criterion. The Standing Committee expressed a number of concerns including a potential misalignment between this measure being specified for Medicare fee-for-service beneficiaries and the inclusion of "elderly individuals " as one of the red-flag conditions in the Appropriate Use guidelines; the use of evaluation and management visits as a proxy for antecedent conservative care as this may not capture all types of conservative care that cannot be captured in claims data (e.g., telephone visits, the use of OTC NSAIDs, acupuncture or massage); and concerns about coding and appropriate look back periods for exclusions.

Section 4: Performance and Reporting Data

Measure unit: Percent of patients

Payment Determination Year	Number of Hospitals Reporting	Mean	Standard Deviation	25th Percentile	Median	75th Percentile
CY2020	4,072	40.18	16.89	32.35	39.29	47.58
CY2021	4,024	40.57	17.04	32.14	39.66	48.39
CY2022	3,852	39.59	21.25	28.57	38.83	50.00

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Proportion
- Measure direction: Smaller results are better
- Adjustment applied: None
- Trend category: Stable
- Average annual percentage change (AAPC): 0.5
- AAPC 90% confidence interval: [0.4, 0.6]
- Score (standard deviation) [provider interquartile range]
    - 2016: 39.8 (48.9) [NA]
    - 2017: 39.3 (48.8) [NA]
    - 2018: 38.7 (48.7) [NA]
- 2018 disparity results
    - Age group
        - 18-64: Similar performance to 65-74
        - 75-84: Higher performance than 65-74
        - 85 and older: Higher performance than 65-74
    - Sex
        - Female: Higher performance than male
    - Race/ethnicity
        - Across race categories, performance was similar to White

- Income
  - Across income categories, performance was similar to high income
- Urban-Rural
  - Across urban-rural categories, performance was similar to large central metro
- Census division
  - Across census divisions, performance was similar to South Atlantic division

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	Data elements are coded by someone other than the person obtaining original information (e.g., DRG, ICD-10 codes on claims). All data elements are in defined fields in electronic claims. The measure developer stated in their measure submission in 2017 that: "This measure is claims-based, and uses CMS hospital outpatient claims as its data source. Special attention needs to be taken when counting procedures on the Medicare claims files. The biggest issue is how to deal with modifier codes. Modifiers are two digit indicators (alpha or numeric) that represent a service or procedure that has been altered by some specific circumstance, which typically will impact the payment amount. Procedure modifier code "26" represents the professional component of a procedure and includes the clinician work (i.e., the reading of the image by a physician), associated overhead and professional liability insurance costs. This modifier corresponds to the human involvement in a given service or procedure. The procedure modifier code "TC" represents the technical component of a service or procedure and includes the cost of equipment and supplies to perform that service or procedure. This modifier corresponds to the equipment/facility part of a given service or procedure. In most cases, unmodified codes represent a global procedure which includes both the professional and technical components. There are also other modifier codes. All other modifier codes have been counted as a technical code for our purposes. When calculating the measures, we are only concerned with procedures associated with technical and global modifiers, as these modifiers refer to services provided by the facility. This reduces the possibility of double-counting procedures, since a single procedure may result in both a technical and professional record on the claims files. There were very few instances when this occurred as it related to procedures applicable to the measure. When developing counts of procedures, the objective is to avoid double-counting procedures that may have been billed through multiple revenue centers within a facility. Billing through multiple centers leads to multiple records in the Medicare claims files (i.e., the SAFs). For instance, there may be multiple bills for a single MRI. On one bill, the charges relate to the application of a radiopharmaceutical, which could have a technical modifier code and come from the pharmacy revenue center. On the other bill, the charges relate to the imaging study and may fall under a technical bill from the imaging center revenue center. In this case, we only count the MRI once, since only one MRI was performed. However, if we were summing up the Medicare paid amounts for this procedure, we would include the Medicare paid amounts from both bills, as they each represent payments for services directly related to the particular MRI procedure.
Source and Date of Feasibility Data	CBE Measure Submission, 07/07/2017

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	01367-C-HOQR Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery 12735-C-HOQR Breast Cancer Screening Recall Rates

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 0
- No (Do Not Support Retaining in Proposed Program) – 7
- Unsure of Retaining in Proposed Program – 0

MAP Health Equity:

- Yes (Support Retaining in Proposed Program) – 4
- No (Do Not Support Retaining in Proposed Program) – 6
- Unsure of Retaining in Proposed Program - 7

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

One advisory group member noted that the measure's performance lacks variation, therefore, it is not seen as a helpful measure for performance evaluation and may not offer benefit in a rural setting.

MAP Health Equity:

An advisory group member noted the significance of imaging utilization and its potential impact on health equity and that literature published by the National Health Interview Survey suggests that Black, Hispanic, and Asian participants are less likely to report ever undergoing a computed tomography (CT) scan in comparison to White participants. The advisory group member also noted there are differences in ED diagnostic imaging at U.S. children's hospitals, which found approximately a 20-30% difference in the use of imaging services among African American and Hispanic populations. Additionally, the member noted a meta-study which found greater overuse among White patients, highlighting that the equity concerns may not be an inappropriate use or overuse, but may be underuse.

Another advisory group member commented the measure is more about overuse and access to these services within minority communities contributes to equity impacts.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Consensus not reached due to lack of quorum.

Workgroup Rationale

The MAP Coordinating Committee will review this measure at the MSR meeting. The workgroup agreed to start with a decision category of support for removal; however, the workgroup did not reach quorum at the meeting or after the meeting via survey. The workgroup noted the CBE's standing committee declined to re-endorse the measure in 2016. The workgroup also acknowledged in 2018 MAP did not support the measure for rulemaking with the rationale from MAP relating to the CBE's standing committee decision from 2016. Lastly, the workgroup noted the measure may have addressed an important topic (overuse) when it was first developed, but that the measure may have served its purpose.

Public Comments

No public comments received.

Public Comments Post-Workgroup Meeting

Blue Cross Blue Shield Association

Do you support retaining this measure in the program? Yes, under certain conditions

It is not quite clear to us why endorsement was lost. We would also like to see data demonstrating that the issue of overuse has been markedly decreased and that decrease has been sustained before removal.

00922-C-HOQR Left Without Being Seen

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	00922-C-HOQR
CMS Program(s) for Which Measure is Being Discussed for Removal	Hospital Outpatient Quality Reporting Program
Measure description	Percent of patients who leave the Emergency Department (ED) without being evaluated by a physician/advanced practice nurse/physician's assistant (physician/APN/PA).
Numerator	The total number of patients who left without being seen (LWBS) by a physician/APN/PA.
Numerator Exclusions	N/A
Denominator	The total number of patients who presented to the emergency department (ED)
Denominator Exclusions	N/A
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Hospital Outpatient Quality Reporting Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Hospital Compare
Measure Steward	Centers for Medicare & Medicaid Services
Data Reporting Begin Date	Hospital Outpatient Quality Reporting Program: 2012-01-01; Hospital Compare: 2016-10-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 7

Field Label	Field Description
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 4. Performance or improvement on the measure does not result in better patient outcomes • Criteria 7. Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation Notes from survey respondents: • Needs more information. Performance of this measure could indicate the health system or availability of care within the community rather than a quality/performance issue at the ED. • Interested in knowing if submitted for endorsement but failed endorsement and why; or if not submitted for endorsement, why. • However, data during the COVID-19 Public Health Emergency could reveal meaningful differences between hospitals, although unclear what actions could be taken.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Endorsement Removed
Consensus-Based Entity Number	0499
History of CBE Endorsement	2008: Initial Endorsement 2012: Measure retired and endorsement removed

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2011-2012 Recommendation: Support Direction Date reviewed: 2012-2013 Recommendation: Phased removal

Field Label	Field Description
Rationale for MAP Recommendation	2011-2012: Important concept but measure needs further development. Public comments received from Baylor Health Care System provided additional information about the measure. MAP will consider this information in future pre-rulemaking activities. 2012-2013: NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).

Section 4: Performance and Reporting Data

Measure unit: Percent of patients

Payment determination year	Number of hospitals reporting	Mean	Standard deviation	25th percentile	Median	75th percentile
CY2020	3,766	1.46	1.66	0.00	1.00	2.00
CY2021	2,911	1.38	1.87	0.00	1.00	2.00
CY2022	3,614	1.45	3.07	0.00	1.00	2.00

Payment determination year	Number of hospitals reporting	Minimum	5th percentile	10th percentile	90th percentile	95th percentile	Maximum
CY2020	3,766	0.00	0.00	0.00	3.00	4.00	33.00
CY2021	2,911	0.00	0.00	0.00	3.00	4.00	57.00
CY2022	3,614	0.00	0.00	0.00	3.00	4.00	100.00

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Proportion
- Measure direction: Smaller results are better
- Adjustment applied: None
- Trend category: Improving
- Average annual percentage change (AAPC): -2.0
- AAPC 90% confidence interval: [-2.1, -2.0]
- Score (standard deviation) [provider interquartile range]
    - 2016: 2.1 (14.2) [1.0]
    - 2017: 1.9 (13.6) [2.0]
    - 2018: 1.8 (13.4) [2.0]

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	During the NQF member and public comment period, reviewers noted that triaging patients in large and busy EDs is more challenging than triaging patients in EDs located in areas with small patient populations.
Source and Date of Feasibility Data	2009: National Voluntary Consensus Standards for Emergency Care Consensus Report

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 1
- No (Do Not Support Retaining in Proposed Program) – 4
- Unsure of Retaining in Proposed Program - 1

MAP Health Equity:

- Yes (Support Retaining in Proposed Program) – 15
- No (Do Not Support Retaining in Proposed Program) – 1
- Unsure of Retaining in Proposed Program - 2

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

An advisory group member noted the measure could be an internal performance improvement metric but would not be useful in a national context for a public quality reporting program.

MAP Health Equity:

An advisory group member noted that this measure can highlight certain important inequities, for example, a lack of basic interpreter services within a hospital could cause certain patients to experience extreme wait times before being effectively triaged.. The member noted the measure is equity sensitive. Another advisory group member concurred certain equity trends could be tracked within this measure, such as lack of childcare, transportation issues, employment conflicts, or other reasons preventing patients from being available to wait in the ED for long periods of time. Additionally, an advisory group member highlighted that some minority populations rely on access to the ED for care rather than primary care services, so removing the measure could impact access issues. Another advisory group member agreed that removing the measure could impact access issues by highlighting that some patients leave the ED due to transphobia or homophobia.

Another advisory group member noted it was helpful to know that the measure is not tied to payment, as hospitals would not be penalized for serving lower income populations or people who utilize the ED as a primary care alternative. The member also suggested the measure could be improved if it could track subpopulations.

An advisory group member suggested a stratification variable of population size or acuity to better examine the communities being served by EDs. The member also suggested the measure gather data at an aggregated level.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Consensus not reached due to lack of quorum.

Workgroup Rationale

The MAP Coordinating Committee will review this measure at the MSR meeting. The workgroup agreed to start with a decision category of support for removal; however, the workgroup did not reach quorum at the meeting or after the meeting via survey. The workgroup noted the measure by itself may not be providing useful information to patients. The workgroup also noted the measure may not have enough granularity to give value.

Public Comments

No public comments received.

Public Comments Post-Workgroup Meeting

No public comments received.

00930-C-HOQR Median time from ED Arrival to ED Departure for Discharged ED patients

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	00930-C-HOQR
CMS Program(s) for Which Measure is Being Discussed for Removal	Hospital Outpatient Quality Reporting Program
Measure description	This measure calculates the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department (ED). The measure is calculated using chart-abstracted data, on a rolling quarterly basis, and is publicly reported in aggregate for one calendar year. The measure has been publicly reported since 2013 as part of the ED Throughput measure set of the CMS Hospital Outpatient Quality Reporting (HOQR) Program.
Numerator	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.
Numerator Exclusions	N/A
Denominator	This measure is reported as a continuous variable statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.
Denominator Exclusions	Patients who expired in the emergency department
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Hospital Outpatient Quality Reporting Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Hospital Compare
Measure Steward	Centers for Medicare & Medicaid Services (CMS)

Field Label	Field Description
Data Reporting Begin Date	Hospital Outpatient Quality Reporting Program: 2012-01-01; Hospital Compare: 2014-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 5
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 4. Performance or improvement on the measure does not result in better patient outcomes Notes from survey respondents: • This measure is hard to collect, lack of definition as to when the clock starts and ends. Need more information about why endorsement was removed. • Interested in knowing if submitted for endorsement but failed endorsement and why; or if not submitted for endorsement, why.

Section 2: Consensus-Based Entity (CBE) Endorsement History

CBE Endorsement Status

Endorsement Removed

Consensus-Based Entity Number

0496

History of CBE Endorsement

Initial Endorsement: 2008

Endorsement Removed: Cost and Efficiency Committee, Spring 2018

The Cost and Efficiency Committee reviewed this measure in 2018. The Committee did not reach consensus on the evidence criterion for this measure. Committee members noted disparities in age and race and wide variability across institutions; however, they noted that differences in performance have also been found based on location, facility size, and type (i.e., teaching versus nonteaching facilities). They noted that variation in performance clearly existed, but they were not convinced that the gap represented meaningful differences in quality. With these concerns in mind, the Committee voted to not pass the measure for the Performance Gap criterion—a must-pass criterion.

For Importance to Measure and Report (Evidence), the vote was: High-0; Moderate-8; Low-3; and Insufficient-5.

For Importance to Measure and Report (Performance Gap), the vote was: High-1; Moderate-2; Low-0; and Insufficient-13.

Rationale:

- Committee members were concerned by the lack of evidence that a change in wait times influences mortality or other patient outcomes. The Committee members acknowledged that a recent literature review that noted the importance of this measure is primarily in the realm of patient satisfaction. There is a relationship between EDs with shorter wait times and higher ED volume, as well as a decrease in the number of patients who left without being seen.
- Committee members expressed concern with the lack of risk adjustment or stratification, noting that EDs may serve different populations (some EDs provide more ambulatory care services, as compared to EDs that handle high levels of trauma or complex care). The evidence presented that did show a relationship to outcomes also found an association between longer through put times and higher complexity cases, a factor that is not addressed in the measure as specified.
- Committee members noted that the measure reports disparities in age and race, but Committee members remained concerned that there was no risk adjustment for the size of the facility or complexity of disease of presenting patients. The Committee noted that certain population types that should be separated, including those seeking mental health services, who should be separated from the nonpsychiatric population. The developer clarified that psychiatric patients are addressed in a separate rate, and the data regarding this population is not publicly reported.
- Committee members noted that the overall change from 2014-2016, was approximately four minutes, and noted concerns about whether this change was significant enough to be meaningful. Committee members noted that a performance gap existed but were not convinced that this gap represented variation in quality. They noted that differences in performance have also been found to vary based on location, facility size, and type (i.e., teaching versus nonteaching facilities).
- A Committee member asked if there were more data on the differences between 2014-2016 performance by facility type. The developer noted that this analysis was not conducted. The developer argued that high-quality care equates to a short wait time for all patients and all facilities should be held to the same standard. However, the Committee maintained concerns that throughput time could not be interpreted without an understanding of the mix of acuity at a given ED.
- Committee members noted that the measure has been endorsed for 10 years but noted that there has been limited improvement in throughput time. Committee members questioned if the measure has been appropriately capturing quality performance, as there has been limited change in throughput time during this period.
- The Committee members expressed that this measure might be strengthened by segmenting the time categories of the measure (e.g., time from presentation to triage, time from triage to treatment, time from treatment to discharge).
- Committee members had concerns regarding the validity of the measure particularly related to the need for risk adjustment. The Committee noted the relationship between the validity of the measure and performance gap, as users do not know how meaningful the measure results are without information on the case mix or diagnostic information. Without this information, users cannot determine what the variation in median time means.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2013 Recommendation: Phased-removal
Rationale for MAP Recommendation	MAP members suggested the removal of the measure 0496 (Chart Abstracted Median Time from ED Arrival to ED Departure for Discharged ED Patients) as it is burdensome to collect. MAP recommended that it could be removed to allow for the implementation of a higher value measure.

Section 4: Performance and Reporting Data

Measure unit: Median Time (minutes)

Payment Determination Year	Performance Period Quarter	Number of Hospitals Reporting	Mean	Standard Deviation	25th Percentile	Median	75th Percentile
OP-18a: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Overall Rate							
CY2020	2018 Q2	3,997	144.64	46.20	114.00	138.50	168.00
CY2020	2018 Q3	3,988	145.43	46.06	115.00	139.00	168.00
CY2020	2018 Q4	4,018	144.70	43.99	115.00	138.00	168.00
CY2020	2019 Q1	4,012	150.32	46.21	118.00	143.00	175.00
CY2021	2019 Q2	4,005	147.20	52.24	115.50	140.50	170.00
CY2021	2019 Q3	4,001	147.24	46.14	116.00	141.00	172.00
CY2021	2019 Q4	3,763	147.28	44.86	116.00	141.00	172.00
CY2021	2020 Q1	2,787	146.06	45.13	115.00	139.50	170.00
CY2022	2020 Q2	2,616	141.41	39.38	114.00	137.00	163.75
CY2022	2020 Q3	3,838	152.79	46.40	121.00	147.00	178.00
CY2022	2020 Q4	3,851	159.37	48.24	126.00	153.00	185.50
CY2022	2021 Q1	3,939	158.22	46.60	125.00	152.00	185.00
CY2023	2021 Q2	3,924	160.69	52.47	123.00	154.00	189.50
CY2023	2021 Q3	3,937	170.21	56.61	129.00	163.00	202.00

Payment Determination Year	Performance Period Quarter	Number of Hospitals Reporting	Mean	Standard Deviation	25th Percentile	Median	75th Percentile
OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Reporting Measure							
CY2020	2018 Q2	3,988	139.72	46.55	109.00	134.00	163.75
CY2020	2018 Q3	3,979	140.28	44.94	109.00	134.00	164.00
CY2020	2018 Q4	4,009	139.77	44.98	109.50	133.00	162.00
CY2020	2019 Q1	4,002	145.59	50.28	113.00	138.00	170.00
CY2021	2019 Q2	3,999	142.66	54.11	110.50	136.00	166.00
CY2021	2019 Q3	3,994	142.52	49.63	110.00	135.25	167.50
CY2021	2019 Q4	3,758	142.14	44.26	110.50	136.00	167.00
CY2021	2020 Q1	2,782	141.16	45.48	109.50	134.00	165.00
CY2022	2020 Q2	2,613	135.17	38.03	107.50	130.50	157.50
CY2022	2020 Q3	3,833	146.29	45.48	115.00	140.00	172.00
CY2022	2020 Q4	3,845	152.55	48.11	120.00	146.00	180.00
CY2022	2021 Q1	3,934	151.57	46.61	118.00	145.00	178.00
CY2023	2021 Q2	3,922	154.11	51.97	116.50	147.50	183.50
CY2023	2021 Q3	3,934	164.06	55.39	123.50	157.00	196.50
OP-18c: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Psychiatric/Mental Health Patients							
CY2020	2018 Q2	3,784	287.45	503.91	142.50	213.00	321.00
CY2020	2018 Q3	3,793	284.55	374.23	149.00	215.50	321.50
CY2020	2018 Q4	3,821	305.79	1485.18	145.00	212.50	319.50
CY2020	2019 Q1	3,769	353.87	2951.13	153.00	224.00	336.50
CY2021	2019 Q2	3,798	278.53	267.58	147.50	215.00	319.50
CY2021	2019 Q3	3,834	303.49	829.14	146.00	215.00	322.00
CY2021	2019 Q4	3,582	292.21	263.45	156.00	223.00	339.00
CY2021	2020 Q1	2,664	409.06	5723.45	152.00	222.50	338.25
CY2022	2020 Q2	2,532	299.39	1338.87	146.25	208.00	309.50

Payment Determination Year	Performance Period Quarter	Number of Hospitals Reporting	Mean	Standard Deviation	25th Percentile	Median	75th Percentile
CY2022	2020 Q3	3,710	320.43	603.90	156.00	229.00	347.00
CY2022	2020 Q4	3,707	327.41	629.10	159.50	235.00	348.00
CY2022	2021 Q1	3,818	316.45	408.58	156.50	234.50	353.00
CY2023	2021 Q2	3,772	338.29	816.74	158.00	237.00	356.50
CY2023	2021 Q3	3,781	359.85	1016.48	168.50	251.00	384.00
OP-18d: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Transfer Patients. Results are shown at the quarterly level.							
CY2020	2018 Q2	3,190	279.96	435.63	177.00	232.00	312.00
CY2020	2018 Q3	3,199	276.71	273.19	175.00	234.50	311.00
CY2020	2018 Q4	3,228	282.86	268.66	179.00	235.00	317.75
CY2020	2019 Q1	3,265	288.53	242.54	181.00	244.00	332.00
CY2021	2019 Q2	3,210	285.60	351.60	178.00	235.00	314.00
CY2021	2019 Q3	3,275	290.07	282.20	183.00	242.00	322.00
CY2021	2019 Q4	3,037	281.72	187.28	184.00	243.50	327.00
CY2021	2020 Q1	2,282	294.80	433.32	184.00	243.00	319.00
CY2022	2020 Q2	2,202	290.68	968.50	183.00	237.75	310.00
CY2022	2020 Q3	3,182	341.25	2085.35	193.50	257.00	346.00
CY2022	2020 Q4	3,203	326.20	230.33	210.00	277.00	371.00
CY2022	2021 Q1	3,232	330.18	362.13	201.00	266.00	364.75
CY2023	2021 Q2	3,224	324.82	306.25	204.00	269.00	361.00
CY2023	2021 Q3	3,159	365.10	353.35	216.00	295.00	417.00

Payment Determination Year	Performance Period Quarter	Number of Hospitals Reporting	Minimum	5th Percentile	10th Percentile	90th Percentile	95th Percentile	Maximum
OP-18a: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Overall Rate								
CY2020	2018 Q2	3,997	0.00	85.00	95.00	201.00	223.50	1110.00
CY2020	2018 Q3	3,988	0.00	84.50	95.00	202.00	229.00	775.50

Payment Determination Year	Performance Period Quarter	Number of Hospitals Reporting	Minimum	5th Percentile	10th Percentile	90th Percentile	95th Percentile	Maximum
CY2020	2018 Q4	4,018	0.00	85.00	96.00	200.00	224.50	486.50
CY2020	2019 Q1	4,012	0.00	88.00	99.00	210.00	234.50	437.00
CY2021	2019 Q2	4,005	0.00	85.00	96.50	205.00	229.50	1492.00
CY2021	2019 Q3	4,001	0.00	86.00	96.00	204.50	229.50	403.00
CY2021	2019 Q4	3,763	0.00	86.00	97.00	204.50	226.00	427.50
CY2021	2020 Q1	2,787	0.00	87.00	96.00	203.00	228.00	446.00
CY2022	2020 Q2	2,616	0.00	87.00	97.00	191.00	213.00	360.00
CY2022	2020 Q3	3,838	22.00	89.50	101.00	211.50	231.50	763.00
CY2022	2020 Q4	3,851	51.00	94.00	106.00	219.00	242.00	774.00
CY2022	2021 Q1	3,939	30.00	94.50	105.00	218.50	243.00	396.00
CY2023	2021 Q2	3,924	15.00	92.00	102.00	228.00	257.00	817.00
CY2023	2021 Q3	3,937	52.00	94.50	106.00	241.00	271.00	502.00
OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Reporting Measure								
CY2020	2018 Q2	3,988	0.00	80.00	90.50	196.00	216.00	1200.00
CY2020	2018 Q3	3,979	33.00	80.00	89.50	197.00	223.00	427.00
CY2020	2018 Q4	4,009	0.00	81.00	91.00	195.00	220.00	798.00
CY2020	2019 Q1	4,002	50.00	83.00	94.50	204.00	229.00	1344.00
CY2021	2019 Q2	3,999	26.00	81.00	91.50	200.50	226.00	1518.00
CY2021	2019 Q3	3,994	0.00	81.00	91.00	200.00	224.50	1288.00
CY2021	2019 Q4	3,758	0.00	81.50	92.00	200.00	222.00	411.00
CY2021	2020 Q1	2,782	6.00	82.50	92.00	198.00	224.00	655.00
CY2022	2020 Q2	2,613	41.00	82.50	91.50	184.00	206.00	306.50
CY2022	2020 Q3	3,833	50.50	84.50	94.50	204.00	226.00	761.00
CY2022	2020 Q4	3,845	51.00	89.00	100.00	211.00	234.00	765.00
CY2022	2021 Q1	3,934	27.00	89.00	98.50	212.00	236.00	646.00

Payment Determination Year	Performance Period Quarter	Number of Hospitals Reporting	Minimum	5th Percentile	10th Percentile	90th Percentile	95th Percentile	Maximum
CY2023	2021 Q2	3,922	15.00	86.00	96.50	221.00	248.00	817.00
CY2023	2021 Q3	3,934	51.50	89.50	101.00	234.00	262.00	483.00
OP-18c: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Psychiatric/Mental Health Patients								
CY2020	2018 Q2	3,784	0.00	79.00	100.00	494.00	683.00	24576.00
CY2020	2018 Q3	3,793	0.00	78.00	103.00	483.00	683.00	13573.00
CY2020	2018 Q4	3,821	10.00	80.00	102.00	492.00	681.00	88045.00
CY2020	2019 Q1	3,769	0.00	84.00	108.00	540.00	764.00	180109.00
CY2021	2019 Q2	3,798	0.00	82.00	103.50	504.00	658.00	5322.00
CY2021	2019 Q3	3,834	0.00	81.00	101.00	514.00	703.00	44706.00
CY2021	2019 Q4	3,582	14.00	85.50	106.00	529.00	698.00	4967.50
CY2021	2020 Q1	2,664	0.00	84.00	105.00	533.00	739.00	295283.00
CY2022	2020 Q2	2,532	12.00	82.00	102.50	472.00	664.50	65820.50
CY2022	2020 Q3	3,710	0.00	84.00	106.75	546.50	737.00	22460.50
CY2022	2020 Q4	3,707	0.00	85.00	110.00	577.00	783.00	22377.50
CY2022	2021 Q1	3,818	14.00	87.00	110.00	561.00	766.50	11733.50
CY2023	2021 Q2	3,772	0.00	87.00	111.00	594.00	868.00	44080.50
CY2023	2021 Q3	3,781	0.00	91.00	114.00	625.00	898.00	57268.50
OP-18d: Median Time from ED Arrival to ED Departure for Discharged ED Patients-Transfer Patients. Results are shown at the quarterly level.								
CY2020	2018 Q2	3,190	15.00	113.50	136.00	423.50	530.00	22154.00
CY2020	2018 Q3	3,199	0.00	114.00	134.00	427.00	532.00	11077.00
CY2020	2018 Q4	3,228	4.00	114.00	138.00	432.50	538.00	8745.00
CY2020	2019 Q1	3,265	2.00	118.00	140.00	453.00	565.00	7391.00
CY2021	2019 Q2	3,210	0.00	116.50	137.00	431.75	564.00	15660.00
CY2021	2019 Q3	3,275	0.00	116.00	140.00	442.00	569.50	7092.00

Payment Determination Year	Performance Period Quarter	Number of Hospitals Reporting	Minimum	5th Percentile	10th Percentile	90th Percentile	95th Percentile	Maximum
CY2021	2019 Q4	3,037	0.00	120.50	143.00	438.50	547.00	4274.50
CY2021	2020 Q1	2,282	28.00	113.50	142.00	430.00	555.50	16893.50
CY2022	2020 Q2	2,202	20.00	121.00	145.00	395.00	485.50	44694.00
CY2022	2020 Q3	3,182	1.00	124.50	147.00	466.00	590.00	116808.00
CY2022	2020 Q4	3,203	6.00	132.00	161.00	510.00	648.50	3341.00
CY2022	2021 Q1	3,232	0.00	125.50	150.00	504.00	649.00	8583.00
CY2023	2021 Q2	3,224	0.00	125.00	152.50	496.00	640.00	6932.50
CY2023	2021 Q3	3,159	0.00	127.50	158.00	607.00	788.00	11798.00

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Median
- Measure direction: smaller results are better
- Adjustment applied: None
- Trend category: Stable
- Average annual percentage change (AAPC): 0.6
- AAPC 90% confidence interval: [0.6, 0.6]
- Score (standard deviation) [provider interquartile range]
    - 2016: 142.0 (253.8) [53.0]
    - 2017: 144.0 (261.1) [53.0]
    - 2018: 146.0 (273.1) [53.5]

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	• The developer stated that for clinical measures, the required data elements are routinely generated/collected during provision of care (e.g., blood pressure, lab value, diagnosis, medication order, depression score). Also, the data is abstracted from a record by another individual than the individual who obtained the original information (e.g., chart abstraction for quality measure/registry). • All data elements in the electronic health records are in defined fields from a combination of electronic sources. • Feedback on this measure were provided by nine expert work group members through an online survey. Expert member had backgrounds in healthcare administration, management, and clinical expertise in emergency medicine, pediatric emergency medicine, and clinical pharmacy. • The majority of the respondents agreed or strongly agreed that this measure do not have undue burden on hospital for its data. Respondents also noted that the data elements are currently available in a structured field in the electronic health record. • There are no fees, licensing, or requirement for this measure.
Source and Date of Feasibility Data	CBE Measure Submission, 7/28/2020

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 1

- No (Do Not Support Retaining in Proposed Program) – 7
- Unsure of Retaining in Proposed Program – 0

MAP Health Equity:

- Yes (Support Retaining in Proposed Program) – 13
- No (Do Not Support Retaining in Proposed Program) – 5
- Unsure of Retaining in Proposed Program - 2

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

An advisory group member noted rural hospitals could potentially perform well on this measure and so its removal would take away one of those opportunities for higher performance, but still expressed support for removing the measure.

MAP Health Equity:

Multiple advisory group members provided support for retaining this measure in the program because of the implications of throughput in EDs along with the health equity implications.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Consensus not reached due to lack of quorum.

Workgroup Rationale

The MAP Coordinating Committee will review this measure at the MSR meeting. The workgroup agreed to start with a decision category of conditional support for removal; however, the workgroup did not reach quorum at the meeting or after the meeting via survey. The workgroup noted the measure may not be burdensome, but there may be inaccuracies. The workgroup also suggested stratification for case complexity. The workgroup acknowledged removing the measure may create a gap in the program.

Public Comments

No public comments received.

Public Comments Post-Workgroup Meeting

No public comments received.

02599-C-HOQR Abdomen Computed Tomography (CT) Use of Contrast Material

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	02599-C-HOQR
CMS Program(s) for Which Measure is Being Discussed for Removal	Hospital Outpatient Quality Reporting Program
Measure description	This measure calculates the percentage of abdomen and abdominopelvic computed tomography (CT) studies that are performed without and with contrast, out of all abdomen and abdominopelvic CT studies performed (those without contrast, those with contrast, and those with both) at each facility. The measure is calculated based on a one-year window of Medicare claims. The measure has been publicly reported, annually, by the measure steward, the Centers for Medicare & Medicaid Services (CMS), since 2009, as a component of its Hospital Outpatient Quality Reporting (HOQR) Program.
Numerator	Of cases in the denominator, the numerator contains those abdomen and abdominopelvic CT studies performed without then with contrast (documented using the CT abdomen with and without contrast and CT abdomen/pelvis with and without contrast CPT codes).
Numerator Exclusions	N/A
Denominator	The denominator contains any Medicare beneficiary (not excluded from the initial patient population because of a diagnosis for which the imaging may be appropriate) who underwent an abdomen or abdominopelvic CT study (without contrast, with contrast, or without then with contrast), performed at a hospital outpatient department within a one-year window of claims.
Denominator Exclusions	Indications for measure exclusion include any beneficiaries with the following diagnoses on the imaging claim: adrenal mass; diseases of the urinary system; hematuria; infections of the kidney; jaundice; liver lesions (mass or neoplasm)s; malignant neoplasms of the bladder; malignant neoplasm of the pancreas; non-traumatic aortic disease; pancreatic disorders; or, unspecified disorders of the kidneys and ureters. Documentation of these exclusions must appear on the imaging claim (i.e., on the claim for the CT abdomen without contrast, with contrast, or both without and with contrast).

Field Label	Field Description
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Hospital Outpatient Quality Reporting Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Hospital Compare
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Data Reporting Begin Date	Hospital Outpatient Quality Reporting Program: 2008-01-01; Hospital Compare: 2009-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 6
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement Notes from survey respondents: • Standard of care • May be tapped out • Interested in knowing if submitted for endorsement but failed endorsement and why; or if not submitted for endorsement, why.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed
Consensus-Based Entity Number	9999

Field Label	Field Description
History of CBE Endorsement	2008: Initial endorsement review OP-10 was submitted to the Outpatient Imaging Efficiency Project for review in 2008; it failed to obtain endorsement at that time. Members of the Steering Committee questioned a number of diagnoses included in the measure's initial patient population, including imaging associated with kidney stones and hydronephrosis. Steering Committee members also did not agree a response provided by the measure developer related to review of requests for imaging by a radiologist, as the technical specifications did not account for the workflow associated with the initial order versus imaging performed based on radiologist judgement. A revised Measure Submission Form was submitted to the Project for review during the public comment period, which expanded the type of cases included in the OP-10 initial patient population; Steering Committee members still felt the technical specifications were insufficiently precise. Steering Committee members recommended reducing the number of exclusions from the measure, to streamline its implementation; they also felt that the evidence base supporting a reduction in scans performed both without and with contrast was not sufficiently robust to warrant endorsement. Information on the Outpatient Imaging Efficiency Project's Steering Committee votes for this measure are not available.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	This measure has not been reviewed by MAP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

Measure unit: Percent of patients

Payment Determination Year	Number of Hospitals Reporting	Mean	Standard Deviation	25th Percentile	Median	75th Percentile
CY2019	4,538	8.34	9.17	3.34	6.04	10.11
CY2020	4,532	7.47	8.11	3.13	5.43	9.02
CY2021	4,486	7.01	7.89	2.93	5.21	8.47

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Proportion
- Measure direction: Smaller results are better
- Adjustment applied: None
- Trend category: Improving
- Average annual percentage change (AAPC): -6.6
- AAPC 90% confidence interval: [-6.7, -6.5]
- Score (standard deviation) [provider interquartile range]
    - 2016: 11.0 (31.3) [NA]
    - 2017: 7.8 (26.8) [NA]
    - 2018: 6.9 (25.4) [NA]
- 2018 disparity results
    - Age group
        - 18-64: Higher performance than 65-74
        - 75-84: Similar performance to 65-74
        - 85 and older: Higher performance than 65-74
    - Sex
        - Female: Higher performance than male
    - Race
        - American Indian or Alaska Native: Higher performance than White
        - Asian: Similar performance to White
        - Black or African American: Higher performance than White
    - Income
        - Across income categories, performance was similar to high income
    - Urban-Rural
        - Large fringe metro and medium metro: Similar performance to large central metro
        - Small metro, micropolitan, and non-core: Lower performance than large central metro
    - Census division
        - New England: Higher performance than South Atlantic division
        - East North-Central: Similar performance to South Atlantic division
        - Middle Atlantic, East South-Central, West North-Central, West South-Central, Mountain, and Pacific: Lower performance than South Atlantic division

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	Data elements are coded by someone other than the person obtaining original information (e.g., DRG, ICD-10 codes on claims). All data elements are in defined fields in electronic claims. This measure is claims-based, and uses CMS hospital outpatient claims as its data source. Special attention needs to be taken when counting procedures on the Medicare claims files. The biggest issue is how to deal with modifier codes. Modifiers are two digit indicators (alpha or numeric) that represent a service or procedure that has been altered by some specific circumstance, which typically will impact the payment amount. Procedure modifier code "26" represents the professional component of a procedure and includes the clinician work (i.e., the reading of the image by a physician), associated overhead and professional liability insurance costs. This modifier corresponds to the human involvement in a given service or procedure. The procedure modifier code "TC" represents the technical component of a service or procedure and includes the cost of equipment and supplies to perform that service or procedure. This modifier corresponds to the equipment/facility part of a given service or procedure. In most cases, unmodified codes represent a global procedure which includes both the professional and technical components. There are also other modifier codes. All other modifier codes have been counted as a technical code for our purposes. When calculating the measures, we are only concerned with procedures associated with technical and global modifiers, as these modifiers refer to services provided by the facility. This reduces the possibility of double-counting procedures, since a single procedure may result in both a technical and professional record on the claims files. There were very few instances when this occurred as it related to procedures applicable to the measure. When developing counts of procedures, the objective is to avoid double-counting procedures that may have been billed through multiple revenue centers within a facility. Billing through multiple centers leads to multiple records in the Medicare claims files (i.e., the SAFs). For instance, there may be multiple bills for a single abdomen CT study. On one bill, the charges relate to the application of a radiopharmaceutical, which could have a technical modifier code and come from the pharmacy revenue center. On the other bill, the charges relate to the imaging study and may fall under a technical bill from the imaging center revenue center. In this case, we only count the CT once, since only one CT was performed. However, if we were summing the Medicare paid amounts for this procedure, we would include the Medicare paid amounts from both bills, as they each represent payments for services directly related to the particular CT study.
Source and Date of Feasibility Data	Measure developer, 05/26/2022

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	01367-C-HOQR Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery 12735-C-HOQR Breast Cancer Screening Recall Rates

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 0
- No (Do Not Support Retaining in Proposed Program) – 7
- Unsure of Retaining Proposed Program – 0

MAP Health Equity:

- Yes (Support Retaining in Proposed Program) – 6
- No (Do Not Support Retaining in Proposed Program) – 7
- Unsure of Retaining in Proposed Program - 5

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns.

MAP Health Equity:

An advisory group member noted comparable findings across the demographic categories but noted geographic differences, which may be due to the availability of resources in smaller and rural areas. The member also noted that intersectionality was not accounted for, such as the experience encountered by an older Black male. Additionally, the member stated there are known racial and ethnic differences attributed to pain treatment.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Consensus not reached due to lack of quorum.

Workgroup Rationale

The MAP Coordinating Committee will review this measure at the MSR meeting. The workgroup agreed to start with a decision category of conditional support for retaining with a condition of CBE endorsement; however, the workgroup did not reach quorum at the meeting or after the meeting via survey. The workgroup acknowledged the initial CBE endorsement attempt was in 2008 and there have been changes to the measure since that date. The workgroup noted removing the measure may create a gap in the program.

Public Comments

No public comments received.

Public Comments Post-Workgroup Meeting

No public comments received.

02930-C-HOQR Hospital Visits after Hospital Outpatient Surgery

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	02930-C-HOQR
CMS Program(s) for Which Measure is Being Discussed for Removal	Hospital Outpatient Quality Reporting Program
Measure description	Facility-level, post-surgical risk-standardized hospital visit ratio (RSHVR) of the predicted to expected number of all-cause, unplanned hospital visits within 7 days of a same-day surgery at a hospital outpatient department (HOPD) among Medicare fee-for-service (FFS) patients aged 65 years and older.
Numerator	The outcome is all-cause, unplanned hospital visits, defined as 1) an inpatient admission directly following surgery or 2) an emergency department [ED] visit, observation stay, or unplanned inpatient admission occurring after discharge from the HOPD and within 7 days of the outpatient surgery.
Numerator Exclusions	N/A
Denominator	Eligible same-day surgeries or cystoscopy procedures with intervention performed at HOPDs for Medicare FFS patients aged 65 years and older with the exception of eye surgeries and same day surgeries performed concurrently with high-risk procedures.
Denominator Exclusions	"The measure excludes: - Surgeries for patients without continuous enrollment in Medicare FFS Parts A and B in the 7 days after the surgery. - Surgeries for patients who have an ED visit on the same day but billed on a separate claim, unless the ED visit has a diagnosis indicative of a complication of care; - Surgeries that are billed on the same hospital claim as an ED visit and that occur on the same calendar day, unless the ED visit has a diagnosis indicative of a complication of care - Surgeries that are billed on the same hospital outpatient claim and that occur after the ED visit - Surgeries that are billed on the same outpatient claim as an observation stay"
Denominator Exceptions	N/A

Field Label	Field Description
CMS Program(s) in Which Measure is Used	Hospital Outpatient Quality Reporting Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Hospital Compare
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Data Reporting Begin Date	Hospital Outpatient Quality Reporting Program: 2020-01-01; Hospital Compare: 2020-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 5

Field Label	Field Description
Rationale for Removal Consideration	Rationale for nominations: • Criteria 2. Measure is duplicative of other measures within the same program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 7. Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation Notes from survey respondents: • This highlights our longstanding concern about the use of ratio measures and preference for risk-adjusted rates or year-over year normalized rates, e.g., "As with CMS's standardized ratio measures in the ESRD-related programs, (e.g., the SMR, SHR, SRR, STrR), we strongly recommend that ratio measures be avoided in favor of risk-adjusted rates or year-over-year normalized rates. Based on our experience in reviewing the QIP measures, the standardized ratio measures have relatively wide confidence intervals that can lead to providers being misclassified and their actual performance being misrepresented. The confusion around the ratio measures and misclassification of providers creates an unnecessary burden on both providers and patients who are interested in understanding the actual performance of providers and cannot. We note that for the ESRD QIP, CMS has acknowledged in rulemaking that rate measures are more transparent and easier for patients and caregivers to understand, but continues to use the ratio measures. We also note that a ratio that is then multiplied by a national median is not a true risk-standardized rate." • Since there is a similar measure that is endorsed by NQF, CMS should consider including the endorsed measure in the HOQRP • Interested in knowing if submitted for endorsement but failed endorsement and why; or if not submitted for endorsement, why.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Endorsed
Consensus-Based Entity Number	2687

Field Label	Field Description
History of CBE Endorsement	2015: Initial Endorsement 2020: Endorsement Renewed Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-11; No-0 The Surgery Standing Committee had no concerns with the performance gap and felt that it supported a national performance measure. The Standing Committee further accepted the Scientific Methods Panel acceptance of validity and reliability testing.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	This measure has not been reviewed by MAP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

Measure unit: Risk-standardized rate

Payment Determination Year	Number of Hospitals Reporting	Mean	Standard Deviation	25th Percentile	Median	75th Percentile
CY2020	3,966	1.01	0.15	0.93	0.99	1.08
CY2021	3,890	1.01	0.16	0.93	0.99	1.07
CY2022	3,747	1.01	0.13	0.94	0.99	1.06

Payment Determination Year	Number of Hospitals Reporting	5th Percentile	10th Percentile	90th Percentile	95th Percentile	Maximum
CY2020	3,966	0.78	0.84	1.19	1.27	2.34
CY2021	3,890	0.78	0.84	1.19	1.28	2.34
CY2022	3,747	0.82	0.87	1.16	1.23	2.50

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Predicted/unexpected ratio
- Measure direction: Smaller results are better
- Adjustment applied: The measure is risk adjusted. The measure adjusts for age, RVUs, body system, and 24 categories of comorbidities.
- Trend category: Not available
- Average annual percentage change (AAPC): Not available

- AAPC 90% confidence interval: NA
- Score (standard deviation) [provider interquartile range]
    - 2018: 7.4 (26.1) [4.9]
- 2018 disparity results
    - Age group
        - 75-84: Lower performance than 65-74
        - 85 and older: Lower performance than 65-74
    - Sex
        - Female: Higher performance than male
    - Race/ethnicity
        - American Indian or Alaska Native: Lower performance than White
        - Asian: Similar performance to White
        - Black or African American: Lower performance than White
        - Hispanic or Latino: Lower performance than White
    - Income
        - Low income: Lower performance than high income
        - Middle income: Similar performance to high income
    - Dual-eligibility
        - Dual-eligible: Lower performance than not DE status
    - Urban-Rural
        - All urban-rural areas similar to large central metro
    - Census division
        - All census division areas similar to South Atlantic division

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	The Standing Committee had no concerns regarding feasibility, noting that the measure uses data that is readily available.
Source and Date of Feasibility Data	2021-03-29: Surgery, Spring 2020 Cycle CDP Report

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	02086-C-HOQR Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 1
- No (Do Not Support Retaining in Proposed Program) – 4
- Unsure of Retaining in Proposed Program – 1

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns.

MAP Health Equity:

An advisory group member noted there were differences in performance by age, income, and dual eligibility status, highlighting this measure could be helpful in the examination of health disparities.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Consensus not reached due to lack of quorum.

Workgroup Rationale

The MAP Coordinating Committee will review this measure at the MSR meeting. The workgroup agreed to start with a decision category of conditional support for retaining with a condition of CBE endorsement; however, the workgroup did not reach quorum at the meeting or after the meeting via survey. The workgroup acknowledged having information across settings can be useful for consumers and for quality improvement.

Public Comments

No public comments received.

Public Comments Post-Workgroup Meeting

Blue Cross Blue Shield Association

Do you support retaining this measure in the program? Yes

Important ambulatory surgery measure.

05735-C-PCHQR Proportion of Patients Who Died from Cancer Not Admitted to Hospice

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	05735-C-PCHQR
CMS Program(s) for Which Measure is Being Discussed for Removal	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
Measure description	Proportion of patients who died from cancer not admitted to hospice
Numerator	Proportion of patients not enrolled in hospice
Numerator Exclusions	N/A
Denominator	Patients who died from cancer
Denominator Exclusions	N/A
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	N/A
Measure Steward	American Society of Clinical Oncology
Data Reporting Begin Date	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program: 2020-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 5

Field Label	Field Description
Rationale for Removal Consideration	Rationale for nominations: • Criteria 2. Measure is duplicative of other measures within the same program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities Notes from survey respondents: • Need more information about this measure, this could be measuring a lack of access to hospice. • Note that the MSR Measure Spreadsheet lists this measure's endorsement status as "Endorsement Removed", but the CMS Measure Inventory says this measure is endorsed. • Does not take into account the availability of hospice services (e.g., for rural patients) and does not take into account those offered hospice but decline. • Many cancer patients benefit from palliative care and do not need to be enrolled in hospice if followed by high quality palliative care programs

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Endorsement Removed
Consensus-Based Entity Number	0215
History of CBE Endorsement	2009: Initial Endorsement 2022: Measure developer made the decision to not maintain endorsement; therefore, NQF removed endorsement.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2016-2017 Recommendation: Support for Rulemaking

Field Label	Field Description
Rationale for MAP Recommendation	MAP 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. MAP suggested that MUC16-274 [Proportion of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days] and MUC16-275 [this measure] be paired to encourage appropriate referral practices.

Section 4: Performance and Reporting Data

There is no publicly available data for this measure.

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	CBE Measure Submission, 2016: Seven published randomized trials demonstrate the feasibility of providing various components of palliative care (PC) alongside usual oncology care. There is, however, a dearth of data evaluating the integration of modern PC practices into standard oncology care, especially in concert with ongoing antitumor therapy. Overall, the addition of PC interventions to standard oncology care delivered via different models to patients with cancer provided evidence of benefit. CBE Measure Submission, 2021: Data used in the measure are coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims) and abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry). All data elements are in defined fields in electronic clinical data (e.g., clinical registry, nursing home MDS, home health OASIS). The measure and its specifications have been in place for several years and the measure developer continues to monitor and ensure that the measure and its specifications are up-to-date for widespread use.
Source and Date of Feasibility Data	CBE Measure Submission, 2/29/2016 CBE Measure Submission, 1/7/2021

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	05736-C-PCHQR Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than Three Days 05734-C-PCHQR Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

Section 7: Negative Unintended Consequences

The measure developer's CBE submission noted there have been no reports of unintended consequences with this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 0
- No (Do Not Support Retaining in Proposed Program) – 7
- Unsure of Retaining in Proposed Program - 0

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

An advisory group member commented the metric does not allow for discernment of the reason a patient may not have accessed hospice care, and if the measure cannot discern this information, it becomes difficult to understand the impacts or any negative unintended consequences to rural populations. Another advisory group member noted it is not possible to discern through the measure if patients are not being offered any services, or if the services they are offered do not qualify as hospice, which may be more of a concern in rural areas with fewer providers.

MAP Health Equity:

An advisory group member noted it is important to track differential access in regard to health equity, so it would be premature to recommend this measure for removal from the program. The MAP member noted it is okay if patients do not want hospice because hospice care in this country does not meet the needs of everyone and, in particular, does not meet the structural issues people of color face. The MAP member stated, in terms of an equity lens, this measure does have implications. The MAP member was in support of removal of this measure. Another advisory group member commented that this measures

only applies to cancer-exempt institutions and works under the assumption hospice care is the right outcome. Another advisory group member agreed with this comment because this care is important as an end-of-life resource and overall patient and family experience. The member also highlighted challenges experienced by patients whose first language is not English. The member stated this care option is not explained in a way in which it is understood by all. The member also noted cultural and ethical components need to be considered during this type of care. The member stated needs are not addressed or often ignored. Regarding an equity perspective, the MAP member stated this measure is needed in regard to race/ethnicity and language.

An advisory group member asked for clarification on previous comments about the potential for the measure to promote care that may not be aligned with patients' values. Another advisory group member responded, noting if hospice is not designed for and responsive to the needs of the whole population and it falls short of important cultural components, then it should not be the desired goal to have the highest proportion of patients who died from cancer to be admitted to hospice. A different advisory group member noted the distinction of a patient not having the choice of care in the first place because there was no hospice available is a different question with equity implications. The member recommended that CMS think in the future about a better equity lens for palliative care. An advisory group co-chair responded with the idea of considering equity with a lens of systems and structures as opposed to personal choice. The co-chair noted that choice becomes relative depending on where a patient lives and insurance status. The co-chair also highlighted the nuance of the discussion so far between evaluating the current limitations of the measure versus the importance of the measure in regard to health equity if certain changes were made.

A MAP member commented in the chat hospice is associated with improved QOL among minority communities enrolled, as well as bereaved caregivers.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program with the following conditions: (1) CBE endorsement, (2) encourage the measure to be paired or harmonized with other measures in the program related to hospice and intensive care units, and (3) consider the health equity and rural health implications. The workgroup recognized this is a new claims-based version of the measure and it may be premature to remove it. The workgroup also noted removing the measure may create a gap in the program. The workgroup acknowledged concerns from the Rural Health Advisory Group that hospice services may not always be available in rural settings. The workgroup also acknowledged concerns from the Health Equity Advisory Group that hospice, in its current form, may not be appropriate for all populations and there may be equity issues related to hospice care.

Public Comments

Alliance of Dedicated Cancer Centers

Do you support retaining this measure in the program? Yes

The Alliance of Dedicated Cancer Centers (ADCC) strongly supports the retention of this measure in the PCHQR Program. We agreed with the commentary in the FY 2018 IPPS/LTCH Rule, which resulted in the addition of this measure to the PCHQR Program. CMS cited many strong reasons to support this measure's inclusion in the PCHQR program which are still true today. Utilization of hospice near the end of life improves both the patient/family and caregiver experience. Encouraging the use of hospice near the end of life can potentially avoid procedures, reduce admissions, decrease costs, and ultimately result in improved quality of life.

One of the key reasons for including a measure in a CMS quality reporting program is that it provides data to the hospitals and providers to act upon. Unfortunately, this data has not yet been made available to the PCHs. It is our understanding that the first confidential national data reports for this measure will soon be available to the PCHs.

A few other factors lead to our request to retain this measure in the PCHQR program. Our understanding is that this measure is seen as important by many payors - for the reasons outlined above. This measure is also a measure in the Improving Goal Concordant Care initiative - a 3 year initiative that our hospitals are engaging in to support the vision that all patients with cancer and their families should receive care that aligns with their values and unique priorities. Lastly, while not official deemed a "paired measure", the numerator of this measure - NQF 0215 is required to measure NQF 0216, "Proportion of Patients Who Died From Cancer Admitted to Hospice for Less Than 3 Days" and this measure is still in the PCHQR program.

Thank you for this opportunity to comment.

Public Comments Post-Workgroup Meeting

Alliance of Dedicated Cancer Centers

Do you support retaining this measure in the program? Yes

The Alliance of Dedicated Cancer Centers (ADCC) concurs with the MAP recommendation to retain the measure in the PCHQR program. The measure contributes to the overall goals and objectives of the program, specifically in equipping consumers with quality-of-care information and encouraging hospitals and clinicians to improve the quality of care provided using with actionable data this measure provides. As pertains to the measure's impact on improving patient outcomes, the ADCC concurs with the commentary of the FY 2018 IPPS/LTCH Rule, which resulted in the addition of this measure to the PCHQR Program. CMS cited several reasons to support this measure's inclusion in the PCHQR program which remain true today. While individual care choices should be informed by a patient's values and preferences, population-level evidence shows that utilization of hospice near the end of life improves both the patient/family and caregiver experience. Hospice care near the end of life can potentially avoid unnecessary procedures, reduce admissions, decrease costs, and ultimately result in improved quality of life. This measure reflects the current evidence that hospice care improves the end-of-life experience for patients and their loved ones. In addition, the MAP Recommendation notes that within the PCHQR Program, this measure is claims-based and therefore incurs no data collection burden for the PPS-Exempt Hospitals (PCHs).

Our understanding is that payors consider this an important and valuable measure for the reasons outlined above. This measure is also included in the Improving Goal Concordant Care initiative, a three-year initiative our hospitals launched to support the vision that all patients with cancer and their families receive care that aligns with their values and unique priorities. Lastly, while not official deemed a "paired measure", the numerator of NQF #0215 is required to measure NQF #0216, "Proportion of Patients Who Died From Cancer Admitted to Hospice for Less Than 3 Days", which is still in the PCHQR program.

As pertains to other comments in the MAP recommendation:
1. This measure is one of a set of four end-of-life (EOL) measures in the PCHQR program. The others are NQF #0210 (chemo in last 14 days of life), #0213 (ICU in last 30 days of life), and as previously noted, NQF #0216 (hospice in last 3 days of life). The MAP recommends that these measures be evaluated pairing or harmonization with other program measures. Of note, the denominators for the claims-based measures NQF #0210, NQF #0213, and NQF #0215 are identical, and the denominator for NQF #0216 is the numerator for NQF #0215.
2. We concur with the concerns of the Rural Health Advisory Group that hospice services may not always be available in rural settings. We agree that if this measure is considered for use in other CMS quality programs with larger numbers of hospitals in more diverse settings, this issue should be explored further.

Thank you for the opportunity to comment. We hope these comments are helpful as you reach your final decision on retaining this important measure in the PCHQR program.