MEASURE APPLICATIONS PARTNERSHIP

MAP 2014 Recommendations on Measures for More Than 20 Federal Programs

FINAL REPORT

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NATIONAL QUALITY FORUM

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CONTENTS

EXECUTIVE SUMMARY

This report contains the third cycle of the Measure Applications Partnership's (MAP) pre-rulemaking recommendations to the Department of Health and Human Services (HHS). Over the course of its work, MAP has made substantial progress in identifying "measures that matter" to those who are affected by the more than 20 federal programs that use performance measures. In addition, MAP has furthered alignment or use of the same measures across federal programs and between public- and private-sector programs. Finally, this report lays out steps MAP has taken and plans on taking to address ongoing challenges to implementing high value measures that drive rapid quality improvement in our nation's health and healthcare.

MAP's work is guided by the three-part aim of the National Quality Strategy (NQS): better care and better health at lower cost. This report on MAP's recommendations—for the more than 230 measures that were under consideration during this pre-rulemaking cycle—contains many illustrations of progress on the NQS aims. For example:

- For hospital programs, MAP recommend measures of hospital-acquired conditions (HACs) to fill critical safety measure gaps in the Inpatient Quality Reporting, Value-Based Purchasing, and HAC Reduction programs.
- For clinician programs, MAP recommended adding specific outcome measures for the Value-Based Payment Modifier and Physician Compare, while recommending removal of certain process measures from the Physician Quality Reporting System that MAP found less meaningful. MAP also recommended measures addressing patient experience of care, care coordination, prevention, and cost across programs.

In addition to recommending selection of more meaningful measures, MAP promotes alignment, or use of the same or related measures, as a critical strategy for accelerating improvement in priority areas, reducing duplicative data collection, and enhancing comparability and transparency of healthcare information. MAP strives for its recommendations to be coordinated across settings of care; federal, state, and private sector programs; levels of measurement analysis; and points in time. MAP relied on its families of related measures and information about current measure use in various public- and private-sector programs to inform selection of measures that promote alignment. MAP also began work to identify a core set of measures for individual clinician reporting that would be applicable across clinician programs.

MAP is continuously working to improve its recommendations by overcoming the challenges it has faced over the past three years. Each year, MAP has provided more detailed rationale and context for its recommendations. This year, MAP replaced the "Support Direction" recommendation

category with "Conditional Support." The purpose of the new recommendation category is to define explicit conditions that must be resolved before a measure receives MAP's full support for implementation, providing a pathway for getting the measure into use. For example, MAP conditionally supported the Hospital-Wide All-Cause Unplanned Readmission Measure for the Hospital Readmissions Reduction Program, specifying that HHS should address two conditions prior to implementing the measure for that program: ensure that readmissions are not being double counted by both all-cause and condition-specific measures, and use peer group comparisons to avoid penalizing hospitals that disproportionately serve economically disadvantaged populations.

MAP and NQF will be undertaking additional activities during 2014 that will build on its first three years of work and enhance its recommendations for future pre-rulemaking cycles. These include:

- Building on the families of measures concept to identify the best available measures and measure gaps for the topics of person- and family-centered care, population health, and affordability;
- Holding a lean (kaizen) event aimed at improving MAP's processes and better integrating the measure endorsement and selection functions;
- Exploring methodologies for appropriately adjusting measures for socioeconomic status to ensure fair comparisons; and
- Holding a design meeting to further conceptualize a "measure incubator" to support measure development through technical support and matchmaking with funders, test beds, and end-users.

Taken together, these activities will accelerate filling the current gaps in performance measurement programs with the measures we need to improve the value of healthcare for patients and our nation as a whole.

MAP is convened by NQF pursuant to statutory requirement. MAP's purpose is to recommend performance measures for federal payment and public reporting programs to enhance healthcare value, and MAP's recommendations also provide measure selection guidance for private sector programs. MAP is now successfully integrated into the federal rulemaking cycle, as an upstream input into rulemaking from a public-private partnership. MAP is comprised of more than 100 members, representing major stakeholder groups, including consumers, purchasers, health plans, clinicians and providers, suppliers, accreditation and certification entities, communities and states, and the federal government. In addition, MAP membership includes more than 25 individual subject matter experts who represent important topics such as health IT, population health, care coordination, palliative care, and disparities.

INTRODUCTION

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for the purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for use in federal public reporting, performance-based payment programs, and other purposes (see Appendices A and B). MAP's careful balance of interests is designed to provide HHS and the field with thoughtful and varied input from stakeholders who are invested in the use of measures. MAP also assesses and promotes alignment of measurement across federal programs and between public- and private-sector initiatives to streamline the costs of measurement and focus improvement efforts.

MAP's recommendations seek to further the three-part aim of the National Strategy for Quality Improvement in Health Care, or National Quality Strategy (NQS): better care, more affordable care, and healthier people living in healthy communities. MAP informs the selection of performance measures to achieve its stated goals of improvement, transparency, and value for all. MAP's objectives are to:

- Improve health outcomes in high-leverage areas for healthcare consumers and their families;
- Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value; and
- Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden.

Under statute, HHS is required to publish annually a list of measures under consideration for future federal rulemaking and to consider MAP's recommendations about the measures during the rulemaking process. Now in its third year, this annual pre-rulemaking process affords MAP the opportunity to review the measures under consideration for federal rulemaking and provide upstream input to HHS in a global and strategic manner.

During its review of the measures under consideration, MAP built on its previous pre-rulemaking decisions and looked to the **coordination strategies and families of measures** that it has created to prioritize the most significant measures and prominent gaps (see **Appendix C**). In addition, the MAP Measure Selection Criteria (see **Appendix D**) enabled MAP to offer specific and actionable pre-rulemaking input that continues to emphasize alignment across programs and the need to fill high-priority gaps in measurement. This 2014 MAP Pre-Rulemaking Report provides recommendations on 234 unique measures under consideration by HHS for 20 clinician, hospital, post-acute care, and long-term care performance measurement programs.

PROGRESS ON THE MAP STRATEGIC PLAN

In recognition of the complexity and importance of MAP's role, MAP completed a strategic planning process in 2012 and produced the MAP Strategic Plan: 2012-2015. The plan offers objectives and actionable steps to make MAP's work more useful to a variety of public- and private-sector stakeholders, representative of a true partnership in pursuit of national improvement priorities.

To meet its stated objectives, MAP identified strategies and tactics designed to ensure that the goals are addressed with increasing sophistication as MAP evolves. The table below lists MAP's tactics to achieve its goals and objectives, accomplishments in 2013, and the contribution of these efforts to enhancing the current pre-rulemaking cycle.

TABLE 1. MAP STRATEGIC PLAN TACTICS, ACCOMPLISHMENTS, AND CONTRIBUTION TO PRE-RULEMAKING

MAP Strategic Plan Tactic	Accomplishments in 2013	Contribution to 2014 Pre-Rulemaking Activities
Approach to Stakeholder Engagement	Increase in nominations submitted for MAP membership (106 in 2013 versus 55 in 2012), leading to a broader spectrum of expert participants and increased consumer and purchaser representation on MAP. Increase in the number of organizations providing public comments on the MAP Pre-Rulemaking Report (93 in 2013 versus 48 in 2012).	NQF began offering an early public comment period on HHS' list of measures under consideration for 2014 rulemaking. MAP received 145 comments from 43 organizations. The early public comments were used to inform MAP's review of the measures under consideration.
Identifying Families of Measures and Core Measure Sets	To date, MAP has developed seven sets of measures that function as families of measures. They cover the topics of cancer care, cardiovascular disease, care coordination, diabetes, dual eligible beneficiaries, hospice care, and patient safety. Consistent adoption of measures from the families of measures for public- and private-sector programs will increase alignment across measurement initiatives.	Families of measures served as an initial starting place for MAP's evaluation of program measure sets, identifying the best available measures that should be added to a program measure set or measures that should replace previously finalized measures in a program measure set.
Addressing Measure Gaps	MAP generated a comprehensive list of previously identified measure gaps to help focus pre-rulemaking discussions. When constructing each family of measures, MAP identified measure gaps for the high-leverage improvement opportunities that lack adequate performance measures.	When reviewing program measure sets, MAP re-evaluated the previously identified gaps, noting where gaps persist and giving a sense of priorities. MAP identified numerous measures to fill gaps during the current pre-rulemaking cycle, and made recommendations to HHS regarding selection of those measures.

MAP Strategic Plan Tactic	Accomplishments in 2013	Contribution to 2014 Pre-Rulemaking Activities
Defining Measure Implementation Phasing Strategies	For MAP's 2013 Pre-Rulemaking Report, MAP provided one or more rationale(s) for each decision, indicating implementation-phasing recommendations when appropriate.	For the 2014 pre-rulemaking deliberations, MAP developed more granular rationale for each decision, designed to make MAP's recommendations more actionable by HHS as the agency implements changes to program measure sets over time.
Analytic Support for MAP Decisionmaking	NQF established an interdisciplinary team of staff to lead the data management and analytic needs of MAP in support of informed decisionmaking. NQF tracks internal and external opportunities for collecting, analyzing, and summarizing measurement information relevant to MAP decisionmaking.	MAP provided additional information—such as measure performance results, testing data, unintended consequences, impact, and implementation experience—when accessible to support MAP's pre-rulemaking review of measures.
Refining the MAP Measure Selection Criteria (MSC)	MAP made careful enhancements to the MSC, including integrating the guiding principles developed by the Clinician and Hospital Workgroups.	MAP used the MSC to support decisionmaking about individual measures under consideration, what they would add to program measure sets, and their potential impact.
Evaluating MAP's Processes and Impact	NQF staff monitor uptake of MAP's recommendations by HHS as proposed and final rules are issued. MAP continues to observe a high level of concordance between MAP recommendations and measures finalized in federal rules.	NQF continued to establish formal and informal feedback loops to support informed MAP decisionmaking. For example, offering a new, structured way for stakeholders to share information on measure use and implementation experience through a feedback form on NQF's online Quality Positioning System (QPS).

PROGRESS TOWARD ALIGNED MEASUREMENT AND FILLING MEASURE GAPS

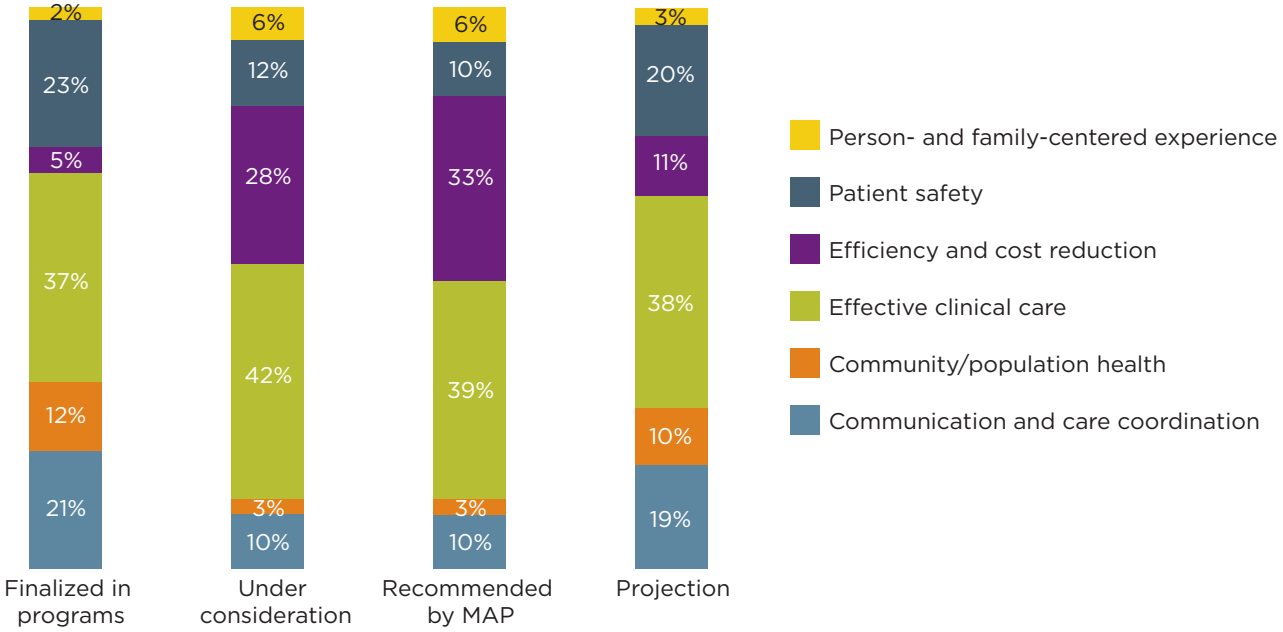
The quest to define and quantify healthcare quality has resulted in the widespread use of performance measures. Alignment of measures across performance measurement programs has usually been secondary to implementing good measures to address measurement gaps, which has resulted in lack of comparability among performance improvement efforts and significant data collection burden. Program implementers, including federal agencies, have been increasing their attention to alignment of measures across programs, and while progress has been made, MAP recommends continuation of these efforts and extension to state and private-sector programs. However, MAP members also noted the ongoing need for flexibility in measure use. For example, local program implementers need to customize performance measures at times to meet specific local objectives, and experimentation is important to promote innovation in measurement and ultimately filling measure gaps.

MAP has continuously focused on promoting aligned measure use and filling critical measure gaps in performance measurement programs. MAP highlighted these objectives in the **MAP Strategic Plan**, and emphasized them in the MAP Measure Selection Criteria (see **Appendix D**). Aligned performance measurement provides clearer direction and stronger incentives to achieve shared goals, while also reducing data collection burden. Measure gap-filling helps address the performance gaps that represent the highest-leverage opportunities for improvement. With each pre-rulemaking cycle, MAP examines progress on alignment and gap-filling, and assesses how best to achieve these objectives.

As one important aspect of alignment, MAP has determined that measures should align with the aims and priorities of the NQS. As seen in Figure 1 below, measures finalized in various federal programs address the NQS priority areas to a greater (e.g., effective clinical care) or lesser (e.g., person- and family-centered experience) extent. Not all individual measures contribute equally, as some priorities may be adequately addressed by fewer measures, and some measures impact multiple priorities. However, the proportion of measures that focus on each priority area provides an indication of whether that area is receiving sufficient attention.

The bar in Figure 1 identified as "Finalized in Programs" represents the current state. Figure 1 also shows the proportion of measures under consideration that are focused on each priority area, and the distribution of measures recommended (supported or conditionally supported) by MAP. Further, the chart displays a projection of how the relative number of measures for each priority area would change from the current state if all of these MAP recommendations were adopted by HHS. This assessment provides a sense of how the future distribution of measures for the different priority areas can be influenced by the current state, the types of measures MAP is asked to consider, and MAP's recommendations regarding those measures.

FIGURE 1. NQS PRIORITY AREA FOCUS OF MEASURES IN HHS PROGRAMS



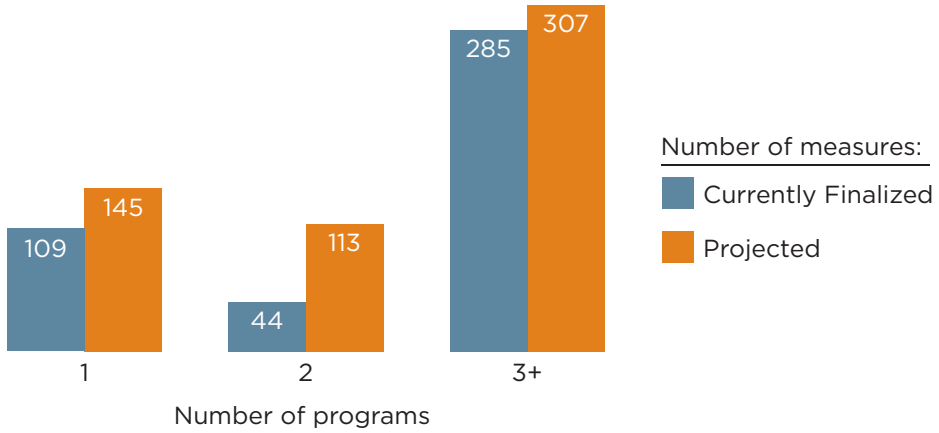
Note: percentages may not sum to 100 because of rounding.

Calling out the priority areas with a smaller proportion of measures in use may provide insight on progress toward aligning to the NQS, as well as highlight persistent gap areas. Figure 1 reveals that a significant proportion of measures under consideration map to the Efficiency and Cost Reduction area, corresponding to the NQS priority of making care more affordable. MAP supported most of these measures. A relatively small number of measures under consideration addressed person- and family-centered experience and community/population health, essential priorities that are underrepresented in terms of quantity of current measures. Several public commenters agreed that more measures are needed in these areas. In contrast, the greatest proportion of measures addresses the priority area of effective clinical care. However, a public commenter noted that even in this category there may be a need for different types of measures, such as those that focus more on outcomes rather than processes.

Another way to assess alignment is to determine whether measures addressing high-priority topics are applicable to and implemented in multiple HHS programs. Given the need for measures to be "fit for purpose" for different programs, not all measures are suitable to apply widely. For example, some measures needed for the Hospice Quality Reporting program are specific for the population affected. Nevertheless, demonstrating that increasing numbers of measures are being appropriately applied in more than one HHS program can signal stronger alignment.

As shown in Figure 2, a majority of measures are being used in more than one HHS program that MAP reviews. Projections show how the number of measures used in multiple programs would be affected if the measures that MAP supported or conditionally supported ultimately become finalized. MAP members voiced interest in tracking this distribution over time. However, several public commenters also recommended focusing on a broader interpretation of alignment through use of different measures for similar topics that still promote alignment around overarching goals. This view is consistent with how MAP has approached the development of families of measures, as discussed further below.

FIGURE 2. MEASURE USE IN MULTIPLE HHS PROGRAMS



A related aspect of alignment is the degree to which the same measures are used across a variety of public- and private-sector initiatives. Alignment across sectors has been challenging, as a **study** of state and regional measure sets completed for the **Buying Value** initiative in 2013 demonstrated. Although the study found a preference for standardized measures among state agencies and regional initiatives, it also found very little alignment among the measures: 1) 80 percent of the measures were not used in more than 1 of the 48 measure sets analyzed; 2) approximately 25 percent of the shared measures were modified in some way; 3) states/regions frequently used non-standardized, "homegrown" measures, which made up 39 percent of the 509 distinct measures in the 48 measure sets. In response to these findings, Buying Value has launched an effort to increase alignment by: 1) providing technical assistance to states and regions that emphasize the importance of comparability among measure sets; 2) developing a consensus strategy to improve alignment while respecting the different needs of all parties and supporting measure innovation; and 3) broadly disseminating the consensus strategy. Buying Value will be coordinating this work with MAP staff, and NQF is providing program and administrative support for the effort.

Similar to alignment, MAP has observed mixed results in filling measure gaps. MAP recommended implementation of a variety of measures last year that addressed critical gap areas. For example, MAP supported the CAHPS In-Center Hemodialysis Survey measure (NQF #0258) for the ESRD Quality Incentive Program and the Medicare Spending Per Beneficiary measure (not endorsed) for the Hospital Inpatient Quality Reporting (IQR) and Value-Based Purchasing (VBP) programs. HHS now plans to implement these measures that address gaps in measuring healthcare consumers' experience of care and affordability, respectively. But many gaps remain (see **Appendix E** for a synthesis of the gaps that MAP has previously identified). Public commenters identified gaps in adequate measures for various topics, including pediatric and maternity care, palliative care, functional limitations, complex conditions, malnutrition, medical subspecialty areas, and "systemness." MAP members noted that they would like to see a more systematic assessment of ongoing progress towards gap-filling going forward.

In the current round of pre-rulemaking, several MAP members and public commenters indicated that progress on filling high-priority measure gaps was moving too slowly. Some MAP members were also concerned that MAP's recently revised

Measure Selection Criteria may place too much emphasis on selection of NQF-endorsed measures, when non-endorsed measures might be available and adequate to fill gaps. However, other MAP members and several public commenters expressed strong reservations about MAP reviewing and recommending use of non-endorsed measures, as non-endorsed measures may not have been subjected to a thorough, transparent, multi-stakeholder evaluation. NQF is working with measure developers and other stakeholder to more rapidly expand the pipeline of new measures that may ultimately become endorsed. Such efforts include more frequent measure submission and endorsement review opportunities, consideration of new approaches to endorsement dependent on application, and exploring the development of a measure "incubator."

In the meantime, the drive to expeditiously fill measure gaps played a role in MAP's decision to support some measures that are currently not NQF-endorsed. For example, MAP supported: 1) a non-endorsed measure for the Inpatient Psychiatric Facility Quality Reporting program measuring how often facilities routinely assess patient experience of care; 2) a non-endorsed measure for Ventilator-Associated Events in Long-Term Care Hospital (LTCH) Quality Reporting, noting that it helps address an NQS priority not adequately covered in the set; and 3) several non-endorsed measures for the Physician Quality Reporting System (PQRS) related to mental/behavioral health, a topic that MAP previously noted as a gap area.

MAP continues to take strides toward promoting alignment and gap-filling through development of **Families of Measures** related to the NQS priority areas. Measure families identify the best available measures that should be applied across settings, levels of analysis, and populations. MAP also notes critical measure gap areas during creation of measure families. New families of measures for person- and family-centered care, population health, and affordability are slated for development in 2014. If maintained and applied broadly, measure families can help achieve increased alignment and keep attention focused on high-priority measure gaps. Public commenters expressed strong support for the use and continued development of MAP measure families.

MAP PRE-RULEMAKING RECOMMENDATIONS

MAP Pre-Rulemaking Approach

MAP enhanced its 2013-2014 pre-rulemaking process by utilizing the following step-wise approach (see Appendix C):

1. Build on MAP's Prior Recommendations

MAP deliberations during this pre-rulemaking cycle were informed by MAP's prior strategic input and pre-rulemaking decisions to date, including:

- Coordination Strategies elucidated opportunities for public and private stakeholders to accelerate improvement and alignment of measurement initiatives. The recommendations in the MAP performance measurement coordination strategies served as setting-specific background for MAP pre-rulemaking.
- 2012 and 2013 Pre-Rulemaking Reports provided program-specific input that included MAP's recommendations about measures previously finalized for federal performance measurement programs and measures on HHS' list of measures under consideration.
- Families of Measures served as an initial starting place for evaluation of program measure sets, assisting with identification of measures that should be added to program measure sets or measures that should replace previously finalized measures in program measure sets.
- **Measure Gaps** were identified across all MAP reports and recent MAP activities (see Appendix C). When reviewing program measure sets, MAP re-evaluated the previously identified gaps, noting where gaps persist. Identification of priority measure gaps is part of the discussion of each program.

2. Evaluate Currently Finalized Program Measure Sets Using MAP Measure Selection Criteria

MAP used its Measure Selection Criteria to evaluate each finalized program measure set (see Appendix D). During the past two years of providing pre-rulemaking input, HHS has asked MAP to review a large number of measures under consideration, under challenging time constraints, for various performance measurement programs. During this pre-rulemaking cycle, MAP began reviewing currently finalized measure sets before receiving the new measures under consideration to make the winter pre-rulemaking meetings more efficient. Information relevant to assessing the adequacy of the finalized program measure sets was provided to MAP members. This assessment led to the identification of measure gaps, measures for potential inclusion, measures for potential removal, and other issues regarding program structure.

In reviewing currently finalized program measure sets, MAP provided rationales for one of the following recommendations for each finalized measure:

- **Retain** indicates measures that should remain in the program measure set.
- **Remove** indicates measures that should be removed from a program measure set, according to a justifiable timeline.

3. Evaluate Measures Under Consideration

Building upon its program measure set evaluations, MAP determined whether the measures on HHS' list of measures under consideration would enhance the program measure sets. For each measure under consideration, MAP provided rationales for one of the following recommendations:

- **Support** indicates measures under consideration that should be added to program measure sets during the current rulemaking cycle.
- **Do Not Support** indicates measures or measure concepts that are not recommended for inclusion in program measure sets.
- **Conditionally Support** indicates measures or measure concepts that should be phased into program measure sets over time, after specific conditions are met.

4. Identify High-Priority Measure Gaps

After reviewing the measures under consideration, MAP reassessed the program measure sets for remaining high-priority gaps.

System Performance Measurement Programs

During its pre-rulemaking process, MAP reviews one program that assesses care at the system level, the Medicare Shared Savings Program (MSSP). This section covers the key issues raised during the pre-rulemaking process for MSSP, and reviews MAP's recommendations for the program.

Key Issues

In addition to reviewing MSSP as part of its pre-rulemaking process, MAP provides input to HHS on other system-level programs outside of the pre-rulemaking cycle, including the **Medicaid Adult Core Measure Set** and the **Quality Rating System for Qualified Health Plans in federal Health Insurance Marketplaces**. One of MAP's goals is to promote alignment across all programs and levels of analysis. MAP generally supports measures for MSSP that are used in other system-level programs (e.g., Medicare Advantage 5-Star Quality Rating System) and measures of population health. Ideally, the same measure could be used across all system-level programs. Additionally, MAP recommends that system-level program measure sets align with measures used for setting-specific performance measurement programs, as harmonized measures can enhance focus on care delivery goals and reduce data collection burden. Public commenters supported MAP's recommendations that system-level program measure sets should align with measures used for setting-specific performance measurement programs and urged MAP to consider innovations in measurement that do not add data collection burden to front line providers.

Medicare Shared Savings Program Measure Set

MAP's previous assessment of the MSSP measure set found it to be comprehensive, addressing cross-cutting measurement priorities such as patient experience as well as high-impact conditions and key quality outcomes. Additionally, observing that the measure set places heavy emphasis on ambulatory care, MAP recommended that it could be enhanced with the addition of acute and post-acute care measures, and measures relevant to individuals with multiple chronic conditions. Public commenters supported enhancing the measure set by adding acute and post-acute care measures. Although the set has many positive attributes, MAP advises movement towards more outcome measures, or composites of related process measures, in the near future. Public commenters emphasized that systems should be held accountable for establishing organized systems of care.

MAP reviewed 15 measures under consideration and supported the inclusion of 5 measures (see **Appendix A, Table A1**). MAP supported NQF #0576 Follow-up after Hospitalization for Mental Illness, as MAP had previously recommended including this measure to align with the Medicare Advantage 5-Star Quality Rating System. MAP reviewed and supported five measures that are collected through the Clinician-Group CAHPS (CG-CAHPS) survey—Courteous & Helpful Office Staff, Supplemental Item Care Coordination, Between Visit Communication, Educating Patient

about Medication Adherence, and Supplemental Item Stewardship of Patient Resources. Medicare ACOs are already required to administer the CG-CAHPS survey, and MAP supports including the individual performance of measures derived from CG-CAHPS in the ACO quality score linked to payment, provided that the individual performance measure is valid and reliable. MAP supported another CAHPS survey, Patient Experience with Surgical Care Based on the Surgical Care Survey CAHPS (S-CAHPS), as its elements are NQF-endorsed, patient-reported outcome measures that addresses the gap in acute care measures in the program set. MAP discussed the potential survey burden imposed on patients, as multiple Medicare programs require CAHPS surveys. MAP recommends that HHS review the sampling methodology for all CAHPS surveys to ensure that individuals are not receiving multiple requests to complete similar surveys.

Additionally, MAP conditionally supported three measures. MAP noted that the full composite Optimal Asthma Care–Control Component should be used in the program once it receives NQF endorsement. This outcome measure supports coordination of care for a prevalent, high-burden, and costly chronic condition, as well as alignment because MAP conditionally supported this measure for use in other clinician programs. The two other measures—SF-36 and Patient Activation Measure—are patient-reported outcome measures (PROMs) or tools to collect information directly from patients addressing an important gap area identified by MAP. However, data generated from these PROMs would need to be aggregated and tested as PRO-based performance measures and then submitted for NQF endorsement. This would include usability and feasibility testing taking into consideration implementation issues, including burden to both the provider and consumer. Additionally, the group encouraged consideration of other nonproprietary tools, such as the VR-12 and PROMIS. Public commenters supported the use of nonproprietary tools, stating that federal policy should not mandate the use of a closed system when nonproprietary, free options are available. Public commenters also noted that the PROMIS system is still under development, and has not been validated across the variety of clinical systems.

MAP did not support the remaining measures under consideration as they address specific conditions, recommending instead that ACOs continue to gain experience with the finalized measure set before expanding to additional condition-specific measures. Accordingly, MAP did not support two osteoporosis measures that MAP had previously recommended for inclusion to promote alignment with the Medicare Advantage 5-Star program. MAP supports future inclusion of these measures in MSSP once ACOs are able to overcome implementation issues with the currently finalized measure set.

MAP notes that the MSSP measure set could be enhanced with other PROMs in the areas of depression remission, functional status, smoking, and medically complex patients (e.g., chronically ill or those with multiple chronic conditions), as well as a measure of health risks with follow-up interventions. Public commenters support system-level measures including patient-reported outcomes measures (PROM). MAP previously discussed cost as a measure gap and the value of including additional cost measures as MSSP is designed to generate cost savings. Ultimately, MAP was split on the inclusion of additional cost measures. Members in support of additional cost measures noted that consumers need cost information to supplement quality data for this program; however, the current MSSP cost calculation only includes Medicare services, thus a complete picture of total Medicare and private payer costs is not possible at this time. MAP members who did not support additional cost measures did not want to increase the reporting burden for ACOs and suggested that the existing ACO cost calculations be made publicly available for consumers. MAP encourages additional work to determine the best methods for increasing

transparency of ACO costs across public and private payers.

Clinician Performance Measurement Programs

MAP reviewed measures in finalized program measure sets and measures under consideration for four clinician programs. The Physician Quality Reporting System (PQRS) and the Medicare and Medicaid EHR Incentive Program for Eligible Professionals (Meaningful Use) are reporting programs that provide performance information for Physician Compare and the Value-Based Payment Modifier (VBPM). Accordingly, all finalized measures and measures under consideration for PQRS and Meaningful Use are also under consideration for Physician Compare and VBPM. As these programs are inextricably linked, MAP integrates its review of all four programs, considering the following:

- If measures should be used for clinician reporting (i.e., should be included in PQRS);
- If measures are e-specified or leverage HIT capabilities (i.e., should be included in Meaningful Use);
- If measures should be publicly reported (i.e., should be included in Physician Compare); and
- If measures should be used for payment incentives and penalties (i.e., should be included in VBPM).

This section covers the key issues and reviews MAP's recommendations for clinician performance measurement programs.

Key Issues

In reviewing the clinician performance measurement programs, MAP utilized its Guiding Principles for Applying Measures to Clinician Programs (see **Appendix F**) in addition to the MAP Measure Selection Criteria. The MAP Clinician Workgroup considered whether its Guiding Principles should be revised based on the review of measures; however, the workgroup determined that the guiding principles still reflect MAP's recommendations, and that the full set of principles should be widely publicized to help promote an efficient pre-rulemaking process and to obtain ongoing feedback to ensure that the principles are working effectively. Public commenters generally agreed with the Guiding Principles and emphasized several of the principles: measures included in maintenance of certification (MOC) programs should be included in clinician programs to promote alignment, PQRS can be used as a vehicle to gain experience with a measure prior to obtaining NQF-endorsement, measures that have had endorsement removed should be removed from programs, and measures should be used for one year prior to inclusion in PQRS to identify any potential measurement issues.

Recognizing that the pre-rulemaking cycle does not allow sufficient time for reviewing a large number of measures under consideration and all currently finalized measures, MAP began its review of finalized measures (see **Appendix A, Table A3**) prior to the winter pre-rulemaking cycle. MAP identified 43 measures for removal from PQRS; many of these measures have been submitted for NQF endorsement and were not endorsed. Additionally, MAP identified 66 finalized PQRS measures that should be included in Physician Compare and VBPM; these measures are primarily NQF-endorsed outcome measures, composite measures, and process measures that address cross-cutting topics. While public commenters agreed with MAP's preference for outcome measures and process measures most proximal to outcomes, commenters expressed concern with MAP's recommendations to remove process measures, particularly process measures that are not NQF-endorsed, are used in registries, or are part of measure groups. MAP recognizes that some clinical areas have more advanced measures and are progressing more rapidly toward outcome measures. In these clinical areas, MAP recommends removing process measures in favor

of the outcome measures, but recognizes that the process measures should still be used for other purposes (e.g., registry reporting, QI). In recognition of MAP's need to balance the goals of advancing measurement and ensuring all clinicians will be able to participate, one public commenter suggested that measures recommended for removal should be available for another two to three years, while more outcome-focused measures are being developed and evaluated.

The majority of measures under consideration for clinician programs are measure concepts, being specified, or being tested (see **Appendix A, Table A4**). While MAP prefers the use of NQF-endorsed measures—ensuring that measures are reliable, valid, and feasible—MAP supported or conditionally supported 63 non-endorsed measures for inclusion in PQRS, recognizing that the program lacks measures relevant to many clinician specialties. Public commenters supported MAP's inclusion of measures that are not endorsed that will allow more specialists to participate in PQRS. MAP did not support the use of most (52) of these measures in Physician Compare and VBPM, as MAP strongly prefers that experience be gained with measures through PQRS and that measures be submitted for and receive NQF endorsement prior to implementation in public reporting and payment programs.

MAP also reviewed 46 condition-specific episode grouper measure concepts. Generally, MAP conditionally supported these measures, recognizing that cost measures are critical to the implementation of the VBPM. After the episode grouper measure concepts are fully specified and tested, they should be submitted for and receive NQF endorsement, and then be paired with relevant clinical outcome measures. In reviewing the episode grouper measures, MAP requested that the measure developer further explore and clarify how costs for patients with multiple chronic conditions are attributed to these measures, as patients' costs would potentially be incorporated into multiple episode grouper measures. Similarly, MAP raised questions about how the episode grouper measures are attributed to clinicians, noting that multiple clinicians, including primary care clinicians and specialists, contribute to the costs associated with a particular condition. Finally, MAP requested clarification about the spectrum of a condition that an episode grouper might cover, recognizing that the severity of the condition may impact the cost; for example, stage-1 breast cancer may be less costly than stage-5 breast cancer. MAP requests that all of these issues be considered in the continued development and endorsement of these measures. Public commenters concurred with the areas of additional exploration in the development of condition-specific episode grouper measures; however, some commenters suggested that MAP should not support these measures until further development is completed.

MAP noted measure gaps for the clinical programs similar to past years, emphasizing the need for measures that lead to improved outcomes and the overall health and well-being of people across the care continuum, from clinical to community settings. MAP also recommended that related process measures be rolled up into composites to illustrate a more comprehensive picture of quality. Accordingly, efforts to develop measures for clinician specialties that lack measures should focus on outcomes and composites. Public commenters noted that little progress has been made in filling critical measure gaps in clinician programs.

Pre-Rulemaking Input on Measures for Clinician Group Reporting

The PQRS Group Practice Reporting Option web interface (GPRO) requires clinician groups to report on a set of 18 finalized measures, rather than selecting a subset of measures. In spring 2013, MAP provided **input** on measures applicable to clinician group reporting, recommending 15 measures for inclusion in Physician Compare and VBPM. This input was developed recognizing that

implementation of Physician Compare and VBPM will begin with clinician groups, before expanding to all clinicians. Having provided prior input on the measure set, MAP considered how the measure set could be enhanced (see **Appendix A, Table A2**).

Recognizing that this reporting option is often selected by large multispecialty group practices, MAP recommends that future expansion of the measure set focus on measures that highlight a group's ability to provide coordinated, seamless care. CMS seeks alignment of MSSP and GPRO; accordingly, MAP supported NQF #0576 Follow-Up After Hospitalization for Mental Illness for inclusion in GPRO. MAP also noted that existing measures address the medication management gap—NQF #0022 Use of High Risk Medications in the Elderly and NQF #0553 Care for Older Adults-Medication Review—however, MAP would ultimately prefer a composite measure that addresses the concepts in one measure.

Similar to MSSP, MAP noted that the GRPO measure set could be enhanced with additional composite measures, such as optimal vascular care and optimal asthma care, and outcome measures related to pain and depression. In addition to alignment with MSSP, MAP recommends that the GPRO measure set align with other system-level reporting programs, such as Medicare Advantage 5-Star and the Medicaid Adult Core Measure Set.

Pre-Rulemaking Input on Measures for Individual Clinician Reporting

Individual clinicians and clinician groups reporting through EHRs or claims (e.g., not reporting through the GPRO web interface) are required to report nine measures that address three National Quality Strategy domains. A goal across all clinician programs is to encourage clinician participation, particularly as PQRS transitions from an incentive program to a penalty program in 2015. MAP seeks to encourage clinician participation by identifying measures that are clinically relevant for all clinician specialties. To accomplish this objective, MAP supports incorporating measures used in Maintenance of Certification (MOC) programs into the federal programs. Additionally, MAP notes that implementation of the Quality Clinical Data Registries reporting option[1] will assist in ensuring that all clinicians will be able to participate in the federal programs.

Core Measures for Clinician Reporting

To further support clinician participation, MAP discussed the development of a core measure set for individual clinician reporting. MAP notes that a core would address critical improvement gaps, align payment incentives across clinician types, and reduce reporting burden. MAP considered two options for implementing a core set: (1) identifying a subset of measures that all clinicians would be required to report or (2) identifying multiple core sets, for each specialty or groups of related specialties. Ideally, MAP would prefer to identify a core that all clinicians could report but recognized this would be a challenging task given the wide variation in clinical practice. Accordingly, MAP recommends the following approach for developing a core measure set for individual clinician reporting:

First, identify logical segments of clinicians that would report common core sets. Options include segmenting clinicians by those who see patients regularly versus those who do not, by care setting, by types of encounters (e.g., those who have episodic interactions with patients versus those who have longitudinal relationships with patients), or by patient population served (e.g., those who serve a high volume of vulnerable patients).

Next, identify a few (e.g., two to three) measures that all clinicians in a segment would report. This step will support comparisons across larger cohorts of clinicians. Regardless of the segment of clinicians, the measures in a core set should focus on measure topics that drive broad improvements in healthcare delivery. MAP noted that core measures should promote shared accountability, address cost, and assess care longitudinally; specifically,

core measure topics should include patient-reported outcomes (e.g., health related quality of life, shared decisionmaking, experience with care), care coordination and communication across providers and settings, medication management, cultural competency, population health, and health disparities.

In defining core measure sets for each clinician segment, alignment with performance measurement and improvement activities in other settings and levels of analysis must be considered. This alignment will ensure that the clinician core sets are also supporting overall system improvement. Additionally, a patient-focused approach is needed when developing core sets, considering how the core sets address quality across the care continuum. The MAP families of measures, which promote alignment across settings and across episodes of care, can serve as a starting place for identifying core sets for each clinician segment. MAP offers to work with HHS to define the logical segments of clinicians and applicable core measures. Public commenters generally agreed with MAP's approach and urged MAP to build on lessons learned from the Stage 1 Meaningful Use core quality measures, emphasizing that MAP should engage a breadth of stakeholders for additional input and guidance on the design of a core measure set. Additionally, one commenter noted that measures of shared accountability included in core sets should consider outcomes where specialties work together (e.g., perioperative care outcomes can serve as a proxy for shared accountability between surgeons and anesthesiologists).

Application of Hospital-Based Measures to Clinician Reporting

Currently, the clinician measurement programs do not include measures that are applicable to many hospital-based physicians. During 2014 rulemaking, HHS identified two options for applying existing hospital measures to the clinician performance measurement programs: (1) re-specify existing hospital-level measures for application to clinicians and (2) apply a hospital's performance rates to clinicians practicing in that hospital. MAP considered these options, reviewing finalized measures and measures under consideration for the Hospital Inpatient Quality Reporting Program and Hospital Outpatient Quality Reporting Program, and discussing their application to clinician programs.

Generally, MAP supports both options for using hospital-level measures to assess clinician performance, depending on individual clinician or hospital system role in improving performance on the measure. Both options support aligned measurement across the hospital and clinician levels of analysis, supporting aligned incentives. Additionally, both options reduce the collective data collection burden for hospitals and clinicians. MAP discussed which measures should apply to each option:

Re-specifying hospital-level measures. MAP noted that individual clinician performance is important to consumers, so a subset of hospital-level measures should be re-specified for individual clinicians. MAP noted that the hospital-level measures that are best suited for this option are in areas of care where consumers are able to select their providers, where there is significant variation in clinician performance, and where care is largely attributed to providers. For example, for planned surgeries (e.g., hip replacement, knee replacement), consumers are able to choose a clinician, so hospital measures for these procedures should be re-specified for clinician reporting. MAP cautioned that HHS would need to develop methods for aggregating clinicians' data from multiple hospitals. Additional testing will be needed for any re-specified measures to ensure psychometric soundness. For example, some variation in provider performance may be caused by the time of day or workflow in the hospital.

Applying hospital performance rates. MAP noted that this option promotes shared

accountability, as it would incentivize both the clinician and hospital to improve performance on the same measures. This option may be best suited for hospitalists and other clinicians who are dedicated to one hospital system. Areas of care where consumers are unable to select their clinicians (e.g., critical events, ED care) and areas that focus on the systems of a hospital (e.g., throughput measures) are best suited for this option.

Public commenters generally supported each option and noted that MAP and CMS should work with the relevant specialties and measure developers to determine the best approach. Two public commenters did not support applying hospital performance rates to clinicians, noting that this option would lead consumers to draw inappropriate conclusions about clinician performance.

MAP would like the opportunity to provide input to HHS on measures that could apply to each option. Further, MAP notes that applying measures from post-acute care and long-term care programs to clinician programs in a similar manner would expand the measures available for clinicians who serve patients in those settings.

Hospital Performance Measurement Programs

MAP reviewed measures in finalized program measure sets and measures under consideration for nine hospital programs that have varying purposes and constructions. This section covers the key issues revealed by MAP deliberations and reviews MAP's recommendations for each hospital program.

Key Issues

During its pre-rulemaking review of hospital programs, MAP discussed a number of challenging issues that had implications for multiple programs. In particular, MAP considered the balance between rapid implementation of measures that address outcomes critical to consumers and concerns about measures' validity, reliability, feasibility, and potential unintended consequences. MAP also evaluated measures' readiness for implementation, including the unique considerations for measures based on electronic clinical data. The importance of balanced review was particularly evident in MAP's decisions regarding stroke outcome measures and healthcare-acquired condition measures, as described in the following sections.

Stroke Outcome Measures in IQR and HRRP

During the MAP's review the finalized IQR measure set, the Hospital Workgroup began to discuss two measures related to stroke outcomes for possible removal: 1) Stroke: 30-day all-cause risk-standardized mortality measure, and 2) Hospital 30-day all-cause risk-standardized readmission rate following an acute ischemic stroke hospitalization. MAP did not support these measures in its 2013 pre-rulemaking recommendations because they are not NQF-endorsed, but identified stroke mortality and readmissions to be measure gaps in the IQR program. These measures were not endorsed in part because the steering committee recognized stroke severity to be the main determinant of outcomes and the NIH Stroke Scale to assess severity was not included in the risk-adjustment model. CMS subsequently finalized the measures for use in the IQR program, citing the importance of the topics and a lack of other feasible or practical measures.

Stroke is a high-impact condition, and improving outcomes for stroke patients is important to all stakeholders. In particular, consumers and purchasers need publicly reported information on stroke outcomes to make informed decisions on where to seek care. Facilities with specialized stroke centers have been shown to perform better on process measures of stroke care, but outcome measures have not yet been implemented nationally. Some stakeholders have continued to express strong concerns during MAP deliberations and through public comments about the scientific

acceptability of the two outcome measures and their use in IQR. One of the primary concerns is that some facilities see more severe patients and use of these measures may unfairly penalize stroke centers and others that serve higher-acuity patients. Moreover, publicly reporting inaccurate data about performance could have the unintended consequence of misdirecting patients.

CMS believes that the stroke outcome measures are sound, and it has reiterated its strong commitment to improving them over time. CMS has noted that the measures are currently designed to account for severity, and it is not feasible to incorporate the NIH Stroke Scale into the risk-adjustment model for a claims-based measure. However, the measures have been compared to results obtained from abstracting medical records and found to be highly correlated. CMS has also suggested that implementation of ICD-10 will allow for more granular coding for stroke location, a factor closely tied to severity and outcomes. Further, CMS and ONC are working to develop an eMeasure that could be included in Meaningful Use Stage 3 and has a marker of severity collected as part of certification. Finally, CMS has commissioned a study from the measure development team to explore whether stoke centers are unfairly penalized by the use of these measures. Preliminary results show that distribution of performance is similar between stroke centers and other types of facilities, with high volume driving outlier results at both ends of the curve for all types of providers.

MAP continued discussion of the stroke measures during its pre-rulemaking process and ultimately agreed that the stroke readmission and mortality measures should be retained in the IQR program. Some members remain concerned about the measures and the study results, questioning whether the data reflect inadequate clinical guidelines for treating stroke, the definition of a stroke center, risk-adjustment of the measures, or some combination of factors. After careful consideration, MAP concluded that the need for data on stroke outcomes outweighs these concerns. MAP recognized the limitations of claims-based measures and encouraged other approaches to stroke outcome measurement, such as using data from registries. However, development of other measures could take years, and an IQR measure based on registry data would require that all participating hospitals use the same registry.

In light of the concerns raised about the stroke outcome measures, MAP did not support the stroke readmission measure for the HRRP program, noting the need for more experience with the measure before it is incorporated into a payment program. MAP reiterated the need to ensure measures in HRRP are scientifically sound as the program penalties can have significant consequences for hospitals. Experience may result in changes being made to improve the functionality of the measure.

Hospital-Acquired Condition Measures in IQR, VBP, and the HAC Reduction Program

In the FY 2011 Inpatient Prospective Payment System (IPPS) Final Rule, CMS finalized eight hospital-acquired condition (HAC) rate measures for the IQR program. These rates were selected to address eight of the ten conditions selected at that time for the HAC payment provision created by the Deficit Reduction Act of 2005 (DRA). In its 2012 Pre-Rulemaking Report, MAP recommended removing these rates from the IQR program that populate Hospital Compare and replacing them with NQF-endorsed measures. Subsequently, HHS removed the rates from the program. HHS also launched the launched HAC Reduction Program with a variety of safety measures that will be publicly reported through Hospital Compare. However, some conditions previously covered by an HAC rate have yet to be replaced with an endorsed measure, leading to a decrease in publicly reported information.

In its 2014 pre-rulemaking activities, MAP examined measures under consideration and sought other endorsed measures to fill these gaps

in HACs on Hospital Compare. Specifically, there were once rates for four safety concerns that are not currently addressed by measures finalized for IQR or the HAC Reduction Program. After reviewing program measure sets, MAP determined that measure gaps existed for air embolism, blood incompatibility, foreign body left during procedure, and manifestations of poor glycemic control. Public commenters noted additional safety topics where reporting is thought to be inadequate, including medication errors, surgical site infections, pressure ulcers, safe staffing levels, and falls and trauma.

During the current pre-rulemaking cycle, MAP supported two endorsed measures and conditionally supported two non-endorsed measures to fill these gaps. These measures are NQF #0349 PSI 16 Transfusion Reaction, NQF #0363 PSI 5 Foreign Body Left During Procedure, Adverse Drug Events–Hyperglycemia, and Adverse Drug Events–Hypoglycemia. Because no measures were available to address air embolism, this condition was called out as a remaining gap area. Table 2 shows how finalized and supported measures in three programs address the conditions previously covered by the HAC rates.

TABLE 2. FINALIZED AND MAP-SUPPORTED HAC MEASURES BY PROGRAM

Condition Previously Addressed by HAC Rate	Addressed in Federal Program		
	Inpatient Quality Reporting (public reporting)	Value-Based Purchasing (payment incentive)	HAC Reduction Program (public reporting and payment incentive)
Air Embolism			
Blood Incompatibility			MAP supported measure on this issue (PSI-16)
Catheter-Associated Urinary Tract Infection	Finalized measure addresses this issue (NQF #138)	Finalized measure addresses this issue (NQF #138)	Finalized measure addresses this issue (NQF #138)
Falls and Trauma	Finalized measure addresses this issue (PSI-90)	Finalized measure addresses this issue (PSI-90)	Finalized measure addresses this issue (PSI-90)
Foreign Body Left During Procedure	MAP supported measure on this issue (PSI-5)		
Manifestations of Poor Glycemic Control	MAP conditionally supported measures on this issue (ADE Hyper/Hypo Glycemia)		
Pressure Ulcers Stages III and IV	Finalized measure addresses this issue (PSI-90)	Finalized measure addresses this issue (PSI-90)	Finalized measure addresses this issue (PSI-90)
Vascular-Catheter Associated Infection	Finalized measure addresses this issue (NQF #139, PSI-90)	Finalized measure addresses this issue (NQF #139, PSI-90)	Finalized measure addresses this issue (NQF #139, PSI-90)

Overview of Recommendations for Hospital Programs

MAP reviewed program measure sets and measures under consideration for nine hospital and facility programs: Hospital Inpatient Quality Reporting (IQR), Hospital Value-Based Purchasing (HVBP), Meaningful Use for Hospitals and Critical Access Hospitals, Hospital Readmissions Reduction Program (HRRP), Hospital-Acquired Condition Payment Reduction Program, PPS-Exempt Cancer Hospital Quality Reporting (PCHQR), Inpatient Psychiatric Facility Quality Reporting (IPFQR), Hospital Outpatient Quality Reporting (OQR), and Ambulatory Surgical Center Quality Reporting (ASCQR). MAP's pre-rulemaking recommendations for measures for these hospital programs reflect the MAP Measure Selection Criteria and build on prior NQF work.

Hospital Inpatient Quality Reporting

MAP reviewed 11 measures under consideration for the IQR program, a pay-for-reporting program for acute care hospitals (see **Appendix A, Table A5**). While the MAP Measure Selection Criteria note a strong preference for NQF-endorsed measures, MAP supported or conditionally supported a number of measures that were not endorsed as they address critical program objectives and previously identified gaps. MAP encouraged further development of these important concepts where applicable and reiterated that the measures should be submitted for NQF endorsement. MAP also discussed the need to balance potential advancement and innovation that can be achieved through the application of eMeasures with the implementation challenges hospitals face in extracting data from electronic health records to support measurement.

MAP supported a number of measures under consideration to help fill previously identified gaps. Two measures under consideration, Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge and PC-02 Cesarean Section are NQF-endorsed and help fill the previously identified gap of maternal/child care. MAP cautioned that C-section rates can be misleading without appropriate context and recommended that CMS work with others to ensure that consumers understand publicly reported results and why the measure is important. Public commenters voiced strong agreement with MAP's recommendations to adopt these and other maternal/child health measures in programs.

MAP supported two measures under consideration that help address the previously identified gap of affordability and overall cost: 1) Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure, and 2) Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia. MAP called for the availability of more condition-specific cost information, while recognizing the attribution challenges inherent in measuring episodes of care that involve post-discharge care. Additionally, MAP reiterated the need for the cost measures to be submitted for NQF endorsement.

Two measures under consideration could serve as replacements for one of the HAC rates previously removed from the IQR program. These measures are Adverse Drug Events–Hypoglycemia and Adverse Drug Events–Hyperglycemia. MAP conditionally supported these measures. MAP expressed concern about including measures that only have electronic specifications, as many hospitals still face significant barriers to reporting eMeasures and using them to drive quality improvement. Finally, MAP noted that the NQF endorsement process should ensure that eMeasures are feasible to implement.

MAP also provided input on another measure addressing adverse drug events and medication safety, Appropriate Monitoring of Patients Receiving an Opioid via an IV Patient Controlled Analgesia Device. While this measure is no longer under consideration by HHS for use in a program, MAP reiterated the importance of opioid monitoring as an important gap area. In particular, high-risk patients should be continually monitored

and sedation outcomes should be tracked. MAP also expressed concern that this measure is limited to patient-controlled analgesia (PCA) and could result in the negative unintended consequence of avoidance of PCA in favor of older, less person-centered therapies. MAP encourages the development of a measure that addresses opioid safety more broadly.

MAP conditionally supported two condition-specific readmission measures for coronary artery bypass graft surgery and vascular procedures, pending NQF endorsement. MAP reiterated the need for condition-specific readmission measures to provide actionable information for quality improvement but had concerns about risk adjustment for socioeconomic status. Finally, MAP conditionally supported two measures addressing mortality: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery and Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure. MAP noted the AMI eMeasure is a promising concept but expressed concerns that some hospitals may have difficulties implementing it because of current limitations of EHR systems.

MAP reiterated the importance of rapidly filling the gaps that have been identified in the IQR program. Specifically, members called for new measures to address pediatrics, maternal/child health, cancer, behavioral health, affordability/cost, care transitions, patient education, and palliative and end-of-life care. MAP is also interested in additional safety measures for medication reconciliation, a hospital's culture of patient safety, pressure ulcers, and adverse drug events. MAP advises HHS to focus on filling gaps where measures already exist, such as the adoption of current measures used in the PCHQR, IPFQR, or the Hospice Quality Reporting program rather than gaps with significant needs for measure development.

To keep the IQR measure set parsimonious, MAP identified six finalized measures within the program for phased removal (see **Appendix A, Table A6**). MAP favored removing measures that are no longer NQF-endorsed or endorsed in reserve status, indicating that performance is very high and there is not significant opportunity to improve. MAP acknowledged the potential burden of retaining topped-out measures but cautioned that the removal of such measures could create gaps in the program or take focus away from important topics. MAP advised careful monitoring to prevent a decline in performance after measures are removed.

Hospital Value-Based Purchasing

MAP reviewed 14 measures under consideration for the HVBP program, a pay-for-performance program. In this program, hospitals receive a payment associated with the higher of two scores: one based on their performance relative to other hospitals and the other reflecting their improvement over time (see **Appendix A, Table A7**). MAP reinforced its previous recommendations that measures within this program should emphasize areas of critical importance for high performance and quality improvement and, ideally, link clinical quality and cost measures to capture value.

MAP supported four measures under consideration addressing stroke care. Stroke is a high-impact condition, and there is a need to promote care processes closely tied to better outcomes. MAP did not support the other measures under consideration because performance on those measures is already very high and there is little opportunity for further improvement. This recommendation is congruent with MAP's previous recommendation that the HVBP program measure set should be parsimonious to avoid diluting the payment incentive. Public commenters generally agreed with MAP's recommendations on VBP measures and noted that the improvement opportunity for NQF #0437 STK-4 Thrombolytic Therapy may be greater than MAP believed at the time of formulating its recommendation. Commenters also noted the need to compare results of VBP measures reported through chart

abstraction against those obtained from a new electronic reporting pilot to ensure they produce similarly valid results.

MAP reiterated its desire to see additional outcome measures in the HVBP measure set. Noting that measures in the HVBP program must be drawn from the IQR measure set, MAP identified current IQR measures that should be prioritized for inclusion in the HVBP program as potential ways to fill gaps in the program (see Appendix A, Table A8). MAP recommended the prioritization of:

- NQF #0469 Elective delivery prior to 39 completed weeks of gestation
- NQF #0351 PSI–4 Death among surgical inpatients with serious treatable complications
- NQF #1550 Hip/Knee Complication: Hospital-level Risk-Standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty
- NQF #1893 COPD 30-day mortality rate
- AMI Payment per Episode of Care

Additionally, MAP supported CMS's previously stated intention to propose NQF #1716 NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure and NQF #1717 NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure for the HVBP program.

Finally, MAP noted additional gap areas, including acute renal failure acquired in the hospital, a hospital's culture of patient safety, and emergency department throughput.

Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals

MAP conditionally supported all six measures under consideration for the Meaningful Use for Hospitals and Critical Access Hospitals program, a pay-for-reporting program (see Appendix A, Table A9). Five of the measures under consideration were either under consideration or finalized for the IQR program. Members and public commenters cautioned that the requirements of the Hospital Meaningful Use program are complex and hospitals have had difficulty understanding and implementing them. While MAP supports alignment across programs and HHS' attempts to minimize reporting burden, it may be appropriate to have different measures for the IQR and Meaningful Use programs. MAP reiterated the need for accurate measure specifications and adequate measure testing. MAP recommended that measures be submitted for NQF endorsement and that the endorsement process should address concerns about the feasibility of the measures.

MAP noted the need to continue development of electronic specifications for NQF #0500 Severe Sepsis and Septic Shock: Management Bundle. While some MAP members challenged the feasibility and evidence behind the measure, others emphasized the very serious nature of sepsis and the high costs associated with it. MAP deferred to the recent endorsement review of this measure and conditionally supported it for the Meaningful Use program.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program is a pay-for-performance program that adjusts payments for hospitals found to have an excessive number of readmissions based on a national average. MAP reviewed three measures under consideration for this program (see Appendix A, Table A10).

Two measures under consideration address specific conditions, and one addresses all-cause readmissions. MAP considered the balance between all-cause measures and condition-specific measures of readmissions and reiterated the importance of both because they provide different types of information to stakeholders. MAP recognized that HRRP has played a large role in driving recent improvements and that including

measures of additional conditions could help focus attention on reducing readmissions for patients with those diseases.

MAP conditionally supported one condition-specific measure, Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery, noting the need for the program to address additional diagnoses and that condition-specific measures provide hospitals with actionable data. The measure should be submitted for NQF endorsement. MAP did not support the inclusion of Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization, wanting more experience with the measure before it is used for payment purposes. As discussed above, MAP voiced concerns about the validity, reliability, and risk adjustment of the measure.

Under consideration for use in HRRP, NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmissions for any eligible condition within 30 days of discharge for patients ages 18 and older. The measure generates a single summary readmission rate that is risk adjusted through hierarchical logistic regression. The measure was tested in Medicare fee-for-service and commercial populations and is designed to include five clinical cohorts: medicine, surgery/gynecology, cardiorespiratory, cardiovascular, and neurology. During the NQF endorsement review of the measure, concerns were raised about the need to risk adjust for socioeconomic status and about the usability of the measure to improve performance. In light of these concerns, the NQF Board of Directors asked MAP to consider the complex issue of admission/readmission measure use. In response, MAP developed a **Guidance Document for the Selection of Avoidable Admission and Readmission Measures** to establish important implementation principles. The principles state:

- Readmission measures should be part of a suite of measures to promote a system of patient-centered care coordination.
- All-cause and condition-specific measures of avoidable admissions and readmissions are both important.
- Monitoring by program implementers is necessary to understand and mitigate potential unintended consequences of measurement.
- Risk adjustment is necessary for fair comparisons of readmission rates.
- Readmission measures should exclude planned readmissions.

During its review of NQF #1789 for HRRP, MAP recognized the important role HRRP has had in changing provider behavior and motivating increased care coordination to prevent readmissions. There is a need to improve readmission rates across all diagnoses, not just the conditions currently addressed in the HRRP measure set. MAP shares the general perception that readmission rates are too high but noted that the appropriate level to target is unknown. In addition to the consequences for patients, the penalties associated with the HRRP can have significant effects on hospitals and these potential impacts warrant increased scrutiny of the measures considered for use in the program set.

MAP reiterated the importance of readmission information to all stakeholders, particularly the availability of all-cause readmission data to support decisionmaking by patients, purchasers, and payers. MAP also noted that this measure has only recently been implemented in the IQR program, congruent with MAP's previous recommendations, and more experience with its use is needed before the measure is implemented in HRRP. Public commenters reiterated the need for more time to analyze and understand the usability of the measure and its effects in IQR. MAP conditionally supported NQF #1789 for the HRRP measure set, noting two conditions that should be resolved before the measure is implemented.

The first condition is that HHS should address the potential for a single readmission to be counted twice if both all-cause and condition-specific readmission measures are included in the program. Including both types of readmission measures would essentially penalize hospitals twice for the same event. MAP recommends that CMS consider programmatic approaches to alleviate this concern, such as creating separately calculated domains within the program for all-cause and condition-specific measures or using only the all-cause measure for this program. MAP recognizes that statutory requirements may prevent the short-term removal of some condition-specific measures. Public commenters also raised concern about the restrictions of the authorizing legislation and urged further consideration by HHS.

The second condition is that HHS should calculate and report results of the measure for peer groups of similar facilities. Despite critical access hospitals being excluded from the HRRP, MAP remained concerned about the implications of implementing this measure for rural and safety net providers. Public commenters also noted that the effect of case mix on the measure is not well-established. MAP noted that implementing MedPAC's recommendation to compare hospitals to peer groups for purposes of HRRP incentives could help minimize concerns about unfairly penalizing hospitals that disproportionately care for economically disadvantaged populations. MAP reiterated that issues of socioeconomic status and disparities in care should not be conflated and that all people deserve high-quality care across the care continuum. In addition, NQF #1789 is included in the Dual Eligible Beneficiaries Family of Measures and addresses a crucial issue for vulnerable populations.

Regarding gaps in the HRRP program measure set, MAP noted that the current measures focus heavily on cardiovascular care and there is a need to address additional conditions in the program. In particular, MAP recommends measures addressing behavioral/mental health and cancer care.

Hospital-Acquired Condition Reduction Program

MAP reviewed four measures under consideration (see **Appendix A, Table A11**) for the HAC Reduction Program, a pay-for-performance program that reduces Medicare payments for the quartile of hospitals that have the highest rates of HACs. The HAC Reduction Program consists of two domains of measures: Domain 1 includes Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) measures; Domain 2 includes measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN). Hospitals will receive a score for each measure within the two domains. Domain scores will also be calculated, with Domain 1 weighted at 35 percent and Domain 2 weighted at 65 percent to determine a total score under the program.

The four measures under consideration for the HAC Reduction Program are AHRQ PSI measures. MAP supported the inclusion of two NQF-endorsed measures, NQF #0349 Transfusion Reaction (PSI 16) and NQF #0533 Postoperative Respiratory Failure Rate (PSI 11). MAP emphasized that these HACs are devastating to patients and are very costly. MAP did not support the inclusion of two measures, PSI 10: Postoperative Physiologic and Metabolic Derangement Rate and PSI 9: Perioperative Hemorrhage or Hematoma Rate because of concerns that the measure specifications are vague and that the measures may not be valid or reliable. MAP noted the significant penalties incurred in the HAC Reduction Program and cautioned that measures for this program should be held to a higher standard.

MAP noted a number of gaps for the HAC Payment Reduction Program. MAP suggested considering PSI-5 to address foreign bodies retained after surgery. However, public commenters encouraged the use of clinically-validated outcome measures rather than additional claims-based measures. Additionally, MAP supported the development of measures to

address wrong site/wrong side surgery and sepsis beyond post-operative infections.

PPS-Exempt Cancer Hospital Quality Reporting

MAP reviewed six measures under consideration for the PCHQR program, a quality reporting program for specialty hospitals exempt from the prospective payment system (PPS) (see Appendix A, Table A12). Several organizations submitted detailed comments on the use of these measures in PCHQR, including important feedback on the feasibility issues.

Two of the measures under consideration are process measures addressing cancer treatment. MAP supported one of these measures, NQF #1822 External Beam Radiotherapy for Bone Metastases, noting the importance of this therapy in controlling pain for patients with advanced cancer. MAP conditionally supported a measure addressing the initiation of osteoclast inhibitors for patients with multiple myeloma or bone metastases associated with breast cancer, prostate cancer, or lung cancer. MAP requested that this measure be submitted for NQF endorsement to review its concordance with current evidence and consider the potential consequences of measuring use of one class of medication.

MAP conditionally supported one measure under consideration related to pain screening, NQF #1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits. Recognizing that pain assessment is a critical component of person-centered care that is already monitored on a consistent basis, MAP noted that this measure involves repeated patient screenings that could prove duplicative to both patients and providers. An outcome measure or sampling methodology may be more feasible than collecting a large volume of process information. MAP also noted that this measure may be redundant with NQF #0383 and NQF #0384, two measures related to pain that are already finalized for the program. MAP encourages CMS to be parsimonious when selecting measures for the program and/or to explore opportunities for measure harmonization.

MAP supported NQF #0450 Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12) for the PCHQR program. This is an NQF-endorsed measure that is included in the MAP Safety Family of Measures and addresses an important patient safety concern. MAP conditionally supported Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy, noting that the measure should be submitted for NQF endorsement.

MAP conditionally supported the measure Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis, noting that preventing overuse is important to addressing waste in the system, improving patient safety, and providing an opportunity for shared decisionmaking. The measure should be submitted and receive NQF endorsement. MAP discussed the importance of promoting patient-centered care with this program. The evidence base for cancer care evolves quickly, and patients should have the opportunity to discuss treatment options and their care plans with their providers.

Previously, MAP had noted palliative care measurement gaps in hospital performance measurement programs, particularly in the PCHQR program. MAP also noted that palliative care is a special concern for dual eligible beneficiaries and other vulnerable populations. MAP identified NQF-endorsed measures that were not on HHS' list of measures under consideration for the program but could help fill these gaps (see Appendix A, Table A13). Two measures, NQF #1634 and NQF #1637, could help address pain screening and assessment. Additionally, they are in two MAP families of measures, therefore promoting alignment across settings and programs. Two additional measures, NQF #0326 Advanced Care Plan and NQF #1641 Treatment Preferences, are currently in the Hospice and Palliative Care Family of Measures and address the previously identified gap of supportive services for patients. MAP

recommended that HHS consider all four of these measures for inclusion in the PCHQR program and that they also be considered for the IQR program at a later date, when EHRs have been more widely implemented. Public commenters voiced disagreement that palliative measures are needed in the PCHQR program given that palliative care teams already provide systemic management and/or that some centers do not offer inpatient hospice care.

Inpatient Psychiatric Facility Quality Reporting

MAP reviewed 10 measures under consideration for the IPFQR program, a pay-for-reporting program (see Appendix A, Table A14). The majority of the measures under consideration address screening, and MAP found that the measures did not adequately meet the needs of the program. While MAP agreed that the requirement to conduct screening for risk of violence, risk of suicide, and alcohol, tobacco, and substance abuse within a day was an improvement over other measures with a three-day screening window, members expressed concern that the measures set a low bar. As alternatives to the measures under consideration, MAP encouraged the inclusion of measures from The Joint Commission's tobacco, substance abuse, and hospital-based inpatient psychiatric services suites, noting that these are currently used in the field and that they are in the final stages of the NQF endorsement process. Public commenters agreed that the use of the alternative measures would be preferable to the measures under consideration.

MAP conditionally supported two measures addressing influenza vaccination for the IPFQR program, noting the importance of vaccination for healthcare personnel, patients, and public health in general. MAP cautioned that CDC and CMS need to collaborate on adjusting the measure specifications for reporting and implementation before they can be included in the reporting program.

As a first step to address the previously identified gap in measures for person-centered psychiatric care, MAP supported the Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care measure for inclusion in this program. MAP encouraged the rapid replacement of this measure with a robust survey of patient experience and a measure based on consumer-reported information, such as a CAHPS tool.

MAP did not support one measure under consideration addressing IPF use of an electronic health record meeting Meaningful Use Criteria. Psychiatric hospitals were excluded from the Meaningful Use EHR Incentive program, and imposing these criteria may not be realistic. Because of the nature of this measure, MAP expressed concern about using quality reporting programs to collect data on system infrastructure and suggested that the American Hospital Association's survey of hospitals may be a better data source.

Finally, MAP reviewed measure gaps in the IPFQR program measure set. MAP recognized that outcome measures take time to develop but reiterated the need for this type of measure in the IPFQR program. Gaps identified for this program include consumer and family engagement including consumer experience, consumer-reported outcomes, medical errors, fear of violence at home, death by suicide within 30 days of admission to inpatient setting, and timely access to psychiatric facilities for individuals that present to emergency departments.

Hospital Outpatient Quality Reporting

MAP reviewed four measures under consideration for the OQR program, a pay-for-reporting program (see Appendix A, Table A15).

MAP did not support three of the measures under consideration for the OQR program. While MAP generally favors the inclusion of readmission measures as part of a broader approach to measuring performance and improving care, MAP did not have enough information on the 30-Day Readmissions measure under consideration to support its use. MAP did not support two

measures under consideration related to psychotherapy: No Individual Psychotherapy and Group Therapy. MAP members wanted evidence on the relative value of individual versus group therapy and recommended that these measures be submitted for NQF endorsement to better understand their merit before they are implemented in the OQR program. MAP recognized the need for individualized psychotherapy services, particularly for vulnerable populations, and these measures conceptually have face validity. However, the measures appear to be more related to previously identified billing issues than to quality of care or consumer outcomes.

MAP conditionally supported the High-Acuity Care Visits after Outpatient Colonoscopy Procedure measure for the OQR program, noting the need to provide outcome information to inform consumer decisions and drive quality improvement. This measure addresses an important quality and safety issue with incidence of these events ranging from 10 to 22 per 1,000 after risk adjustment. MAP recognized the need for the measure to be further developed and gain NQF endorsement. MAP expects the endorsement process to resolve questions of the reliability and validity of the measure as well as with the accuracy of the algorithm for attributing claims data in light of possible effects of the Medicare three-day payment window policy.

MAP identified shared decisionmaking and patient experience reporting beyond CAHPS as gaps in the OQR program measure set. In addition, MAP identified wrong site or wrong person surgery, a potential adverse event in outpatient facilities, as a measure gap.

Ambulatory Surgical Center Quality Reporting

MAP reviewed one measure under consideration for the ASCQR program, a pay-for-reporting program (see Appendix A, Table A16). MAP conditionally supported the same colonoscopy measure for the ASCQR program as for the OQR program, reiterating concerns about the need for further development and NQF endorsement of the measure.

During review of finalized measures for the ASCQR program, MAP discussed the difficulty in attributing two measures related to polyp surveillance to the ASC facility given that much of the decisionmaking of colonoscopy timing is under the purview of the primary care provider. Public commenters reiterated this concern. However, MAP also noted that these are important measures of overuse and ambulatory surgery centers should share responsibility for ensuring that their clinicians are not performing procedures more often than necessary. MAP ultimately supported retaining these measures in the program, noting the important role they play in promoting shared accountability.

MAP identified a number of priority measure gap areas for the ASCQR program, including shared decisionmaking and infections. Infection data could be collected through post-surgical infection surveys and data from hospital admissions and emergency department visits.

Post-Acute Care and Long-Term Care Performance Measurement Programs

This section presents key issues related to performance measurement in PAC/LTC settings that MAP identified during pre-rulemaking activities, and an overview of MAP's pre-rulemaking recommendations for the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program, Long-Term Care Hospital (LTCH) Quality Reporting Program, End Stage Renal Disease Quality Incentive Program (ESRD-QIP), and Home Health (HH) Quality Reporting Program.

This year, MAP was not asked to provide input on measures under consideration for the Nursing Home (NH) Quality Initiative and NH Compare programs, or for the Hospice Quality Reporting (HQR) Program. MAP typically reviews the finalized program measure set when there are

no measures under consideration; however, the Nursing Home quality measure set has not changed since MAP's 2013 review. Additionally, HHS has updated the Hospice Quality Reporting Program measure set to reflect MAP's 2013 recommendations. Accordingly, MAP did not review these programs as part of this pre-rulemaking cycle.

Key Issues

MAP reiterated several key issues related to the selection of measures for PAC/LTC programs during this pre-rulemaking cycle, including the importance of measure alignment, care coordination, and shared accountability across settings.

MAP emphasized the need to align performance measurement across PAC/LTC settings as well as with other settings. When recommending measures for inclusion in the programs, MAP considered harmonization of measures to promote patient-centered care across the healthcare continuum. Recognizing the heterogeneity of populations served in each setting, MAP recommended that measures be specified and applicable to specific populations. For example, MAP noted that falls are more important in long-term care and typically associated with other conditions such as dementia and delirium. However, to encourage harmonization across settings, MAP recommended inclusion of a falls measure in the IRF Quality Reporting Program once the measure has been tested and re-specified for IRFs. Public commenters generally supported MAP's recommendations regarding harmonization of measures across programs and settings; however, they urged caution regarding inclusion of measures that are not clinically relevant or representative of a given setting or patient population.

MAP has repeatedly recommended that care transition measures, including setting-specific admission and readmission measures that address the unique needs of the heterogeneous PAC/LTC population, are needed to promote coordination and shared accountability across the care continuum. Last year, MAP supported the direction of admission/readmission measures that were not NQF-endorsed but were under consideration for the PAC/LTC programs, noting that the measures should be appropriately risk adjusted to account for various population characteristics. Through HHS rulemaking in 2013, four of those measures were implemented in several PAC/LTC programs: two measures of 30-day all cause post discharge readmission for IRFs and LTCHs, and two measures of rehospitalization during first 30 days and emergency department use without readmission for HH. MAP noted the importance of identifying attribution issues and unintended consequences when further refining these measures.

Highlighting the importance of providing preventive care for patients seen in PAC/LTC settings, MAP encouraged care coordination, better communication, and shared accountability among acute care providers and PAC/LTC facilities to ensure the timely receipt of appropriate services. MAP acknowledges the challenges associated with providing preventive care for vulnerable populations such as dual eligible beneficiaries and patients with multiple chronic conditions, as it is often unclear which provider is responsible for monitoring their complex care needs. For example, ESRD patients spend more time in dialysis facilities and visit their primary care clinicians less frequently; regardless, it is crucial that ESRD patients receive timely vaccinations.

Application of Prior Coordination Strategies to Pre-Rulemaking Decisions

In addition to the MAP Measure Selection Criteria, MAP's **Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement** and **Performance Measurement Coordination Strategy for Hospice and Palliative Care** served as guides for MAP's pre-rulemaking review of measures for the PAC/LTC programs.

In the PAC/LTC coordination strategy, MAP defined

high-leverage areas for performance measurement and identified 13 core measure concepts to address each of the high-leverage areas.

TABLE 3. PAC/LTC HIGHEST-LEVERAGE MEASUREMENT AREAS AND CORE MEASURE CONCEPTS

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental health
Goal Attainment	• Establishment of patient/family/caregiver goals • Advanced care planning and treatment
Patient Engagement	• Experience of care • Shared decisionmaking
Care Coordination	• Transition planning
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions

In the hospice coordination strategy, MAP identified 28 high-leverage measurement opportunities that are important for hospice and palliative care. Further, MAP prioritized 13 measurement opportunities: 7 for hospice and palliative care, 3 specific to hospice care, and 3 specific to palliative care. The opportunities specific to hospice care reflect patients' needs for increased access and communication and include timeliness/responsiveness of care, access to the healthcare team on a 24-hour basis, and avoiding unwanted treatments.

This year, MAP emphasized the importance of filling the critical measure gaps (i.e., the core concepts not addressed in the programs) across PAC/LTC programs and expressed strong desire to revisit the PAC/LTC coordination strategy outside of the pre-rulemaking process with a focus on identifying opportunities to make progress on filling key measure gaps. The PAC/LTC core measure concepts that MAP found would greatly enhance the current measure sets include goal attainment; medication management, medication reconciliation, and adverse drug events; functional and cognitive status; patient and family experience of care and engagement in care; shared decisionmaking; and transitions in care.

Overview of Recommendations for Post-Acute and Long-Term Care Programs

Inpatient Rehabilitation Facility Quality Reporting Program

MAP reviewed the five measures currently finalized for the IRF Quality Reporting Program measure set and eight measures under consideration for the program (see Appendix A, Table A18). MAP reiterated its previous recommendation that the program measure set is too limited and could be enhanced by addressing core measure concepts not currently addressed in the set. Recognizing that there has been progress in the area of patient safety with HHS' adoption of vaccination and readmission measures for the FY 2016 and 2017 IRF PPS annual payment increase factor, MAP noted that the program measure set still has gaps in high-priority measurement areas for IRFs. Accordingly, MAP supported one NQF-endorsed measure under consideration that addresses *C. difficile*, a high incidence healthcare-acquired condition in IRFs that can affect patients' ability to participate in rehabilitation programs.

MAP conditionally supported the remaining measures under consideration, noting that they all address PAC/LTC core measure concepts but need further modification or development. MAP conditionally supported a measure of falls with injury, stating that the measure needs modification to clarify the scale of the injury, consider where falls occur in the facility, and distinguish between assisted falls and unassisted falls. MAP also conditionally supported two measures addressing

methicillin-resistant *Staphylococcus aureus* (MRSA) and pain, stating that management of these conditions would enable patients to participate fully in their treatment. Several public commenters expressed concern that these measures may not be relevant to IRFs' purpose, which is to promote functional recovery and achievement of patients' goals. One public commenter agreed with MAP's recommendations provided that the measures are appropriately specified to take into consideration attribution. Another public commenter supported MAP's recommendation to include a falls measure in the program, but expressed concern that MAP did not further discuss strategies for ensuring the measure is specified and tested immediately.

MAP conditionally supported four functional status outcome measures, noting that the measures are important indicators for this setting but are still in development. A few public commenters concurred with MAP that measures addressing function are important; however, they noted that measures under consideration need to be risk-adjusted and fully specified prior to inclusion in the program. One public commenter urged MAP to consider the existing Functional Independence Measure (FIM) instrument that is widely used in PAC/LTC settings and for the IRF Prospective Payment System for this program.

Long-Term Care Hospital Quality Reporting Program

MAP reviewed the nine measures currently finalized for the LTCH Quality Reporting Program measure set and three measures under consideration for the program (see Appendix A, Table A19). MAP conditionally supported two measures that address the core concept of functional and cognitive assessment. MAP agreed that functional status is a critical area of measurement, and that functional status assessment should cover a broad range of mobility issues, such as position changes, locomotion, poor mobility, picking up objects, and chair-to-bed transfers. MAP expressed concern that Functional Outcome Measure: change in mobility among patients requiring ventilator support is limited to patients requiring ventilator support, which is a relatively small percentage of patients in LTCH facilities. Increased attention should be given to pain, agitation, and delirium among the ventilated population, as these factors are the biggest impediments to mobility.

MAP also supported a measure addressing Ventilator-Associated Events, which addresses complications that have developed from ventilator use, as well as infections as a subset of those complications. MAP agreed that although this measure is not NQF-endorsed, it provides useful information for healthcare facilities to help them monitor ventilator use and identify improvements for preventing complications.

End Stage Renal Disease Quality Incentive Program

MAP reviewed the 15 measures currently finalized for the ESRD Quality Incentive Program measure set and 21 measures under consideration for the program (see Appendix A, Table A20). MAP previously recommended that the measure set expand beyond dialysis procedures to include nonclinical aspects of care such as care coordination, medication reconciliation, functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression.

MAP supported seven measures under consideration, addressing several cross-cutting areas previously noted as gaps and other important measurement topics for the ESRD population. These measures address areas ranging from counseling on physical activity, depression, pain, and health behaviors (substance use treatment) to safety issues such as vaccinations of healthcare personnel and testing for Hepatitis C, which is a prevalent comorbid condition in the ESRD population. MAP also noted that depression is a common condition among dialysis patients and has been correlated with mortality, and that pain is important to assess for quality of life because it can signal other problems. Several

public commenters did not agree with MAP's recommendations regarding these measures, citing that most of the measures are not specified for dialysis facilities or will be burdensome and redundant as they are currently a requirement of the Medicare Conditions for Coverage. One public commenter agreed with the MAP's support of the depression and pain measures and noted that patients need to be referred to specialists for further follow-up and treatment.

MAP conditionally supported nine measures, deeming them conceptually important but in need of further development. These included vaccination measures and clinical quality measures that address the ESRD program's statutory requirements, including dialysis adequacy and bone mineral metabolism. Several public commenters did not agree with MAP's recommendation regarding the dialysis measures, noting that the measures have not been tested for validity or reliability.

MAP did not support five measures, including NQF #0260 Assessment of Health-related Quality of Life, noting that dialysis facilities annually collect and report this data to CMS through the Kidney Disease Quality of Life (KDQOL) survey. MAP preferred other measures that address quality of life, such as pain and depression. Additionally, the measures MAP supported go beyond assessment by including follow-up interventions. Similarly, MAP did not support including the comorbidity report, as facilities are required to update and annually report the comorbidity data to CMS, and it was unclear how this information could be used as a performance measure. Finally, MAP did not support additional vaccination measures under consideration because the measure specifications are not aligned with the Center for Disease Control and Prevention's (CDC) recommendations.

Home Health Quality Reporting Program

MAP reviewed the 82 measures finalized for the Home Health Quality Reporting Program measure set and 4 measures under consideration for the program (see Appendix A, Table A21).

Two measures under consideration addressed the PAC/LTC core concept of avoidable admissions, and MAP reinforced the important role measures of readmissions play in promoting shared accountability across the care continuum. These measures, Rehospitalization during the First 30 Days of Home Health and Emergency Department Use without Hospital Readmission during the First 30 Days of Home Health, were adopted for the HHQR program in the CY 2014 Rule, but HHS asked MAP to provide input on revisions to the risk-adjustment methodology for the measures. The measures were revised to include a hierarchal risk-adjustment model to better align them with NQF #1789, Hospital-Wide All-Cause Unplanned Readmission Measure (HWR). MAP supported the revised measures, noting that applying a hierarchical risk-adjustment model would be an improvement, but raised concerns that the measures still do not adjust for all factors that could influence a patient's likelihood of readmission to the hospital or emergency department. One public commenter supported MAP's recommendation of these measures, noting that they address important issues for care coordination.

MAP also reviewed two new measures under consideration. One measure under consideration, Depression Screening Conducted and Follow-Up Plan Documented, addresses the PAC/LTC core concept of mental health. MAP supported this measure noting that it includes an element of follow-up, better promoting person- and family-centered care. MAP believed this measure would be preferable to the depression screening measure currently in the HHQR set and recommended that this improved measure replace the current measure. Finally, MAP supported one measure under consideration that addresses the PAC/LTC core concept of pressure ulcers and raised concern over risk-adjustment issues for this measure.

Hospice Quality Reporting Program

There were no measures under consideration for the Hospice Quality Reporting Program this

year, so MAP used the opportunity to consider alignment of the HQR program with hospital programs by identifying finalized hospice measures that could be incorporated into hospital programs. Accordingly, the MAP PAC/LTC Workgroup provided input to the MAP Hospital Workgroup (see the Hospital section above). During this discussion, MAP expressed concern that NQF #0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment had been finalized for removal from the HRQ program measure set. MAP stated support for further measure development in this area, recognizing that hospice patients may not be able to respond within 48 hours.

Assessing Impact

The Affordable Care Act requires HHS to assess the impact of quality and efficiency measures used in federal healthcare programs, and to provide the findings in a report to Congress every three years. The first such report, the **National Impact Assessment of Medicare Quality Measures**, was released in March 2012. CMS convened a Technical Expert Panel (TEP) to advise the agency on subsequent reports.

In addition, HHS requested that MAP provide input on the potential impact of quality measures under consideration that MAP recommends for future use in federal programs. MAP has been collaborating with HHS to refine an approach for these assessments based on the data and resources available. More sophisticated analysis and assessment of potential measure impact presents an opportunity for MAP to provide better guidance to HHS on the selection of measures having the highest potential to achieve programmatic goals, and ultimately improve health outcomes. A comparison of the roles of the CMS TEP and MAP is summarized in Table 4 below.

TABLE 4. COMPLEMENTARY ROLES OF CMS TECHNICAL EXPERT PANEL AND MAP IN ASSESSING IMPACT

	CMS TEP Role	MAP Role
Perspective	Retrospective evaluation	Prospective evaluation
Composition	Primarily academic and technical experts	Broad multistakeholder group with diverse backgrounds
Primary Anticipated Output	Detailed analyses of impact, which may be at the individual measure level	Broad assessment of the potential impact of adding new measures under consideration to measure sets
Cross-Effort Representation	George Isham – TEP co-chair; Karen Adams and Allen Leavens – TEP members; CMS staff	George Isham – Coordinating Committee co-chair; Karen Adams and Allen Leavens – NQF staff; CMS staff
Funding	CMS contract with Health Services Advisory Group (HSAG)	No separate funding beyond CMS funding of MAP pre-rulemaking activities

Progress to Date

MAP has accepted a straightforward definition of "impact" as: "The extent to which a program measure set addresses the aims of and accelerates progress on the priorities of the National Quality Strategy." The current approach that MAP uses to evaluate potential measure impact involves determining which new measures under consideration help program measure sets better meet the MAP Measure Selection Criteria. In particular, MAP places strong emphasis on increasing alignment and filling important measure gaps to support the NQS. The CMS TEP and subcontractors are using the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework for their detailed retrospective impact assessments. Use of RE-AIM promotes a broad assessment of impact by focusing attention on the multiple dimensions of an intervention that influence whether outcomes are successful. MAP members advocated for access to results of the retrospective measure impact analyses as soon as feasible.

MAP determined that a logic model could be helpful in thinking about how to advance the assessment of measure impact. After evaluating a draft model, MAP members agreed that determining potential measure impact is a highly complex challenge, and that many factors beyond measurement can influence outcomes. Therefore, MAP recognized that implicit assumptions are made when attempting to evaluate a direct link between measure selection and impact. However, MAP members did make the following recommendations:

- Seek and utilize additional quantitative and qualitative information on measures, and explore pathways to doing more sophisticated predictive analytics.
- Ensure that both potential positive and negative impacts are evaluated.
- Consider a stronger focus on measures addressing upstream health determinants.
- Look beyond general impact to variations in impact for different populations that may signal disparities, which might potentially include stratified assessments.
- Take a consumer-oriented approach to provide an additional lens for assessing potential impact, with consideration for outcomes that matter most to consumers – such as quality of life and pain management.
- Work toward explicit hypotheses and/or estimates of the range of impact for supported measures under consideration that can be evaluated against outcomes at a later time.

Next Steps

MAP members suggested incorporating information on measure impact assessment into an ongoing summary of measures supported by MAP that can be tracked over time. Lessons learned from prior experience may thereby more directly inform future MAP decisions. One public commenter also suggested conducting an independent stakeholder evaluation of measure impact that could be used as a feedback loop to MAP and NQF. The measure impact assessment logic model will be refined based on MAP's input, and MAP will continue to pursue opportunities to enhance assessment of potential measure impact that are consistent with its recommendations.

CONCLUSION

MAP's 2014 pre-rulemaking recommendations provide guidance to HHS on the use of 234 measures in 20 federal programs. Now concluding its third cycle of pre-rulemaking input, MAP has continually enhanced the specificity and actionability of its recommendations to identify "measures that matter." The tactics identified in MAP's strategic plan, including identifying families of measures and high-priority measure gaps, have been effective in informing MAP's decisionmaking. However, there is much to be done to achieve MAP's strategic goals, and MAP's balance of stakeholders and collaboration with HHS provide a unique opportunity for achieving more consistent, meaningful, and efficient measurement over time.

NQF and HHS will continue to collaborate and improve the process for formulating pre-rulemaking input. MAP members and public commenters offered many helpful suggestions in this regard, including appreciation of the new opportunity to provide input on measures to MAP in advance of meetings, approval of the "Conditional Support" decision category, and suggestions for additional expertise that is needed among MAP members. In comments on measures under consideration, stakeholders repeatedly emphasized the importance of information, such as that gained during the NQF endorsement process, in guiding decisions about measure use. NQF has signaled that it will hold a process improvement event aimed at better integrating the measure endorsement and selection functions.

In 2014, MAP will continue its efforts in developing additional families of measures focused on affordability, population health, and person- and family-centered care. In addition, MAP will continue its work in addressing quality measurement issues on behalf of vulnerable beneficiaries. Specifically, MAP will convene a Medicaid Task Force to provide guidance to HHS on updates to the Core Set of Measures for Medicaid-Eligible Adults, and the Dual Eligible Beneficiaries Workgroup will explore topics relevant to that population.

ENDNOTES

1 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014. Final Rule. *Fed Regist*. 2013;78:74229-74823. Available at https://www.federalregister.gov/articles/2013/12/10/2013-28696/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory. Last accessed January 2014.

APPENDIX A:
Program Summaries and Measure Tables

MAP Input on System Programs

Medicare Shared Savings Program

Program Type
Pay for Reporting and Pay for Performance.[1]

Incentive Structure
Option for one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years).[2]

Care Settings Included
Providers, hospitals, and suppliers of services

Statutory Mandate
Sec. 3022 of the Affordable Care Act (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Medicare Shared Savings Program (MSSP) that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.[3]

Statutory Requirements for Measures
Appropriate measures of clinical processes and outcomes; patient, and, wherever practicable, caregiver experience of care; and utilization (such as rates of hospital admission for ambulatory sensitive conditions).[4]

MAP Pre-Rulemaking 2014 Input
The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A1. MAP INPUT ON MEDICARE SHARED SAVINGS PROGRAM MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0005 Endorsed	CG CAHPS: Courteous & Helpful Office Staff	Support. Promotes person- and family-centered care.	Public comment from the Armstrong Institute notes concerns about the denominator population.
0005 Endorsed	CG CAHPS: Supplemental Item Care Coordination	Support. Promotes person- and family-centered care.	Public comment from the Armstrong Institute notes concerns about the denominator population.
0005 Endorsed	CG CAHPS Supplemental and New Items: Between Visit Communication	Support. Promotes person- and family-centered care.	Public comment from the Armstrong Institute notes concerns about the denominator population.
0005 Endorsed	CG CAHPS Supplemental Item: Educating Patient about Medication Adherence	Support. Promotes person- and family-centered care.	Public comment from the Armstrong Institute notes concerns about the denominator population.
0005 Endorsed	CG CAHPS: Supplemental Item Stewardship of Patient Resources	Support. Promotes person- and family-centered care.	Public comment from the Armstrong Institute notes concerns about the denominator population.
0046 Endorsed	Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older	Do Not Support. Measure does not adequately address any current needs of the program.	MAP previously supported this measure; however, at this time the measure set should only be expanded for cross-cutting measures. This measure should be considered for inclusion in future years as ACOs have more experience with the currently finalized measure set. Public comment from the Armstrong Institute supports MAP's conclusion noting that disease specific guidelines focuses physician/patient effort too narrowly for a population that is heterogeneous with respect to function and goals. Public comment from Amgen does not support MAP's conclusion noting known gaps in care, impact on patient outcomes, and costs to the program.

TABLE A1. MAP INPUT ON MEDICARE SHARED SAVINGS PROGRAM MEASURES UNDER CONSIDERATION
(continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0053 Endorsed	Osteoporosis Management in Women Who Had a Fracture	Do Not Support. Measure does not adequately address any current needs of the program.	MAP previously supported this measure; however, at this time the measure set should only be expanded for cross-cutting measures. This measure should be considered for inclusion in future years as ACOs have more experience with the currently finalized measure set. Public comment from the Armstrong Institute cites concerns about this measure noting disease specific guidelines focus physician/patient effort too narrowly for a population that is heterogeneous with respect to function and goals. Public comment from Amgen does not support MAP's conclusion noting known gaps in care, impact on patient outcomes, and costs to the program.
0543 Endorsed	Adherence to Statin Therapy for Individuals with Coronary Artery Disease	Do Not Support. Measure does not adequately address any current needs of the program.	Public comments from AHIP and the Armstrong Institute do not support MAP's conclusion.
0555 Endorsed	Lack of Monthly INR Monitoring for Individuals on Warfarin	Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from the Armstrong Institute does not support MAP's conclusion.
0556 Endorsed	INR for Individuals Taking Warfarin and Interacting Anti-Infective Medications	Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from the Armstrong Institute does not support MAP's conclusion.
0576 Endorsed	Follow-Up After Hospitalization for Mental Illness	Support. Promotes person- and family-centered care.	Public comment from the Armstrong Institute notes concern about how often depression is properly diagnosed in non-psychiatric settings.
1741 Endorsed	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	Support. Promotes person- and family-centered care.	Public comment from ASA supports MAP's conclusion.

TABLE A1. MAP INPUT ON MEDICARE SHARED SAVINGS PROGRAM MEASURES UNDER CONSIDERATION
(continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFLE Not Endorsed	Optimal Asthma Care-Control Component	Support. Promotes alignment across programs, settings, and public and private sector efforts.	Public comment from NPWF supports MAP's conclusion.
Not Endorsed	Patient Activation Measure	Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Data generated from this patient reported outcome measure or tool should be aggregated and tested as a PRO-based performance measure. Additionally, other PROMs/tools in this area should be explored. Public comment from NPWR supports including prior to endorsement.
Not Endorsed	SF-36 (included in the HOS)	Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Data generated from this patient reported outcome measure or tool should be aggregated and tested as a PRO-based performance measure. Additionally, other PROMs/tools in this area should be explored. Public comment from AHIP supports the SF-36 survey. Public comment from NPWR supports including prior to endorsement.

MAP Input on Clinician Programs

Physician Quality Reporting System (PQRS)

Program Type
Pay for Reporting

Incentive Structure
In 2012-2014, eligible professionals can receive an incentive payment equal to a percentage (2% in 2010, gradually decreasing to 0.5% in 2014) of the eligible professional's estimated total allowed charges for covered Medicare Part B services under the Medicare Physician Fee Schedule.[5] Beginning in 2015, eligible professionals and group practices that do not satisfactorily report data on quality measures will receive a reduction (1.5% in 2015 and 2% in subsequent years) in payment.[6,7]

Care Settings Included
Multiple. Eligible professionals include:

- Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist[8]

Statutory Mandate
The 2006 Tax Relief and Healthcare Act (TRHCA) required the establishment of a physician quality reporting system. The PQRS was initially implemented in 2007 and was extended as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2008 (MMSEA), the Medicare Improvements for Patients and Providers Act of 2009 (MIPPA), and the Affordable Care Act.[9]

Statutory Requirements for Measures
The number and type of measures required vary by reporting option (e.g., individual reporting, group web reporting option, EHR reporting).

Medicare and Medicaid EHR Incentive Program for Eligible Professionals

Program Type
Incentive program

Incentive Structure
Eligible professionals who demonstrate meaningful use of certified EHR technology, which includes reporting clinical quality measures, can receive incentive payments. The incentives vary by program.[10]

- Medicare. Up to $44,000 over 5 continuous years. The program started in 2011 and will continue through 2014. The last year to begin participation is 2014. Penalties will take effect in 2015 and in each subsequent year for providers who are eligible but do not participate. The penalty is a payment adjustment to Medicare reimbursements that starts at 1% per year, up to a maximum 5% annual adjustment.
- Medicaid. Up to $63,750 over 6 years. The program started in 2011 and will continue through 2021. The last year to begin participation is 2016. Payment adjustments do not apply to Medicaid.[11]

Care Settings Included
Multiple. Under the Medicare EHR incentive program, eligible professionals include doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry as well as chiropractors. Under the Medicaid EHR incentive program eligible professionals include doctors of medicine and osteopathy, nurse practitioners, certified nurse-midwives, dentists, and physician assistants furnishing services in a federally qualified health center or rural health clinic.[12]

Statutory Mandate
The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Statutory Requirements for Measures
Measures are of processes and experience and outcomes of patient care that relate to one or more quality aims for healthcare such as effective, safe, efficient, patient-centered, equitable, and timely care. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.[13] Preference should be given to quality measures endorsed by NQF. [14]

Anticipated Future Rules
It is anticipated that the Meaningful Use Stage 3 proposed rule will be published in early 2014.

Additional Program Considerations
The goal of the Medicare and Medicaid Electronic Health Record (EHR) Incentive program is to provide measures for eligible professionals under three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing;
- The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and
- The use of certified EHR technology to submit clinical quality and other measures.

For Stage 1:[15]

- Eligible professionals must report on 6 total clinical quality measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures (selected from a set of 38 clinical quality measures).

For Stage 2 (2014 and beyond):[16]

- Eligible Professionals must report on 9 total clinical quality measures that cover 3 of the National Quality Strategy Domains (selected from a set of 64 clinical quality measures).

Physician Compare

Program Type
Public Reporting[17]

Incentive Structure
None

Care Settings Included
Multiple. Eligible professionals include:[18]

- Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologist
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist

Statutory Mandate
Section 10331 of the Patient Protection and Affordable Care Act of 2010. The website was launched on December 30, 2010. Performance information will be reported on the website in 2013 or early 2014.

Statutory Requirements for Measures
Data reported under the existing Physician Quality Reporting System will be used as an initial step for making physician measure performance information public on Physician Compare. The following types of measures are required to be included for public reporting on Physician Compare:[19]

- Patient health outcomes and functional status of patients

- Continuity and coordination of care and care transitions, including episodes of care and risk adjusted resource use
- Efficiency
- Patient experience and patient, caregiver, and family engagement
- Safety, effectiveness, and timeliness of care

Value-Based Payment Modifier/Physician Feedback Program

Program Type

Pay for Performance

Incentive Structure

Physician Feedback Program

CMS is statutorily required to provide confidential feedback reports to physicians that measure the quality and resources involved in furnishing care to Medicare Fee-for-Service (FFS) beneficiaries. Physician feedback reports also serve currently as the preview vehicle to inform physicians of the types of measures and methodologies that will comprise the value modifier. Starting in the fall of 2013, all groups of physicians with 25 or more eligible professionals will begin receiving Physician Feedback reports.[20]

Value-Based Payment Modifier

The VBPM begins in 2015 for groups of 100 or more eligible professionals and will expand to groups of 10 or more eligible professionals in 2016. VBPM will apply to all physicians and groups of physicians on or after January 1, 2017. The VBPM payment adjustment varies over time and must be implemented in a budget neutral manner. Payment adjustment amount is built on satisfactory reporting through PQRS.[21]

In 2015 and 2016, the VBPM will not be applied to groups of physicians that are participating in the Medicare Shared Savings Program, testing of the Pioneer ACO model, or the Comprehensive Primary Care Initiative.[22] Additionally, future rulemaking cycles will determine a VBPM for individuals, smaller groups, and hospital-based physicians.[23]

Care Settings Included

Multiple. Eligible professionals include:

- Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologist
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist[24]

Statutory Mandate

Section 1848(p) of the Social Security Act as established by Section 3003 and 3007 of the Affordable Care Act of 2010 (ACA). [25]

Statutory Requirements for Measures:

The program must include a composite of appropriate quality measures and a composite of appropriate cost measures.[26] The Secretary is also required to use NQF-endorsed measures, whenever possible. Final rule indicated, for 2013 and beyond, the use of all measures included in the PQRS.

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable for clinician programs.

TABLE A2. MAP INPUT ADDITIONAL MEASURES FOR PQRS GPRO-WEB

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0022 Endorsed	Use of High Risk Medications in the Elderly	PQRS GPRO: Support. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts.	Explore combining with NQF# 0553. Public comment from AmeriHealth Caritas supports MAP's conclusion and cautions that it must be monitored for unintended consequences. Public comment from AHIP does not support MAP's conclusion, noting the measure may result in the under-treatment of pain and depression in the elderly and therefore should be monitored.
0053 Endorsed	Care for Older Adults – Medication Review	PQRS GPRO: Support. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private- sector efforts.	Explore combining with NQF# 0022.
0576 Endorsed	Follow-up After Hospitalization for Mental Illness	PQRS GPRO: Support. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0005 Endorsed	CAHPS Clinician / Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set. Promotes person- and family-centered care.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting. Measure is a patient experience measure that applies to many types of providers. Public comment from AANS/CNS does not support MAP's conclusion.
0006 Endorsed	CAHPS Health Plan Survey v 4.0 - Adult questionnaire	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support A finalized measure addresses a similar topic and better addresses the needs of the program.	This measure is intended for a system level of analysis; rates cannot be attributed to individual clinicians. Public comment from AANS/CNS supports MAP's conclusion.
0031 Not Endorsed	Breast Cancer Screening	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be updated to reflect current guidelines.	
0032 Endorsed	Cervical Cancer Screening	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be updated to reflect current guidelines.	
0034 Endorsed	Colorectal Cancer Screening	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	Public comment from ASGE supports MAP's conclusion, noting the measure is consistent with the U.S. Preventive Services Task Force (USPSTF) recommendation.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0384 Endorsed	Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comments from CAPC and MITA do not support MAP's conclusion. CAPC notes that the measure is particularly appropriate for Physician Compare, as they address patient experience, safety, and affect health outcomes and functional status.
0385 Endorsed	Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients	Physician Compare: Do Not Support. VBPM: Do Not Support Measure does not adequately address any current needs of the program.	
0387 Endorsed	Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0389 Endorsed	Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Provides consideration for healthcare disparities. Included in a MAP family of measures. Addresses program goals/ objectives.	
0561 Not Endorsed	Melanoma Coordination of Care	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	Public comment from AMA does not support MAP's conclusion, noting the measure was developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes.
0377 Endorsed	Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow	Physician Compare: Do Not Support. VBPM: Do Not Support Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0378 Endorsed	MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0379 Endorsed	Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0380 Endorsed	Multiple Myeloma – Treatment with Bisphosphonates	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0382 Endorsed	Oncology: Radiation Dose Limits to Normal Tissues	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a condition not adequately represented in the program measure set. Addresses program goals/ objectives. Included in a MAP family of measures.	Public comment from MITA supports MAP's conclusion.
0383 Endorsed	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from CAPC does not support MAP's conclusion, noting that the measure are particularly appropriate for Physician Compare, as they address patient experience, safety, and affect health outcomes and functional status.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0386 Endorsed	Oncology: Cancer Stage Documented	Physician Compare: Support. VBPM: Support. NQF-endorsed measures. Provides consideration for healthcare disparities and cultural competency. Included in a MAP family. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ objectives.	
0390 Endorsed	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0391 Endorsed	Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0392 Endorsed	Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0455 Endorsed	Recording of Clinical Stage Prior to Surgery for Lung Cancer or Esophageal Cancer Resection	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0457 Endorsed	Recording of Performance Status prior to Lung or Esophageal Cancer Resection	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0508 Endorsed	Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Performance of the measure may be topped out. Public comment from AMA does not support MAP's conclusion, noting the measure was developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes.
0650 Endorsed	Melanoma Continuity of Care – Recall System	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0658 Endorsed Time-Limited	Endoscopy/ Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ objectives.	Public comment from ASGE supports MAP's conclusion.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0659 Endorsed Time-Limited	Endoscopy/ Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Included in a MAP family. Addresses program goals/ objectives.	
1853 Endorsed	Radical Prostatectomy Pathology Reporting	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
1854 Endorsed	Barrett´s Esophagus	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
N/A Not Endorsed	Colonoscopy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Colonoscopy)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBAFH Not Endorsed	251 Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBBAA Not Endorsed	263 Preoperative Diagnosis of Breast Cancer	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBBAB Not Endorsed	264 Sentinel Lymph Node Biopsy for Invasive Breast Cancer	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBLLC Not Endorsed	Radiation Dose Optimization: Cumulative Count of Potential High Dose Radiation Imaging Studies: CT Scans and Cardiac Nuclear Medicine Scans	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA supports MAP's conclusion. Public comment from AdvaMed does not support MAP's conclusion, noting that evidence supports this measure.
XBLLD Not Endorsed	Radiation Dose Optimization: Utilization of a Standardized Nomenclature for CT Imaging Description	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA supports MAP's conclusion. Public comment from AdvaMed does not support MAP's conclusion, noting that evidence supports this measure.
XBLLL Not Endorsed	Radiation Dose Optimization: Search for Prior Imaging Studies through a Secure, Authorized, Media-free, Shared Archive	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA supports MAP's conclusion. Public comment from AdvaMed does not support MAP's conclusion, noting that evidence supports this measure.
XCEEC Not Endorsed	Radiation Dose Optimization: Images Available for Patient Follow-up and Comparison Purposes	Physician Compare: Do Not Support VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA supports MAP's conclusion. Public comment from AdvaMed does not support MAP's conclusion, noting that evidence supports this measure.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCEED Not Endorsed	Radiation Dose Optimization: Reporting to a Radiation Dose Index Registry	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA supports MAP's conclusion. Public comment from AdvaMed does not support MAP's conclusion, noting evidence supports this measure.
XCMDL Not Endorsed	Screening Colonoscopy Adenoma Detection Rate Measure	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from ASGE does not support MAP's conclusion, noting the measure is associated with better outcomes and would provide valuable outcome information to inform consumer decisions and drive quality improvement.
0643 Endorsed	Cardiac Rehabilitation Patient Referral From an Outpatient Setting	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Outcome measures are preferred. Public comment from ACC does not support MAP's conclusion, noting the measure is evidence-based, patient-centered, and designed to evaluate adherence to clinical practice guidelines.
XCCHH Not Endorsed	Closing the referral loop: receipt of specialist report	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Measure addresses transfer of information between providers.
0645 Not Endorsed	Biopsy Follow-up	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	
XCMLH Not Endorsed	Acute Composite: Acute Composite (1 of 3): Bacterial pneumonia Acute Composite (2 of 3): UTI Acute Composite (3 of 3): Dehydration	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	This measure should be tested for use at the individual clinician level of analysis.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCMMB Not Endorsed	Chronic Composite (See 2 individual measures AND 1 composite measure consisting of 4 additional individual measures below [Total of 7 measures] to define Chronic Composite)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	This measure should be tested for use at the individual clinician level of analysis.
0018 Endorsed	Controlling High Blood Pressure	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Included in a MAP family of measures. Provides consideration for healthcare disparities and cultural competency. Addresses program goals/ requirements.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting. Critically important outcome and population health measure.
0067 Endorsed	Chronic Stable Coronary Artery Disease: Antiplatelet Therapy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for other outcome measures that address coronary artery disease. Public comment from ACC does not support MAP's conclusion, noting that the measure is evidence-based, patient-centered, and designed to evaluate adherence to clinical practice guidelines.
0068 Endorsed	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public- and private-sector efforts. Included in a MAP family of measures. Address program goals/ requirements.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0070 Endorsed	Chronic Stable Coronary Artery Disease: Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for other outcome measures that address coronary artery disease. Public comment from ACC does not support MAP's conclusion, noting that the measure is evidence-based, patient-centered, and designed to evaluate adherence to clinical practice guidelines.
0074 Endorsed	Chronic Stable Coronary Artery Disease: Lipid Control	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for other outcome measures that address coronary artery disease.
0075 Endorsed	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100 mg/dL	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Address a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Included in a MAP family of measures. Addresses program goals/ requirements.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0081 Endorsed	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	Physician Compare: Support. VBPM: Support NQF-endorsed measure. Promotes person- and family-centered care. Promotes alignment across programs, settings, and public- and private-sector efforts. Provides consideration for healthcare disparities and cultural competency. Included in a MAP family of measures. Addresses program goals/ requirements.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting. Public comment from ACC supports MAP's conclusion.
0083 Endorsed	Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes person- and family-centered care. Promotes alignment across programs, settings, and public- and private-sector efforts. Included in a MAP family of measures. Addresses program goals/ requirements.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting. Public comment from ACC supports MAP's conclusion.
XCCHE Not Endorsed	Hypertension: Improvement in Blood Pressure	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Measure goes beyond existing NQF-endorsed measures (e.g., blood pressure control) to assess change over time.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCCHF Not Endorsed	Preventive Care and Screening: Screening for High Blood Pressure and Follow up Documented	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	
XCCHG Not Endorsed	Functional status assessment for complex chronic conditions	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Functional status is a priority gap; however, outcome measures are preferred. Public comment from CAPC does not support MAP's conclusion, noting that in the absence of available outcome measures, this measure remains extremely valuable for improving care for this high-risk, high need population.
0057 Endorsed	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for other outcome measures.
0063 Endorsed	Comprehensive Diabetes Care: LDL-C Screening	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for other outcome measures.
0066 Endorsed	Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes person- and family-centered care. Promotes alignment across programs, settings, and public- and private-sector efforts. Included in a MAP family of measures. Addresses program goals/ requirements.	Public comment from ACC supports MAP's conclusion.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0076 Endorsed	Optimal Vascular Care	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	
0079 Endorsed	Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0090 Endorsed	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for outcome measures that assess care for cardiovascular conditions.
0092 Endorsed	Emergency Medicine: Aspirin at Arrival for Acute Myocardial Infarction (AMI)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for outcome measures that assess care for cardiovascular conditions.
0093 Endorsed	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for outcome measures that assess care for cardiovascular conditions.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0543 Endorsed	Adherence to Statin Therapy for Individuals with Coronary Artery Disease	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Workgroup expressed implementation concerns regarding the ability to obtain pharmacy data. Measure is duplicative of measure NQF #0074 and is not consistent with newly released guidelines.
1525 Endorsed	Chronic Anticoagulation Therapy	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public- and private-sector efforts. Promotes person- and family-centered care. Included in a MAP family of measures. Addresses program goals/ requirements.	Public comment from ACC supports MAP's conclusion.
XBADD Not Endorsed	242 Coronary Artery Disease (CAD): Symptom Management	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from ACC does not support MAP's conclusion, noting that the measure is evidence-based, patient-centered, and designed to evaluate adherence to clinical practice guidelines.
XBCEL Not Endorsed	228 GPRO HF-2 Heart Failure (HF): Left Ventricular Function (LVF) Testing	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Duplicative of measure NQF# 0079.
XBLHB Not Endorsed	295 Hypertension: Appropriate Use of Aspirin or Other Anti-Platelet or Anti-Coagulant Therapy	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Other NQF-endorsed measures address hypertension; however, this measure is used in the ABIM MOC program, promoting alignment with the private sector. MAP recommends that if possible the same measure be used across the private- and public-sector programs.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBLHC Not Endorsed	296 Hypertension: Complete Lipid Profile	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Other NQF-endorsed measures address hypertension; however, this measure is used in the ABIM MOC program, promoting alignment with the private sector. MAP recommends that if possible the same measure be used across the private- and public-sector programs.
XBLHD Not Endorsed	297 Hypertension: Urine Protein Test	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Other NQF-endorsed measures address hypertension; however, this measure is used in the ABIM MOC program, promoting alignment with the private sector. MAP recommends that if possible the same measure be used across the private and public sector programs. Public comment from NKF does not support MAP's conclusion, noting that this would improve detecting CKD in patients that are at high risk.
XBLHE Not Endorsed	298 Hypertension: Annual Serum Creatinine Test	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Other NQF-endorsed measures address hypertension; however, this measure is used in the ABIM MOC program, promoting alignment with the private sector. MAP recommends that if possible the same measure be used across the private- and public-sector programs. Public comment from NKF does not support MAP's conclusion, noting that this would improve detecting CKD in patients that are at high risk.
XBLHG Not Endorsed	302 Hypertension: Dietary and Physical Activity Modifications Appropriately Prescribed	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Other NQF-endorsed measures address hypertension; however, this measure is used in the ABIM MOC program, promoting alignment with the private sector. MAP recommends that if possible the same measure be used across the private- and public-sector programs

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBLHH Not Endorsed	300 Hypertension: Blood Pressure Control	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Other NQF-endorsed measures address hypertension; however, this measure is used in the ABIM MOC program, promoting alignment with the private sector. MAP recommends that if possible the same measure be used across the private- and public-sector programs.
XBLHL Not Endorsed	301 Hypertension: Low Density Lipoprotein (LDL-C) Control	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Other NQF-endorsed measures address hypertension; however, this measure is used in the ABIM MOC program, promoting alignment with the private sector. MAP recommends that if possible the same measure be used across the private- and public-sector programs.
XCEBC Not Endorsed	299 Hypertension: Diabetes Mellitus Screening Test	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCEDG Not Endorsed	Preventive Cardiology Composite	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCMLG Not Endorsed	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Remove from PQRS unless the only reportable measure for specialty professionals, and if so, phased removal. It is not evidence-based, nor patient-centered, and is too complicated to measure reliably. Other NQF-endorsed measures in the program address atrial fibrillation.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public- and private-sector efforts Provides consideration for healthcare disparities and cultural competency. Included in a MAP family of measures. Addresses program goals/ requirements.	Measure does not account for readiness of patient to engage in care.
0028 Endorsed	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public- and private-sector efforts. Provides consideration for healthcare disparities and cultural competency. Included in a MAP family of measures. Addresses program goals/ requirements	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting. Measure will provide a greater understanding of the existence of any health disparities in this population.
0055 Endorsed	Comprehensive Diabetes Care: Eye Exam	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for composites that assess care for diabetes and measures that may reveal health disparities. Public comment from AOA does not support MAP's conclusion, noting that the measure addresses a high-risk population and a critical gap in eye care.
0056 Endorsed	Diabetes: Foot exam	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for composites that assess care for diabetes and measures that may reveal health disparities.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0059 Endorsed	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Physician Compare: Do Not Support. VBPM: Do Not Support Measure does not adequately address any current needs of the program.	Preference for A1c good control.
0062 Endorsed	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for composites that assess care for diabetes and measures that may reveal health disparities.
0064 Endorsed	Comprehensive Diabetes Care: LDL-C Control <100 mg/dL	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Address a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements. Included in a MAP family of measures.	
0088 Endorsed	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for outcome-oriented measures that assess care for diabetes. Public comments from AAO, AOA, and AMA do not support MAP's conclusion. AAO notes the measure addresses a current gap in care, promotes delivery of efficacious care, and leads to cost savings to the health care system. AMA notes, removal of this eCQM from PQRS would result in a lack of alignment between PQRS and MU.
0089 Endorsed	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for composites that assess care for diabetes and measures that may reveal health disparities. Public comments from AAO and AOA do not support MAP's conclusion, noting the measure addresses a current gap in care and promotes delivery of efficacious care.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0259 Not Endorsed	Hemodialysis Vascular Access Decisionmaking by surgeon to Maximize Placement of Autogenous Arterial Venous Fistula	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0321 Endorsed	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set.	
0323 Endorsed	Adult Kidney Disease: Hemodialysis Adequacy: Solute	Physician Compare: Support. VBPM: Support. NQF-endorsed measure Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	
0416 Endorsed Time-Limited	Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	The measure set includes other outcome measures addressing this condition.
0417 Endorsed Time-Limited	Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Preference for outcome-oriented measures that assess care for diabetes.
0583 Endorsed	Dyslipidemia new med 12-week lipid test	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for other measures that assesses dyslipidemia.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0729 Endorsed	Optimal Diabetes Care	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector programs. Addresses program goals/ requirements. Promotes parsimony. Included in a MAP family of measures.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting.
1667 Endorsed	(Pediatric) ESRD Patients Receiving Dialysis: Hemoglobin Level <10g/dL	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	Measure will provide a greater understanding of the existence of any health disparities in this population (e.g., access to care, insurance status, etc.).
N/A Not Endorsed	Renal Physician's Association/American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement : Adult Kidney Disease: Catheter Use for greater than or equal to 90 Days	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Measure does not include situations where patient may decline for palliative care concerns. Public comment from NKF does not support MAP's conclusion, noting that the measure is designed to protect hemodialysis patients from infections and increased clot formation related to catheters.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not Endorsed	Renal Physician's Association/American Society of Pediatric Nephrology/ Physician Consortium for Performance Improvement: Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis access is a catheter at the time maintenance hemodialysis is initiated	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	There is a concern about the possibility of unfairly penalizing providers who get a higher percentage of ESRD patients after acute kidney injury (AKI) than others who get a higher percentage of ESRD patients due to CKD. Potential small numbers issue. Public comment from NKF does not support MAP's conclusion, noting that the measure is designed to protect hemodialysis patients from infections and increased clot formation related to catheters.
XABLM Not Endorsed	121 Adult Kidney Disease: Laboratory Testing (Lipid Profile)	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program. A finalized measure addresses a similar topic and better addresses the needs of the program.	Likely to be redundant as many patients with CKD will have HTN, diabetes or CAD, and other measures address lipid testing in these patients. Public comments from RPA and NKF do not support MAP's conclusion. RPA notes that this measure is a NQF-endorsed measure #1668. .
1633 Not Endorsed	122 Adult Kidney Disease (CKD): Blood Pressure Management	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Should explore if existing NQF-endorsed measures addressing blood pressure management can be expanded to include the ESRD population. Need a more robust measure that assesses BP management for DM, ESRD, CHF, etc.
XACCH Not Endorsed	123 Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Should explore if existing NQF-endorsed measures addressing A1c control can be expanded to include the ESRD population.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XACHC Not Endorsed	173 Preventive Care and Screening: Unhealthy Alcohol Use Screening	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for other, more inclusive, screening measures for unhealthy alcohol use. Public comment from AMA supports MAP's conclusion and suggests a measure currently under review by NQF (NQF #2152) for endorsement as a replacement.
XBACM Not Endorsed	248 Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBHMF Not Endorsed	316 Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed AND Risk-Stratified Fasting LDL	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Preference for other LDL screening measures.
XCBED Not Endorsed	247 Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	12 month timeframe is insufficient for alcohol abuse and counseling.
XCFCM Not Endorsed	Pediatric Kidney Disease: Adequacy of Volume Management	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0002 Endorsed	Appropriate Testing for Children With Pharyngitis	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements. Included in a MAP family.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0086 Endorsed	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from the AAO does not support MAP's conclusion, noting that the measure addresses a current gap in care and promotes delivery of efficacious care.
0564 Endorsed Time-Limited	Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	
0565 Endorsed Time-Limited	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	
1335 Endorsed	Children Who Have Dental Decay or Cavities	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
1419 Endorsed Time-Limited	Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0087 Endorsed	Age-Related Macular Degeneration: Dilated Macular Examination	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from AAO does not support MAP's conclusion, noting that the measure addresses a current gap in care and promotes delivery of efficacious care.
0563 Endorsed Time-Limited	Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comments from AAO, AOA and AMA do not support MAP's conclusion. AAO notes the measure addresses a current gap in care and promotes delivery of efficacious care. AMA notes the measure was developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes.
0566 Endorsed Time-Limited	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comments from AAO, AOA, and AMA do not support MAP's conclusion AAO notes that the measure addresses a current gap in care, promotes delivery of efficacious care, and leads to cost savings to the health care system. AMA notes the measure was developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes.
0653 Endorsed Time-Limited	Acute Otitis Externa: Topical therapy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0654 Endorsed Time-Limited	Acute Otitis Externa: Systemic antimicrobial therapy – Avoidance of inappropriate use	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across program, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	This measure should be expanded to include NQF #655, #656, and #657
1536 Endorsed	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, and settings. Addresses program goals/ requirements.	
XBAAG Not Endorsed	304 Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from AAO does not support MAP's conclusion, noting that this measure will address a gap in care and promote patient participation and patient- and family-centered care.
XBALA Not Endorsed	261 Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBALE Not Endorsed	269 Inflammatory Bowel Disease (IBD): Type, Anatomic Location and Activity All Documented	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBALF Not Endorsed	270 Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Sparing Therapy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBALG Not Endorsed	271 Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBALH Not Endorsed	272 Inflammatory Bowel Disease (IBD): Preventive Care: Influenza Immunization	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Prefer use of broader vaccination measures rather than condition-specific vaccination measures.
XBALL Not Endorsed	273 Inflammatory Bowel Disease (IBD): Preventive Care: Pneumococcal Immunization	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Prefer use of broader vaccination measures rather than condition-specific vaccination measures.
XBALM Not Endorsed	274 Inflammatory Bowel Disease (IBD): Screening for Latent TB Before Initiating Anti-TNF Therapy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBAMA Not Endorsed	275 Inflammatory Bowel Disease (IBD): Hepatitis B Assessment Before Initiating Anti-TNF Therapy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0403 Not Endorsed	HIV / AIDS: Medical Visit	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0033 Endorsed	Chlamydia screening in women	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public- and private-sector efforts Addresses program goals/ requirements.	
0038 Endorsed	Childhood Immunization Status	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a population not represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	
0041 Endorsed	Influenza Immunization	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public- and private-sector efforts. Provides consideration for healthcare disparities and cultural competency. Addresses program goals/ requirements.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0043 Endorsed	Pneumonia vaccination status for older adults	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public and private sector efforts. Provides consideration for healthcare disparities and cultural competency. Included in a MAP family. Addresses program goals/ requirements.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting.
0393 Endorsed	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from the Armstrong Institute supports MAP's conclusion but notes that requiring dialysis facilities to measure HCV RNA in a patient with known HCV may lead to additional tests without impacting patient care.
0395 Endorsed	Paired Measure: Hepatitis C Ribonucleic Acid (RNA) Testing Before Initiating Treatment (paired with 0396)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0396 Endorsed	Paired Measure: HCV Genotype Testing Prior to Treatment (paired with 0395)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0398 Endorsed	Hepatitis C: HCV RNA Testing at No Greater Than Week 12 of Treatment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0399 Endorsed	Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Potential issue with retaining measure since it is paired with NQF #0400, which has lost endorsement and is not recommended to be retained.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0404 Endorsed	HIV/AIDS: CD4 Cell Count or Percentage Performed	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0405 Endorsed	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Physician Compare: Do Not Support. VBPM: Do Not Support Measure does not adequately address any current needs of the program.	
0409 Endorsed	HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
2079 Endorsed	HIV medical visit frequency	MU-EP: Support. Physician Compare: Do Not Support. VBPM: Do Not Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Measure does not adequately address any current needs of the program.	Prefer outcome measures for use in Physician Compare and VBPM. Public comment from the Armstrong Institute seeks clarification on the measure specifications.
2080 Endorsed	Gap in HIV medical visits	MU-EP: Support. Physician Compare: Do Not Support. VBPM: Do Not Support. NQF-endorsed measure Addresses a measure type not adequately represented in the program measure set. Measure does not adequately address any current needs of the program.	Prefer outcome measures for use in Physician Compare and VBPM. Public comment from the Armstrong Institute seeks clarification on the measure specifications.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
2082 Endorsed	HIV viral load suppression	MU-EP: Support. Physician Compare: Do Not Support. VBPM: Do Not Support NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Measure does not adequately address any current needs of the program.	Prefer outcome measures for use in Physician Compare and VBPM. Public comment from the Armstrong Institute notes that patients starting ART should be willing and able to commit to treatment and understand the benefits and risks of therapy and the importance of adherence.
2083 Endorsed	Prescription of HIV Antiretroviral Therapy	MU-EP: Support. Physician Compare: Do Not Support. VBPM: Do Not Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Measure does not adequately address any current needs of the program.	Prefer outcome measures for use in Physician Compare and VBPM. Public comment from the Armstrong Institute notes that patients starting ART should be willing and able to commit to treatment and understand the benefits and risks of therapy and the importance of adherence.
0045 Endorsed	Osteoporosis: Communication with the Physician Managing On-going Care Post Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes person- and family-centered care. Addresses program goals/ requirements.	
0046 Endorsed	Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA does not support MAP's conclusion.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0048 Endorsed	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes person- and family-centered care. Promotes alignment across program, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	Encourages communication and care coordination.
0049 Endorsed	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0050 Endorsed	Osteoarthritis: Function and Pain Assessment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0051 Endorsed	Osteoarthritis (OA): Assessment for use of anti-inflammatory or analgesic over-the-counter (OTC) medications	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0053 Endorsed	Osteoporosis Management in Women Who Had a Fracture	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0054 Endorsed	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes alignment across program, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	Public comment from ACR supports MAP's conclusion.
0313 Endorsed	Back Pain: Advice Against Bed Rest	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0314 Endorsed	Back Pain: Advice for Normal Activities	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0319 Endorsed	Back Pain: Physical Exam	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Low-bar process measure as it assesses if a physical exam is conducted for patients experiencing back pain.
0322 Endorsed	Back Pain: Initial Visit	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0422 Endorsed	Functional status change for patients with knee impairments	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	Consider whether functional status assessment measures could be combined into a composite.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0423 Endorsed	Functional status change for patients with hip impairments	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across program, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	Consider whether functional status assessment measures could be combined into a composite.
0424 Endorsed	Functional status change for patients with foot/ankle impairments	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	Consider whether functional status assessment measures could be combined into a composite.
0425 Endorsed	Functional status change for patients with lumbar spine impairments	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	Consider whether functional status assessment measures could be combined into a composite.
0426 Endorsed	Functional status change for patients with shoulder impairments	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	Consider whether functional status assessment measures could be combined into a composite.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0427 Endorsed	Functional status change for patients with elbow, wrist or hand impairments	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	Consider whether functional status assessment measures could be combined into a composite.
0428 Endorsed	Functional status change for patients with general orthopedic impairments	Physician Compare: Support. VBPM: Support. NQF-endorsed measure Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	Consider whether functional status assessment measures could be combined into a composite.
XACHF Not Endorsed	176 Rheumatoid Arthritis (RA): Tuberculosis Screening	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XACHG Not Endorsed	177 Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XACHH Not Endorsed	178 Rheumatoid Arthritis (RA): Functional Status Assessment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XACHL Not Endorsed	179 Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XACHM Not Endorsed	180 Rheumatoid Arthritis (RA): Glucocorticoid Management	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XACLB Not Endorsed	182 Functional Outcome Assessment in Chiropractic Care	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCCHB Not Endorsed	Functional Status assessment for knee replacement	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. An endorsed measure addresses a similar topic and better addresses the needs of the program.	NQF-endorsed measure 0422 captures functional status change for knee impairments.
XCCHC Not Endorsed	Functional Status assessment for hip replacement	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. An endorsed measure addresses a similar topic and better addresses the needs of the program.	NQF-endorsed measure 0423 captures functional status change for hip impairments.
XCMFB Not Endorsed	Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Workgroup has previously suggested expanding the measure to all patients on a biological immune response modifier.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0240 Endorsed	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis (DVT) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Measure may be topped out; if so, it should be removed from the PQRS program. Public comment from AMA does not support MAP's conclusion, noting the measure was developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes.
0241 Endorsed	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0243 Endorsed	Stroke and Stroke Rehabilitation: Screening for Dysphagia	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0244 Endorsed	Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0325 Endorsed	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference should be given to outcome measures that address adherence to medications as opposed to measures that just assess whether a medication was prescribed. The measure set already includes outcome measures addressing this condition. Public comment from AMA does not support MAP's conclusion, noting the measure was developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes.
0437 Endorsed	STK 04: Thrombolytic Therapy	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family. Promotes alignment across programs, settings, and public- and private-sector programs. Addresses program goals/ requirements.	
XBAEA Not Endorsed	280 Dementia: Staging of Dementia	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	XBAEA, XBAEB, and XBAEC should be explored for combining into a composite. Public comment from MITA supports MAP's conclusion.
XBAEB Not Endorsed	281 Dementia: Cognitive Assessment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	XBAEA, XBAEB, and XBAEC should be explored for combining into a composite. Public comment from MITA supports MAP's conclusion.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBAEC Not Endorsed	282 Dementia: Functional Status Assessment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	XBAEA, XBAEB, and XBAEC should be explored for combining into a composite. Public comment from MITA supports MAP's conclusion.
XBAED Not Endorsed	283 Dementia: Neuropsychiatric Symptom Assessment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	XBAED and XBAEE should be explored for combining into a composite. Public comment from MITA supports MAP's conclusion.
XBAEE Not Endorsed	284 Dementia: Management of Neuropsychiatric Symptoms	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	XBAED and XBAEE should be explored for combining into a composite. Public comment from MITA supports MAP's conclusion.
XBAEF Not Endorsed	285 Dementia: Screening for Depressive Symptoms	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBAEG Not Endorsed	286 Dementia: Counseling Regarding Safety Concerns	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	XBAEG and XBAEH should be explored for combining into a composite.
XBAEH Not Endorsed	287 Dementia: Counseling Regarding Risks of Driving	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	XBAEG and XBAEH should be explored for combining into a composite.
XBAEM Not Endorsed	288 Dementia: Caregiver Education and Support	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBDLA Not Endorsed	266 Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBDLB Not Endorsed	267 Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	MAP has previously recommended that this measure be removed from the program.
XBDLH Not Endorsed	268: Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBLAH Not Endorsed	289 Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBLAL Not Endorsed	290 Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBLAM Not Endorsed	291 Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBLBA Not Endorsed	292 Parkinson's Disease: Querying about Sleep Disturbances	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBLBB Not Endorsed	293 Parkinson's Disease: Rehabilitative Therapy Options	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	MAP has previously recommended that this measure be removed from the program.
XBLBD Not Endorsed	294 Parkinson's Disease: Medical and Surgical Treatment Options Reviewed	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0024 Endorsed	Weight Assessment and Counseling for Nutrition and Physical Activity for Children / Adolescents	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a population not represented in the program measure set. Included in a MAP family of measures. Promotes alignment across programs, settings, and public- and private-sector efforts Addresses program goals/ requirements.	
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family of measures. Provides consideration for healthcare disparities and cultural competency. Addresses program goals/ requirements.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not Endorsed	Bariatric Lap Band Procedure 2: Unplanned reoperation within the 30 day postoperative period (2 of 3 Measures Group: Bariatric lap Band Procedure)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	All bariatric lap band measures should be explored for combining into a composite measure. Public comment from ACS does not support MAP's conclusion, noting that the measure represents some of the most common procedure performed in the United States, is clinically relevant, and has been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP).
N/A Not Endorsed	Bariatric Lap Band Procedure 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 3 Measures Group: Bariatric lap Band Procedure)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	All bariatric lap band measures should be explored for combining into a composite measure. Public comment from ACS does not support MAP's conclusion, noting that the measure represents some of the most common procedure performed in the United States, is clinically relevant, and has been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP).
N/A Not Endorsed	Bariatric Sleeve Gastrectomy 3: Unplanned reoperation within the 30 day postoperative period (3of 6 Measures Group: Bariatric Sleeve Gastrectomy)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	All bariatric lap band measures should be explored for combining into a composite measure. Public comment from ACS does not support MAP's conclusion, noting that the measure represents some of the most common procedure performed in the United States, is clinically relevant, and has been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP).

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not Endorsed	Bariatric Sleeve Gastrectomy 4: Unplanned hospital readmission within 30 days of principal procedure (4of 6 Measures Group: Bariatric Sleeve Gastrectomy)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	All bariatric lap band measures should be explored for combining into a composite measure. Public comment from ACS does not support MAP's conclusion, noting that the measure represents some of the most common procedure performed in the United States, is clinically relevant, and has been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP).
N/A Not Endorsed	Bariatric Sleeve Gastrectomy 5: Surgical site infection (SSI) (5 of 6 Measures Group: Bariatric Sleeve Gastrectomy)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	All bariatric lap band measures should be explored for combining into a composite measure. Public comment from ACS does not support MAP's conclusion, noting that the measure represents some of the most common procedure performed in the United States, is clinically relevant, and has been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP).
XCLCM Not Endorsed	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 1: Anastomotic Leak Intervention (1 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	All bariatric lap band measures should be explored for combining into a composite measure. Public comment from ACS does not support MAP's conclusion, noting that the measure represents some of the most common procedure performed in the United States, is clinically relevant, and has been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP).

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCLDB Not Endorsed	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 3: Unplanned reoperation within the 30 day postoperative period (3 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	All bariatric lap band measures should be explored for combining into a composite measure. Public comment from ACS does not support MAP's conclusion, noting that the measure represents some of the most common procedure performed in the United States, is clinically relevant, and has been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP).
XCLDC Not Endorsed	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	All bariatric lap band measures should be explored for combining into a composite measure. Public comment from ACS does not support MAP's conclusion, noting that the measure represents some of the most common procedure performed in the United States, is clinically relevant, and has been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP).
XCLDD Not Endorsed	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 5: Surgical site infection (SSI) (5 of 6 Measures Group: Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	All bariatric lap band measures should be explored for combining into a composite measure. Public comment from ACS does not support MAP's conclusion, noting that the measure represents some of the most common procedure performed in the United States, is clinically relevant, and has been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP).
D0608 Not Endorsed	Pregnant women that had HBsAg testing.	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	Preference for "ACOG/NCQA/AMA-PCPI: Maternity Care: Prenatal Care Screening" measure.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0651 Endorsed Time-Limited	Ultrasound determination of pregnancy location for pregnant patients with abdominal pain.	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA supports MAP's conclusion if NQF endorsement is withdrawn.
0652 Endorsed Time-Limited	Rh immunoglobulin (Rhogam) for Rh negative pregnant women at risk of fetal blood exposure.	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
N/A Not Endorsed	ACOG/NCQA/ AMA-PCPI: Maternity Care: Prenatal Care Screening	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCHML Not Endorsed	ACOG/NCQA/ AMA-PCPI: Maternity Care: Elective Delivery or Early Induction Without Medical Indication at >=37 and < 39 weeks (overuse)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCLAB Not Endorsed	ACOG/NCQA/ AMA-PCPI: Maternity Care: Post-Partum Follow-Up and Care Coordination	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0104 Endorsed	Major Depressive Disorder (MDD): Suicide Risk Assessment	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for other outcome measures that assess care for depression and/ or process measures more proximal to outcome that include an engagement and follow-up component. Public comment from AMA does not support MAP's conclusion, noting that since the PQRS and Meaningful Use (MU) programs share measures sets, the removal of this eCQM from PQRS would result in a lack of alignment between PQRS and MU.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0105 Endorsed	Antidepressant Medication Management	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for outcome measures related to antidepressant medication management.
0108 Endorsed	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Process measure, preference for outcome measure that focuses less on frequency of visits.
0110 Endorsed	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. An endorsed measure addresses a similar topic and better addresses the needs of the program.	Workgroup has previously suggested outcome measures addressing depression (e.g., NQF #0710 Depression Remission, NQF #0712 Depression Utilization, PHQ-9 Tool).
0418 Endorsed	Screening for Clinical Depression	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family of measures. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0710 Endorsed	Depression Remission at Twelve Months	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Included in a MAP family of measures. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	
0712 Endorsed	Depression Utilization of the PHQ-9 Tool	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Included in a MAP family of measures. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	
1365 Endorsed	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for outcome measures.
1401 Endorsed	Maternal Depression Screening	Physician Compare: Support. VBPM: Support. NQF-endorsed measure Addresses a population not represented in the program measure set. Addresses program goals/ requirements.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0103 Endorsed	Major Depressive Disorder (MDD): Diagnostic Evaluation	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for other outcome measures that assess care for depression and/or process measures more proximal to outcome that include an engagement and follow-up component. Public comment from AMA does not support MAP's conclusion, noting the measure was developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes.
0576 Endorsed	Follow-Up After Hospitalization for Mental Illness	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family of measures. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/requirements.	NQF-endorsed measure that was previously supported by Workgroup for inclusion in Physician Compare and VBPM for clinician group reporting.
XCFAM Not Endorsed	Adult Major Depressive Disorder: Coordination of Care of Patients with Comorbid Conditions	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0001 Not Endorsed	Asthma: Assessment of Asthma Control	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. A "Supported" measure under consideration addresses a similar topic and better addresses the needs of the program.	Recommend replacing this measure with the Minnesota Community Measurement measure of Optimal Asthma Care that includes a PRO addressing patient-achieved asthma control. Public comment from AMA does not support MAP's conclusion, noting the measure was developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes.
0036 Endorsed	Use of appropriate medications for people with asthma	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Measure previously was not supported by the workgroup for inclusion in Physician Compare and VBPM.
0047 Endorsed	Asthma: Pharmacologic Therapy for Persistent Asthma	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Measure previously was not supported by Workgroup for inclusion in Physician Compare and VBPM.
0069 Endorsed	Appropriate treatment for children with upper respiratory infection (URI)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0232 Not Endorsed	Vital Signs for Community-Acquired Bacterial Pneumonia	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	Public comment from AMA does not support MAP's conclusion, noting the measure was developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0058 Endorsed	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not represented in the program measure set. Included in a MAP family of measures. Addresses program goals/ requirements.	
0091 Endorsed	COPD: spirometry evaluation	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	This measure and NQF #0577 are duplicative; one measure should be considered for removal.
0096 Endorsed	Empiric Antibiotic for Community-Acquired Bacterial Pneumonia	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for outcome measure that contains a follow-up or care management component for Physician Compare and VBPM.
0102 Endorsed	COPD: inhaled bronchodilator therapy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	The measure was not previously supported by the workgroup for inclusion in Physician Compare and VBPM.
0147 Endorsed	Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0577 Endorsed	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	The measure was not previously supported by the workgroup for inclusion in Physician Compare and VBPM. This measure and NQF #0091 are duplicative; one measure should be considered for removal.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBAHG Not Endorsed	276 Sleep Apnea: Assessment of Sleep Symptoms	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBAHH Not Endorsed	277 Sleep Apnea: Severity Assessment at Initial Diagnosis	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBAHL Not Endorsed	278 Sleep Apnea: Positive Airway Pressure Therapy Prescribed	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBAHM Not Endorsed	279 Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBCEM Not Endorsed	231 Asthma: Tobacco Use Screening - Ambulatory Care Setting	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for outcome measures that address patient engagement and management in tobacco cessation programs for Physician Compare and VBPM.
XBCFA Not Endorsed	232 Asthma: Tobacco Use Intervention - Ambulatory Care Setting	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Preference for outcome measures that address patient engagement and management in tobacco cessation programs for Physician Compare and VBPM.
XCEBF Not Endorsed	AAO- HNS/AMA-PCPI: Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCEBG Not Endorsed	AAO- HNS/AMA-PCPI: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Acute Bacterial Sinusitis (Appropriate Use)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Explore combining XCEBG and XCEBL into a composite.
XCEBL Not Endorsed	AAO- HNS/AMA-PCPI: Adult Sinusitis: Computerized Tomography for Acute Sinusitis (overuse)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Explore combining XCEBG and XCEBL into a composite.
XCEBM Not Endorsed	AAO- HNS/AMA- PCPI: Adult Sinusitis: More than 1 Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0022 Endorsed	Use of High Risk Medications in the Elderly	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family of measures. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	Measure previously supported by Workgroup for inclusion in Physician Compare and VBPM. Public comment from AmeriHealth Caritas supports MAP's conclusion and cautions that the measure must be monitored for unintended consequences. Public comment from AHIP does not support MAP's conclusion, noting the measure may result in unintended consequences.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0101 Endorsed Time-Limited	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family of measures. Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	The measure was previously supported for inclusion in Physician Compare and VBPM.
0419 Endorsed	Documentation of Current Medications in the Medical Record	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family of measures. Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0097 Endorsed	Medication Reconciliation	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family of measures. Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries. Promotes person- and family-centered care. Promotes alignment across programs, settings, and public- and private-sector efforts. Addresses program goals/ requirements.	Measure previously supported by the Clinician workgroup for inclusion in Physician Compare and VBPM.
0098 Not Endorsed	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0099 Not Endorsed	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0100 Not Endorsed	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0209 Endorsed	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type and condition not represented in the program measure set. Included in a MAP family of measures. Address program goals/ requirements.	
0326 Endorsed	Advance Care Plan	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family of measures. Provides consideration for healthcare disparities and cultural competency. Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries. Addresses program goals/ requirements.	
0420 Endorsed	Pain Assessment and Follow-Up	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type and condition not represented in the program measure set. Included in a MAP family of measures. Provides consideration for healthcare disparities and cultural competency. Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries. Addresses program goals/ requirements.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0464 Endorsed Time-Limited	Anesthesiology and Critical Care: Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC) Insertion Protocol	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0486 Endorsed	Adoption of Medication e-Prescribing	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts. Included in a MAP family of measures Addresses program goals/ requirements	Although a structure measure, the measure is included in several MAP families, is reportable through various options, and promotes alignment between federal and private-sector programs. Measure documents important structure for efficiency and patient safety. This information would be useful to purchasers and consumers.
0555 Endorsed	Lack of Monthly INR Monitoring for Individuals on Warfarin	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	The workgroup has previously not supported this measure for inclusion in the Physician Compare and VBPM, preferring outcome measures.
XACLA Not Endorsed	181 Elder Maltreatment Screen and Follow-Up Plan	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBACA Not Endorsed	245 Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (overuse measure)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBACB Not Endorsed	246 Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (overuse measure)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCECF Not Endorsed	Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Low-bar process measure as it only assesses documentation of use of a device.
0114 Endorsed	Risk-Adjusted Post-operative Renal Failure	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.
0115 Endorsed	Risk-Adjusted Surgical Re-exploration	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.
0116 Endorsed	Anti-Platelet Medication at Discharge.	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.
0117 Endorsed	Beta Blockade at Discharge	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.
0118 Endorsed	Anti-Lipid Treatment Discharge	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0129 Endorsed	Risk-Adjusted Prolonged Intubation (Ventilation)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.
0130 Endorsed	Risk-Adjusted Deep Sternal Wound Infection Rate	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.
0131 Endorsed	Risk-Adjusted Stroke/ Cerebrovascular Accident	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.
0134 Endorsed	Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.
0236 Endorsed	Pre-op beta blocker in patient with isolated CABG (2)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	A composite of CABG measures is preferred.
0458 Endorsed	Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0637 Endorsed Time-Limited	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from AANS/CNS does not support MAP's conclusion, noting that the perioperative measure set is one of the most meaningful and relevant measures available to many surgeons.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
1534 Endorsed	In-hospital mortality following elective EVAR of AAAs	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	This is a rare procedure and may have small number issues.
1540 Endorsed	Postoperative Stroke or Death in Asymptomatic Patients undergoing Carotid Endarterectomy	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	The measure captures important information for patient decisionmaking.
1543 Endorsed	Postoperative Stroke or Death in Asymptomatic Patients undergoing Carotid Artery Stenting (CAS)	Physician Compare: Support VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Addresses program goals/ requirements.	The measure captures important information for patient decisionmaking.
XBAHC Not Endorsed	257 Statin Therapy at Discharge after Lower Extremity Bypass (LEB)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBAHD Not Endorsed	258 Rate of Open Elective Repair of Small or Moderate Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day 7)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBAHE Not Endorsed	259 Rate of Elective Endovascular Aortic Repair (EVAR) of Small or Moderate Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day 2)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XBAHF Not Endorsed	260 Rate of Carotid Endarterectomy for Asymptomatic Patients, without Major Complications (discharged to home no later than post-operative day 2)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCLMA Not Endorsed	HRS-3 Implantable Cardioverter-Defibrillator (ICD) Complications Rate.	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCMDA Not Endorsed	Rate of Major Complications (Discharged to Home by Post- Operative Day 2) Carotid Artery Stenting (CAS) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day 2	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0239 Endorsed Time-Limited	Venous Thromboembolism (VTE) Prophylaxis	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from ACS does not support MAP's conclusion, noting that the measure has been used in PQRS and has proven valid, reliable, and feasible.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0268 Endorsed Time-Limited	Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comments from AANS/CNS and ACS do not support MAP's conclusion, noting that the perioperative measure set is one of the most meaningful and relevant measures available to many surgeons.
0269 Endorsed Time-Limited	Timing of Prophylactic Antibiotics - Administering Physician	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0270 Endorsed Time-Limited	Perioperative Care: Timing of Prophylactic Parenteral Antibiotics – Ordering Physician	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comments from AANS/CNS and ACS do not support MAP's conclusion, noting that the perioperative measure set is one of the most meaningful and relevant measures available to many surgeons.
0271 Endorsed Time-Limited	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comments from AANS/CNS and ACS do not support MAP's conclusion, noting that the perioperative measure set is one of the most meaningful and relevant measures available to many surgeons.
0454 Endorsed Time-Limited	Anesthesiology and Critical Care: Perioperative Temperature Management	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
N/A Not Endorsed	Appendectomy 4: Surgical site infection (SSI) (4 of 4: Measures Group Appendectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related appendectomy measures.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not endorsed	Condition-specific per capita cost measures for COPD, diabetes, HF, and CAD	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement. Not ready for implementation; data sources do not align with program's data sources.	Further development should explore how to address individuals with multiple chronic conditions.
N/A Not endorsed	Total Per Capita Cost Measure	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement. Not ready for implementation; data sources do not align with program's data sources.	Measure was submitted for endorsement and was not endorsed. Further development should address risk-adjustment and attribution issues.
N/A Not Endorsed	Appendectomy 2: Unplanned reoperation within the 30 day postoperative period (2 of 4: Measures Group Appendectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related appendectomy measures.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not Endorsed	Appendectomy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Appendectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related appendectomy measures.
N/A Not Endorsed	AV Fistula 3: Unplanned reoperation within the 30 day postoperative period (3 of 5 Measures Group: AV Fistula)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related AV Fistula measures.
N/A Not Endorsed	AV Fistula 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 5 Measures Group: AV Fistula)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related AV Fistula measures.
N/A Not Endorsed	AV Fistula 5: Surgical site infection (SSI) (5 of 5 Measures Group: AV Fistula)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related AV Fistula measures.
N/A Not Endorsed	Cholecystectomy 1: Iatrogenic injury to adjacent organ/ structure (1 of 4: Measures Group Cholecystectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related cholecystectomy measures.
N/A Not Endorsed	Cholecystectomy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Cholecystectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related cholecystectomy measures.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not Endorsed	Cholecystectomy 4: Surgical site infection (SSI) (4 of 4: Measures Group Cholecystectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related cholecystectomy measures.
N/A Not Endorsed	Colectomy 1: Anastomotic Leak Intervention (1 of 6: Measures Group Colectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related colectomy measures. Public comment from ACS supports MAP's conclusion.
N/A Not Endorsed	Colectomy 4: Unplanned reoperation within the 30 day postoperative period (4 of 6: Measures Group Colectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related colectomy measures. Public comment from ACS supports MAP's conclusion.
N/A Not Endorsed	Colectomy 5: Unplanned hospital readmission within 30 days of principal procedure (5 of 6: Measures Group Colectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related colectomy measures. Public comment from ACS supports MAP's conclusion.
N/A Not Endorsed	Colectomy 6: Surgical site infection (SSI) (6 of 6: Measures Group Colectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related colectomy measures. Public comment from ACS supports MAP's conclusion.
N/A Not Endorsed	Hemorrhoidectomy 3: Unplanned reoperation within the 30 day postoperative period (3 of 4: Measures Group Hemorrhoidectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related hemorrhoidectomy measures.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not Endorsed	Hemorrhoidectomy 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 4: Measures Group Hemorrhoidectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related hemorrhoidectomy measures.
N/A Not Endorsed	Inguinal Hernia 2: Unplanned reoperation within the 30 day postoperative period (2 of 3) Measures Group Inguinal Hernia	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related inguinal hernia measures.
N/A Not Endorsed	Inguinal Hernia 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 3) Measures Group Inguinal Hernia	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related inguinal hernia measures.
N/A Not Endorsed	Mastectomy +/- Lymphadenectomy or SLNB 2: Unplanned reoperation within the 30 day postoperative period (2 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related mastectomy measures.
N/A Not Endorsed	Mastectomy +/- Lymphadenectomy or SLNB 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related mastectomy measures.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not Endorsed	Mastectomy +/- Lymphadenectomy or SLNB 4: Surgical site infection (SSI) (4 of 4: Measures Group Mastectomy +/- Lymphadenectomy or SLNB)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related mastectomy measures.
N/A Not Endorsed	Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB 2: Unplanned reoperation within the 30 day postoperative period (2 of 4: Measures Group Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related partial mastectomy measures.
N/A Not Endorsed	Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related partial mastectomy measures.
N/A Not Endorsed	Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB 4: Surgical site infection (SSI) (4 of 4: Measures Group Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related partial mastectomy measures.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not Endorsed	Skin / Soft Tissue Lesion Excision 2: Unplanned reoperation within the 30 day postoperative period (2 of 4: Measures Group Skin / Soft Tissue Lesion Excision)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related lesion excision measures.
N/A Not Endorsed	Skin / Soft Tissue Lesion Excision 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Skin / Soft Tissue Lesion Excision)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related lesion excision measures.
N/A Not Endorsed	Skin / Soft Tissue Lesion Excision 4: Surgical site infection (SSI) / wound dehiscence (4 of 4: Measures Group Skin / Soft Tissue Lesion Excision)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related lesion excision measures.
N/A Not Endorsed	Thyroidectomy 4: Unplanned reoperation within the 30 day postoperative period (4 of 5: Measures Group Thyroidectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related thyroidectomy measures.
N/A Not Endorsed	Thyroidectomy 5: Unplanned hospital readmission within 30 days of principal procedure (5 of 5: Measures Group Thyroidectomy)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related thyroidectomy measures.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
N/A Not Endorsed	Varicose veins 3: Surgical site infection (SSI) (3 of 3 : Measures Group Varicose Veins)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related varicose vein measures.
XCECH Not Endorsed	Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCECM Not Endorsed	Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCHLM Not Endorsed	Ventral Hernia 5: Surgical site infection (SSI) (1 of 5 : Measures Group Ventral Hernia)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related ventral hernia measures.
XCHMA Not Endorsed	Ventral Hernia 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 5 : Measures Group Ventral Hernia)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related ventral hernia measures.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCMBG Not Endorsed	Patient-centered Surgical Risk Assessment and Communication: the percent of patients who underwent non-emergency major surgery who received preoperative risk assessment for procedure-specific postoperative complications using a data-based, patient-specific risk calculator	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from ACS does not support MAP's conclusion.
XCMDM Not Endorsed	Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
XCMFM Not Endorsed	Ventral Hernia 3: Unplanned reoperation within the 30 day postoperative period (3 of 5 : Measures Group Ventral Hernia)	Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Could be included in Physician Compare and VBPM if it is made into a composite with other related ventral hernia measures.
0052 Endorsed	Use of Imaging Studies for Low Back Pain	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Included in a MAP family. Promotes alignment across programs, settings, and public and private sector efforts. Address program goals/ requirements.	Public comment from MITA supports MAP's conclusion.
0562 Endorsed	Overutilization of Imaging Studies in Melanoma	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Address program goals/ requirements.	Public comment from MITA supports MAP's conclusion.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0670 Endorsed	Cardiac stress imaging not meeting appropriate use criteria: Preoperative evaluation in low risk surgery patients	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts Included in a MAP family. Addresses program goals/ requirements.	Public comment from MITA supports MAP's conclusion.
0671 Endorsed	Cardiac stress imaging not meeting appropriate use criteria: Routine testing after percutaneous coronary intervention (PCI)	Physician Compare: Support. VBPM: Support: NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts Included in a MAP family. Addresses program goals/ requirements.	Public comment from MITA supports MAP's conclusion.
0672 Endorsed	Cardiac stress imaging not meeting appropriate use criteria: Testing in asymptomatic, low risk patients	Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts Included in a MAP family. Addresses program goals/ requirements.	Public comment from MITA supports MAP's conclusion.

TABLE A3. MAP INPUT ON FINALIZED PQRS MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0507 Endorsed	Stenosis measurement in carotid imaging studies	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA does not support MAP's conclusion.
0509 Endorsed	Reminder System for Mammograms	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	
0510 Endorsed	Exposure time reported for procedures using fluoroscopy	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA does not support MAP's conclusion.
N/A Not Endorsed	American Board of Radiology/American Board of Medical Specialties/American College of Radiology/ Physician Consortium for Performance Improvement: [DRAFT] Radiation Dose Optimization: Appropriateness: Follow-up CT Imaging for Incidental Pulmonary Nodules A	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA supports MAP's conclusion.
XBAMM Not Endorsed	262 Image Confirmation of Successful Excision of Image-Localized Breast Lesion	Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from MITA supports MAP's conclusion.
0511 Not Endorsed	Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	PQRS: Remove. Physician Compare: Do Not Support. VBPM: Do Not Support. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	Public comment from MITA supports MAP's conclusion.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
1741 Endorsed	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	PQRS: Support. MU-EP: Support. Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set.	Public comment from ACS supports MAP's conclusion. Public comment from AANS/CNS does not support MAP's conclusion, noting that the measure is burdensome.
XDFDB Not Endorsed	Head and Neck Cancer: Weight Loss Prevention	PQRS: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Other interventions that prevent weight loss, such as care management and shared decisionmaking, are better than achieving a 10% target which may not signal greater issues. Public comment from the Armstrong Institute supports MAP's conclusion.
XDFGL Not Endorsed	Repeat Colonoscopy due to poor bowel preparation	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comments from ASGE, MITA, and the Armstrong Institute support MAP's conclusion. The Armstrong Institute provides suggestions for modifying the measure specifications.
XDFGM Not Endorsed	Appropriate age for colorectal cancer screening colonoscopy	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	The age limits of this measure should align with the age limits of colorectal cancer screening measures in the program. This measure should cover ages above the screening measure. Public comments from ASGE and MITA support MAP's conclusion.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEDC Not Endorsed	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comments from the Armstrong Institute and MITA support MAP's conclusion.
XDEDD Not Endorsed	Draft: Breast Cancer Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comments from the Armstrong Institute and MITA support MAP's conclusion.
XDEDE Not Endorsed	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from MITA supports MAP's conclusion.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEDF Not Endorsed	Draft: Lung Cancer Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from MITA supports MAP's conclusion.
XDEDG Not Endorsed	Draft: Prostate Cancer Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from MITA supports MAP's conclusion. Public comment from the Armstrong Institute does not support MAP's conclusion, noting that the measure should be fully supported.
XDEDH Not Endorsed	Draft: Prostate Cancer Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from MITA supports MAP's conclusion. Public comment from the Armstrong Institute does not support MAP's conclusion, noting that the measure should be fully supported.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEDL Not Endorsed	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from MITA supports MAP's conclusion.
XDEDM Not Endorsed	Draft: Colon Cancer Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from MITA supports MAP's conclusion.
0662 Endorsed Time-Limited	Median Time to Pain Management for Long Bone Fracture	PQRS: Support. Physician Compare: Do Not Support. VBPM: Do Not Support. NQF-endorsed measure. Promotes alignment across programs, settings, and public- and private-sector efforts Addresses program goals/ requirements.	

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
1399 Endorsed	Developmental Screening in the First Three Years of Life	PQRS: Support. MU-EP: Support. Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Promotes person- and family-centered care. Provides considerations for healthcare disparities and cultural competency. Addresses program goals/ requirements.	
XDAEB Not Endorsed	Annual Wellness Assessment: Assessment of Health Risks	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Measures XDAEC, XDBGH, and XDBHA are preferred; however all three measures could be combined into a composite. Public comment from the Armstrong Institute supports MAP's conclusion and offers suggestions for modifying the measure specifications. .
XDAEC Not Endorsed	Annual Wellness Assessment: Management of Health Risks	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	A composite of XDAEB, XDAEC, XDBGH, and XDBHA is preferred. Public comment from the Armstrong Institute supports MAP's conclusion and requests clarity on measure specifications.
XDBGH Not Endorsed	Annual Wellness Assessment: Reduction of Health Risks	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development	A composite of XDAEB, XDAEC, XDBGH, and XDBHA is preferred. Public comment from the Armstrong Institute supports MAP's conclusion and requests clarity on the denominator specifications.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDBHA Not Endorsed	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	A composite of XDAEB, XDAEC, XDBGH, and XDBHA is preferred. Additionally, this measure should be expanded to address all the risks assessed in XDAEB. Public comment from the Armstrong Institute supports MAP's conclusion and requests clarity on the measure specifications.
XDBBM Not Endorsed	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	PQRS: Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Measure development should explore risk adjustment in addition to testing at the individual clinician level of analysis.
XDCLD Not Endorsed	DRAFT: Closing the Referral Loop - Critical Information Communicated with Request for Referral	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Further development should explore the quality of information being sent. Public comment from the Armstrong Institute supports MAP's conclusion and notes concern with the measure specifications.
XDDAC Not Endorsed	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Further development should explore the quality of the information being sent, in addition to accounting for patients who see a specialist and do not have a primary care physician. Public comment from the Armstrong Institute supports MAP's conclusion and notes concerns with the measure specifications.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDCMD Not Endorsed	Oral Health: Children aged 6-9 years who receive sealants in the first permanent molar	PQRS: Do Not Support. MU-EP: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Preference for NQF #1419.
XDCME Not Endorsed	Oral Health: Children who receive a comprehensive or periodic oral evaluation in two consecutive years	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Measure should align with an endorsed measure NQF #1308.
N/A Not Endorsed	Patient Activation Measure	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	The tool should be tested as a performance measure. Additionally, other tools/measures in this area should be explored.
N/A Not Endorsed	SF-36 (included in the HOS)	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	The tool should be tested as a performance measure. Additionally, other tools/measures in this area should be explored.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDBBG Not Endorsed	All-Cause Unplanned Admissions for Patients with Heart Failure	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Measure development should explore risk adjustment in addition to testing at the individual clinician level of analysis.
XDELB Not Endorsed	DRAFT: Functional Status Assessment and Goal Achievement for Patients with Congestive Heart Failure	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Public comment from the Armstrong Institute supports MAP's conclusion and notes concerns with the measure specifications.
XAHDH Not Endorsed	Adherence to Antiplatelet Treatment after Stent Implantation	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	
XDELF Not Endorsed	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	PQRS: Do Not Support. MU-EP: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Measure is limited to patients with atrial fibrillation; it should be expanded to include all patients on warfarin. Additionally, this measure and measure XDELE should be merged into a single measure. Public comment from the Armstrong Institute does not support MAP's conclusion.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDELE Not Endorsed	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	PQRS: Do Not Support. MU-EP: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Measure is limited to patients with atrial fibrillation; it should be expanded to include all patients on warfarin. Additionally, this measure and measure XDELF should be merged into a single measure. Public comment from the Armstrong Institute supports MAP's recommendation.
XDEME Not Endorsed	Post-procedural Optimal medical therapy Composite (percutaneous coronary intervention)	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should incorporate follow-up and adherence. This measure should be harmonized with an existing endorsed measure NQF #0964. Public comment from the Armstrong Institute supports MAP's conclusion and notes concerns with the measure specifications.
XCLLL Not Endorsed	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from HRS supports MAP's conclusion.
XDECF Not Endorsed	Draft: Hypertension Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes implementation concerns.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDDMH Not Endorsed	Draft: Acute Myocardial Infarction Condition Phase Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion.
XDDMG Not Endorsed	Draft: Ischemic Heart Disease Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and seeks clarification on attribution.
XDDML Not Endorsed	Draft: Coronary Artery Bypass Graft Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes attribution issues.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDDMM Not Endorsed	Draft: Heart Catheterization Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and seeks clarification on attribution.
XDEAA Not Endorsed	Draft: Percutaneous Coronary Intervention Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and seeks clarification on attribution.
XDECA Not Endorsed	Draft: Heart Block Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.
XDEBL Not Endorsed	Draft: Heart Failure Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEDA Not Endorsed	Draft: Ischemic Cerebral Artery Disease Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.
XDEBM Not Endorsed	Draft: Cardiac Arrhythmia Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes implementation issues.
XDEDB Not Endorsed	Draft: Carotid Artery Stenosis Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDECB Not Endorsed	Draft: Cardioversion Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute does not support MAP's conclusion and notes anesthesiology charges are the major cost driver and cannot be controlled by other providers.
XDECG Not Endorsed	Draft: Shock/ Hypotension Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes implementation issues.
XDECC Not Endorsed	Draft: Pacemaker/AICD Implantation Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes device hardware is the major cost driver and cannot be controlled by providers.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
2158 Endorsed	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	PQRS: Conditional Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement. Not ready for implementation; data sources do not align with program's data sources.	Measure is currently endorsed for the hospital level of analysis; additional development and testing are needed to apply this measure to the clinician level of analysis. Public comments from the Armstrong Institute and AAMC support MAP's conclusion and note implementation issues. Public comment from ACS does not support MAP's conclusion, noting concerns with the validity of the measure.
0545 Endorsed	Adherence to Chronic Medications for Individuals with Diabetes Mellitus	PQRS: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Prefer outcome measures for diabetes. Public comment from the Armstrong Institute supports MAP's conclusion and notes concerns with the measure specifications.
XDBBL Not Endorsed	All-Cause Unplanned Admissions for Patients with Diabetes	PQRS: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Measure development should explore risk adjustment in addition to testing at the individual clinician level of analysis. Public comment from the Armstrong Institute does not support MAP's conclusion, and notes implementation issues.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDECL Not Endorsed	Draft: Diabetes Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion, and notes implementation issues.
XDECH Not Endorsed	Draft: Nephropathy/ Renal Failure Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion, and notes implementation issues.
XDFAG Not Endorsed	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)	PQRS: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from the Armstrong Institute supports MAP's conclusion, and notes concerns with the measure specifications.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFAM Not Endorsed	Cataract Surgery: Difference Between Planned and Final Refraction	PQRS: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from the Armstrong Institute does not support MAP's conclusion, noting concern with the measure specifications and implementation issues.
XDFAH Not Endorsed	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	PQRS: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	
XDFAL Not Endorsed	Adult Primary Rhegmatogenous Retinal Detachment Reoperation Rate	PQRS: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEBC Not Endorsed	Draft: Cataract Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from AAO does not support MAP's conclusion, noting that treatment for chronic eye disease depends on the staging and acuity and costs associated cannot be assessed/ attributed using the grouper. Public comment from the Armstrong Institute supports MAP's conclusion, but notes attribution issues.
XDEBD Not Endorsed	Draft: Cataract Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from AAO does not support MAP's conclusion for the episode groupers related to eye conditions, noting that treatment for chronic eye disease depends on the staging and acuity and that costs associated cannot be assessed/ attributed using the grouper. Public comment from the Armstrong Institute supports MAP's conclusion and notes attribution issues.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEBE Not Endorsed	Draft: Glaucoma Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes attribution and implementation issues. Public comment from AAO does not support MAP's conclusion, noting that treatment for chronic eye disease depends on the staging and acuity and costs associated cannot be assessed/ attributed using the grouper.
XDEBF Not Endorsed	Draft: Glaucoma Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes attribution and implementation issues. Public comment from AAO does not support MAP's conclusion, noting that treatment for chronic eye disease depends on the staging and acuity and costs associated cannot be assessed/ attributed using the grouper.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEBG Not Endorsed	Draft: Retinal Disease Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes attribution and implementation issues. Public comment from AAO does not support MAP's conclusion, noting that treatment for chronic eye disease depends on the staging and acuity and costs associated cannot be assessed/ attributed using the grouper.
XDEBH Not Endorsed	Draft: Retinal Disease Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes attribution and implementation issues. Public comment from AAO does not support MAP's conclusion, noting that treatment for chronic eye disease depends on the staging and acuity and costs associated cannot be assessed/ attributed using the grouper.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
1407 Endorsed	Immunizations for Adolescents	PQRS: Support. MU-EP: Support. Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measurement area not adequately represented in the program measure set.	
1959 Endorsed	Human Papillomavirus Vaccine for Female Adolescents	PQRS: Support. MU-EP: Support. Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measurement area not adequately represented in the program measure set.	The measure should be expanded to include males in the denominator population.
XDFBC Not Endorsed	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Further development should explore combining XDFBC, XDFBD, and XDFBE into a composite measure. Public comments from AMA and CDC express concern with combining XDFBC, XDFBD, and XDFBE because they address different populations and outcomes.
XDFBD Not Endorsed	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Further development should explore combining XDFBC, XDFBD, and XDFBE into a composite measure. Public comments from AMA and CDC express concern with combining XDFBC, XDFBD, and XDFBE because they address different populations and outcomes.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFBE Not Endorsed	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Further development should explore combining XDFBC, XDFBD, and XDFBE into a composite measure. Public comments from AMA and CDC express concern with combining XDFBC, XDFBD, and XDFBE because they address different populations and outcomes.
XDFBF Not Endorsed	Discontinuation of Antiviral Therapy for Inadequate Viral Response	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Workgroup expressed concerns that this may be a low-bar measure; further development and testing should explore if there is variation in care.
XDFBG Not Endorsed	Discussion and Shared Decision Making Surrounding Treatment Options	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Ideally, the measure should be assessed from the patient perspective.
XDFBH Not Endorsed	Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFCM Not Endorsed	Minimum antimicrobial therapy for Staph A. - For adult patients with Staphylococcus aureus bacteremia, the minimum duration of antimicrobial therapy is 14 days.	PQRS: Insufficient Information. Physician Compare: Insufficient Information. VBPM: Insufficient Information. MAP requests more information on the evidence supporting this measure.	
XDFDA Not Endorsed	Appropriate in vitro susceptibility testing - The agent(s) used for definitive therapy in invasive staphylococcal disease should be confirmed by in vitro susceptibility testing as interpreted by the CLSI to be active against the clinical isolate	PQRS: Insufficient Information. Physician Compare: Insufficient Information. VBPM: Insufficient Information. MAP requests more information on the evidence supporting this measure.	
XDFHL Not Endorsed	Appropriate Treatment of MSSA - For MSSA bacteremia, a β-lactam antibiotic is the drug of choice in the hospitalized patient in the absence of a documented allergy or drug intolerance.	PQRS: Insufficient Information. Physician Compare: Insufficient Information. VBPM: Insufficient Information. MAP requests more information on the evidence supporting this measure.	
XDECD Not Endorsed	Draft: Pneumonia Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes implementation issues.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDAFC Not Endorsed	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure should align with, and possibly replace, a measure in the finalized set XACHH. This measure goes beyond assessment and includes goals setting. Public comments from Armstrong Institute and ACR support MAP's conclusion.
XDFHD Not Endorsed	Assessment and Classification of Disease Activity	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure should align with, and possibly replace, a measure in the finalized set XACHG. Public comment from ACR supports MAP's conclusion.
XDFHE Not Endorsed	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure should align with, and possibly replace, a measure in the finalized set XACHF. Public comment from AAD supports MAP's conclusion.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFEF Not Endorsed	Osteoporotic Fracture Risk	PQRS: Do Not Support. MU-EP: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Public comment from the Armstrong Institute supports MAP's conclusion.
XDFEH Not Endorsed	Bone Mineral Density (BMD) & Fracture Risk	PQRS: Do Not Support. MU-EP: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. A finalized measure addresses a similar topic and better addresses the needs of the program.	Public comment from Armstrong Institute supports MAP's conclusion.
XDEGH Not Endorsed	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from MITA supports MAP's conclusion.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFEG Not Endorsed	Prednisone Use with Anabolic Agent	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure should be expanded to address all prednisone use. Public comment from AAD supports MAP's conclusion.
XDFHF Not Endorsed	History of Fragility Fracture with Prednisone Use	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure should be expanded to address all prednisone use.
XDELC Not Endorsed	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Knee Replacement	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure should align with, and possibly replace, NQF #0422.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDELD Not Endorsed	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure should align with, and possibly replace, NQF #0423.
XDEAB Not Endorsed	Draft: Hip Osteoarthritis Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.
XDEAC Not Endorsed	Draft: Hip Replacement/Revision Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.
XDEAD Not Endorsed	Draft: Hip/Femur Fracture Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEAE Not Endorsed	Draft: Hip/Femur Fracture Repair Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.
XDEAF Not Endorsed	Draft: Knee Osteoarthritis Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.
XDEAG Not Endorsed	Draft: Knee Replacement/Revision Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.
XDEAH Not Endorsed	Draft: Shoulder Osteoarthritis Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEEB Not Endorsed	Draft: Back Pain Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes implementation issues.
XDEAL Not Endorsed	Draft: Shoulder Replacement/Repair Treatment Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.
XDFLL Not Endorsed	National Institutes of Health Stroke Scale (NIHSS) for ED patients	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from the Armstrong Institute supports MAP's conclusion and notes that the benefit/harm ratio for use of thrombolytics is uncertain.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCLAL Not Endorsed	ALS Patient Care Preferences	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Care planning for patients with ALS should occur more than once annually, further development should explore more frequent care planning or shorter intervals of measurement. Public comment from AAHPM does not support MAP's conclusion, noting that the measure addresses a critical gap in care and measurement.
XDEEA Not Endorsed	Draft: Dementia Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comments from the Armstrong Institute and MITA support MAP's conclusion. The Armstrong Institute seeks clarification regarding risk adjustment and attribution.
1507 Endorsed	Risky Behavior Assessment or Counseling by Age 18 Years	PQRS: Support. Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measurement area not adequately represented in the program measure set.	
1879 Endorsed	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	PQRS: Support. Physician Compare: Support. VBPM: Support. NQF-endorsed measure. Addresses a measurement area not adequately represented in the program measure set.	Explore combining NQF #1879 and NQF #1880 into a composite. Public comment from the Armstrong Institute notes concern with the measure specifications.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
1880 Not Endorsed	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	PQRS: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Explore combining NQF #1879 and NQF #1880 into a composite. Additionally, the measure should be incorporated in Physician Compare and VBPM once it receives NQF endorsement.
1884 Not Endorsed	Depression Response at Six Months- Progress Towards Remission	PQRS: Support. MU-EP: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	The measure should be incorporated in Physician Compare and VBPM once it receives NQF endorsement. Public comment from Armstrong Institute supports MAP's conclusion.
1885 Not Endorsed	Depression Response at Twelve Months- Progress Towards Remission	PQRS: Support. MU-EP: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	The measure should be incorporated in Physician Compare and VBPM once it receives NQF endorsement. Public comment from Armstrong Institute supports MAP's recommendation.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEMG Not Endorsed	ACORN Adolescent (Youth) Outcome Questionnaire	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	This is a survey tool; additional testing is needed to determine how to use the results as a performance measure.
XDEMF Not Endorsed	ACORN Adult Outcome Questionnaire	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	This is a survey tool; additional testing is needed to determine how to use the results as a performance measure.
XDFGC Not Endorsed	IPF Drug Use Screening completed within one day of admission	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	
XDFGD Not Endorsed	IPF Alcohol Use Screening completed within one day of admission	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Further development should explore if a one-day turnaround time is appropriate. Public comment from the Armstrong Institute supports MAP's conclusion.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFGE Not Endorsed	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	PQRS: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	This measure only determines if experience of care was assessed in some manner. A standardized tool should be used across all inpatient psychiatric facilities. Public comment from the Armstrong Institute supports MAP's conclusion.
XDEHE Not Endorsed	DRAFT: Tobacco Use and Help with Quitting Among Adolescents	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	
XDEHF Not Endorsed	DRAFT: Substance Use Screening and Intervention Composite	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDBGL Not Endorsed	Functional Status Assessments and Goal Setting for Patients with Asthma	PQRS: Do Not Support. MU-EP: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. A "Supported" measure under consideration addresses a similar topic and better addresses the needs of the program.	Preference for XDGBM.
XDBGM Not Endorsed	Functional Status Assessments and Goal Setting for Patients with Chronic Obstructive Pulmonary Disease	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	
XDFLE Not Endorsed	Optimal Asthma Care-Control Component	PQRS: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Addresses a measurement area not adequately represented in the program measure set.	
XDEAM Not Endorsed	Draft: Asthma Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes implementation issues.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEBA Not Endorsed	Draft: Bronchiectasis Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator.
XDEBB Not Endorsed	Draft: Chronic Bronchitis/Emphysema Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes implementation issues.
XDECE Not Endorsed	Draft: Respiratory Failure Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comment from the Armstrong Institute supports MAP's conclusion and notes implementation issues.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XAHDG Not Endorsed	Bleeding Outcomes Related to Oral Anticoagulants	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure should be expanded beyond oral anticoagulants. Public comment from the Armstrong Institute supports MAP's conclusion and notes that it may be difficult to compare results between centers without risk adjustment.
XCLMD Not Endorsed	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	This measure should be expanded to cover all implants. Public comments from HSR and the Armstrong Institute support MAP's conclusion.
XDECM Not Endorsed	Draft: Sepsis/SIRS Condition Episode for CMS Episode Grouper	VBPM: Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Measure should be paired with relevant clinical outcome measures. Further development should explore how costs for patients with MCCs are attributed, how severity of disease is addressed in a measure, and how the measure is attributed to multiple clinicians that may see an individual included in the denominator. Public comments from the Armstrong Institute and Edwards Lifesciences support MAP's conclusion. The Armstrong Institute seeks clarification regarding risk adjustment and attribution.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0465 Endorsed Time-Limited	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy	PQRS: Support. Physician Compare: Support. VBPM: Support. NQF-endorsed measure Addresses a measure type not adequately represented in the program measure set.	Public comments from AANS/CNS and the Armstrong Institute support MAP's conclusion.
XDFDG Not Endorsed	Recurrence or amputation following open infrainquinal lower extremity revascularization	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Further development should explore combining XDFDG and XDFDH. Public comment from the Armstrong Institute supports MAP's conclusion, noting that it is reasonable to measure one-year amputation rates after revascularization.
XDFDH Not Endorsed	Recurrence or amputation following endovascular infrainguinal lower extremity revascularization	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; should be submitted for and receive NQF endorsement.	Further development should explore combining XDFDG and XDFDH. Public comment from the Armstrong Institute supports MAP's conclusion, noting that it is reasonable to measure one-year amputation rates after revascularization.
XDFLD Not Endorsed	Average change in functional status following lumbar spine fusion surgery	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Not ready for implementation; measure concept is promising but requires modification or further development.	This measure should be paired with measures of appropriate use of spinal surgery and episode-of-care measures that begin with initial assessments of back pain. Public comment from the Armstrong Institute supports MAP's conclusion.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCMDH Not Endorsed	Reduction of complications through the use of cystoscopy during surgery for stress urinary incontinence	PQRS: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Measure does not adequately address any current needs of the program.	Public comment from the Armstrong Institute supports MAP'S conclusion, noting that there are other opportunities for measurement in this area.
XDAFA Not Endorsed	Overuse of Diagnostic Imaging for Uncomplicated Headache	PQRS: Conditional Support. MU-EP: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from MITA supports MAP's conclusion.
XDFDL Not Endorsed	Avoidance of inappropriate use of head CT in ED patients with minor head injury	PQRS: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. An endorsed measure addresses a similar topic and better addresses the needs of the program.	Consider including NQF #0668. Public comments from the Armstrong Institute and MITA support MAP's conclusion. The Armstrong Institute notes that the measure conflicts with ACEP guidelines.
XDFGF Not Endorsed	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	PQRS: Do Not Support. Physician Compare: Do Not Support. VBPM: Do Not Support. An endorsed measure addresses a similar topic and better addresses the needs of the program.	Consider using NQF #0514 or NQF #0052. Public comments from the Armstrong Institute and MITA support MAP's conclusion. The Armstrong Institute notes that the measure conflicts with ACEP guidelines.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFCA Not Endorsed	Appropriate use of imaging for non-traumatic shoulder pain	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comments from AMA and MITA support MAP's conclusion.
XDFCB Not Endorsed	Appropriate use of imaging for non-traumatic knee pain	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comments from AMA and MITA support MAP's conclusion.
XDFBM Not Endorsed	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	PQRS: Support. Physician Compare: Conditional Support. VBPM: Conditional Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comments from AMA and MITA support MAP's conclusion. The Armstrong Institute notes concern with measure implementation.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFCC Not Endorsed	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comments from AMA and MITA support MAP's conclusion. The Armstrong Institute notes concern with measure implementation.
XDFCE Not Endorsed	Appropriate follow-up imaging for incidental thyroid nodules in patients	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comments from AMA and MITA support MAP's conclusion.
XDFCF Not Endorsed	Composite measure: 1) Appropriate follow-up imaging for incidental liver lesions	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from MITA supports MAP's conclusion. Public comment from the Armstrong Institute does not support MAP's conclusion, recommending strict adherence to published literature for liver lesions.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFCG Not Endorsed	Composite measure: 2) Appropriate follow-up imaging for incidental kidney lesions composite measure	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from MITA supports MAP's conclusion. Public comment from the Armstrong Institute supports MAP's conclusion and notes concern with the measure specifications.
XDFCH Not Endorsed	Composite measure: 3) Appropriate follow-up imaging for incidental adrenal lesions composite measure	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from MITA supports MAP's conclusion.
XDFCL Not Endorsed	Appropriate follow-up imaging for incidental simple ovarian cysts	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comments from AMA and MITA support MAP's conclusion.

TABLE A4. MAP INPUT ON PQRS MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFBL Not Endorsed	Utilization of ultrasonography in children with clinically suspected appendicitis	PQRS: Conditional Support. Physician Compare: Do Not Support. VBPM: Do Not Support. Addresses a measurement area not adequately represented in the program measure set. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from MITA supports MAP's conclusion.

MAP Input on Hospital Programs

Hospital Inpatient Quality Reporting Program

Program Type

Pay for Reporting – Information is reported on the Hospital Compare website.[27]

Incentive Structure

Nonparticipating Hospitals receive a reduction of 2.0% of their annual market basket payment update (the change in costs of goods and services used by hospitals in treating Medicare patients).[28]

Care Settings Included

Hospitals paid under the Inpatient Prospective Payment System (IPPS). This includes more than three-quarters of all hospitals.[29]

Statutory Mandate

The Hospital Inpatient Quality Reporting Program (IQR) was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and subsequently updated in the Deficit Reduction Act of 2005.

Statutory Requirements for Measures

The program was required to begin with the baseline set of performance measures set forth in a November 2005 report by the Institute of Medicine under section 238(b) of the MMA.

According to statute, the program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs-of-care measures. Measures should align with the National Quality Strategy[30] and promote the health and well-being of Medicare beneficiaries.[31,32] Measures should align with the Meaningful Use program when possible.[33,34]

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A5. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0475 Endorsed	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Support. NQF-endorsed measure. Addresses program goals/ requirements. Promotes alignment across programs, settings, and public- and private-sector efforts	Measure addresses a previously identified program gap. Public comment from C-P Alliance supports MAP's conclusion.
0471 Endorsed	PC-02 Cesarean Section	Support. NQF-endorsed measure. Addresses program goals/ requirements. Promotes alignment across programs, settings, and public- and private-sector efforts	MAP noted that there is an important public education piece to the reporting of PC-02 and recommended that CMS work with others to ensure consumers understand what the results mean and why the measure is important. Public comments from UHC, TJC and C-P Alliance support MAP's conclusion. Public comment from the Armstrong Institute does not support MAP's conclusion noting a better performance measure would be adherence to criteria for definitions of protraction or arrest disorders in labor prior to performing cesareans for "failure to progress."
XDELG Not Endorsed	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	Support. Addresses program goals/ requirements. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public- and private-sector efforts	Measure addresses the previously identified gap of affordability/cost measures. MAP noted the need for condition-specific cost information because the measures are actionable but recognized the attribution challenges between hospitals and care provided after discharge. MAP reiterated the need for these measures to be submitted for NQF endorsement. Public comments from C-P Alliance and UHC support MAP's conclusion.

TABLE A5. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDELH Not Endorsed	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Support. Addresses program goals/ requirements. Addresses a measure type not adequately represented in the program measure set. Promotes alignment across programs, settings, and public and private sector efforts.	Measure addresses the previously identified gap of affordability/cost measures. MAP noted the need for condition-specific cost information because the measures are actionable but recognized the attribution challenges between hospitals and care provided after discharge. MAP reiterated the need for these measures to be submitted for NQF endorsement. Public comments from C-P Alliance and UHC support MAP's conclusion.
XBELG Not Endorsed	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP reiterated the need for condition-specific readmission measures to accompany all-cause readmission measures. MAP also noted concerns about the lack of risk adjustment for socioeconomic status and suggested that measure results could be stratified. Public comments from UHC, Edwards Lifesciences, and the Armstrong Institute support MAP's conclusion.
XBGDL Not Endorsed	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP reiterated the need for condition-specific readmission measures to accompany all-cause readmission measures. MAP also noted concerns about the lack of risk adjustment for socioeconomic status and suggested that measure results could be stratified. Public comments from UHC, Edwards Lifesciences, and the Armstrong Institute support MAP's conclusion.
XDBCB Not Endorsed	Adverse Drug Events – Hyperglycemia	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Use of this measure would fill a previously identified gap in HAC public reporting and address a very common condition. MAP expressed concerns over the feasibility of using this measure in the IQR program as it has been tested using electronic data. The NQF endorsement process should resolve this issue. Public comment from Edwards Lifesciences supports MAP's conclusion.

TABLE A5. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDBGA Not Endorsed	Adverse Drug Events – Hypoglycemia	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Use of this measure would fill a previously identified gap in HAC public reporting and address a common condition that is very dangerous to patients. MAP expressed concerns over the feasibility of using this measure in the IQR program as it has been tested using electronic data. The NQF endorsement process should resolve this issue. Public comments from Edwards Lifesciences and the Armstrong Institute support MAP's conclusion.
XDEEH Not Endorsed	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comment from Edwards Lifesciences supports MAP's conclusion. Public comment from the Armstrong Institute does not support MAP's conclusion, noting the measure is widely used and should be fully supported.
XDEEL Not Endorsed	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement. Not ready for implementation; data sources do not align with program's data sources. Not ready for implementation; measure needs further experience or testing before being used in the program.	MAP noted the AMI eMeasure is a promising concept but expressed concerns that some hospitals may have difficulties implementing it because of current limitations of EHR systems. Others noted that the electronic elements for this measure are relatively easy to extract. Public comment from the Armstrong Institute does not support MAP's conclusion, noting concerns that AMI episode is not well-defined.
0363 Endorsed	Foreign Body Left During Procedure (PSI 5)	Recommend for inclusion in IQR.	While this measure was not under consideration for the IQR program, MAP recommended its inclusion to fill a gap left by the removal of the Foreign Body Left During Procedure rate. Public comments from C-P Alliance and the Leapfrog Group support MAP's conclusion.

TABLE A5. MAP INPUT ON IQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDAEA Not Endorsed	Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	No longer under consideration per HHS.	MAP reiterated the importance of opioid monitoring as an important gap area. In particular, high-risk patients should be continually monitored and sedation outcomes should be tracked. MAP also expressed concern that this measure is limited to patient-controlled analgesia and could result in the negative unintended consequence of avoidance of PCA in favor of older therapies.

TABLE A6. MAP INPUT ON FINALIZED IQR MEASURES

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0374 Not Endorsed	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages / Platelet Count Monitoring by Protocol or Nomogram	Remove. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	
0375 Not Endorsed	Venous Thromoboembolism Warfarin Therapy Discharge Instructions	Remove. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	
0440 Not Endorsed	Stroke Education	Remove. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	
0113 Endorsed Reserve	Participation in a Systematic Database for Cardiac Surgery	Remove. NQF endorsement placed in reserve status (performance on this measure is topped out).	
0135 Endorsed Reserve	Evaluation of Left ventricular systolic function (LVS)	Remove. NQF endorsement placed in reserve status (performance on this measure is topped out).	
0527 Endorsed	Prophylactic antibiotic received within 1 hour prior to surgical incision	Remove. Performance on this measure may be topped out.	

TABLE A6. MAP INPUT ON FINALIZED IQR MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
2027 Not Endorsed	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization	Retain.	MAP discussed the possibility of recommending this measure's removal and ultimately decided that it should be retained. MAP encourages continued refinement of the measure's risk-adjustment methodology and obtaining NQF endorsement. Public comments from UHC and C-P Alliance support MAP's conclusion. Public comments from AHA, TJC, Florida Hospital, and CHA do not support MAP's conclusion, noting the need for further adjustment for stroke severity. Public comment from Highmark does not support MAP's conclusion, noting this measure is not NQF-endorsed. Public comment from AHIP recommends CMS monitor for unintended consequences.
2026 Not Endorsed	Stroke: 30-day all-cause risk-standardized mortality measures	Retain.	MAP discussed the possibility of recommending this measure's removal and ultimately decided that it should be retained. MAP encourages continued refinement of the measure's risk-adjustment methodology and obtaining NQF endorsement. Public comment from C-P Alliance supports MAP's conclusion. Public comments from AHA, TJC, Florida Hospital, and CHA do not support MAP's conclusion, noting the need for further adjustment for stroke severity. Public comment from AHIP recommends CMS monitor for unintended consequences.
0351 Endorsed	Death among surgical inpatients with serious, treatable complications (PSI 4)		Prioritize this measure for inclusion in VBP. Public comments from the Leapfrog Group and C-P Alliance support MAP's conclusion. Public comments from GNYHA do not support MAP's conclusion, noting readmission and HAC measures do not belong in VBP.

TABLE A6. MAP INPUT ON FINALIZED IQR MEASURES (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0469 Endorsed	PC-01 Elective Delivery		Prioritize for inclusion in VBP. Public comments from TJC, the Leapfrog Group, and C-P Alliance support MAP's conclusion.
1550 Endorsed	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)		Prioritize for inclusion in VBP. Public comment from Edwards Lifesciences supports MAP's conclusion. Public comments from GNYHA do not support MAP's conclusion, noting readmission and HAC measures do not belong in VBP.
1716 Endorsed	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure		Prioritize for inclusion in VBP; MAP supports CMS's intention to propose this measure for VBP.
1717 Endorsed	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure		Prioritize for inclusion in VBP; MAP supports CMS's intention to propose this measure for VBP.
1893 Endorsed	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization		Prioritize for inclusion in VBP.
XCGML Not Endorsed	AMI episode of care (inpatient hospitalization + 30 days post-discharge)		Prioritize for inclusion in VBP.

Hospital Value-Based Purchasing Program

Program Type

Pay for Performance – Payments are based on information publicly reported on the Hospital Compare website.[35]

Incentive Structure

Starting on October 1, 2012, Medicare began basing a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing Program (VBP). Medicare began withholding 1% of its regular hospital reimbursements from all hospitals paid under its inpatient prospective payment system (IPPS) to fund a pool of VBP incentive payments. The amount withheld from reimbursements increases over time:

- FY 2014: 1.25%
- FY 2015: 1.5%
- FY 2016: 1.75%
- FY 2017 and future fiscal years: 2%

Hospitals are scored based on their performance on each measure within the program relative to other hospitals as well as on how their performance on each measure has improved over time. The higher of these scores on each measure is used in determining incentive payments.

Care Settings Included

Hospitals paid under the IPPS. This includes more than three-quarters of all hospitals.[36]

Statutory Mandate

Hospital VBP was mandated by section 3001 of the Patient Protection and Affordable Care Act.

Statutory Requirements for Measures

Measures selected for the VBP program must be included in IQR and reported on the Hospital Compare website for at least 1 year prior to use in the VBP program.

The program was required to begin with a baseline set of performance measures for FY 2013 that included measures addressing acute myocardial infarction (heart attack or AMI), heart failure, pneumonia, surgeries as measured by the Surgical Care Improvement Project (SCIP), healthcare-associated infections as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan), and HCAHPS (a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care). For FY 2014 or a subsequent fiscal year, the program set should include efficiency measures including measures of "Medicare Spending per Beneficiary."

The Secretary of HHS can replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice). Measures of readmissions are statutorily excluded from the Hospital VBP program.[37]

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A7. MAP INPUT ON VBP MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0437 Endorsed	STK 04: Thrombolytic Therapy	Support. NQF-endorsed measure.	Stroke is a high-impact condition and there is a need to promote processes closely tied to better outcomes. MAP questioned whether there is sufficient opportunity for performance on this measure to continue to improve and recommended that CMS reconsider the measure's exclusion criteria. Public comment from Genentech supports MAP's conclusion; however, Genentech offered evidence of a significantly larger opportunity for performance improvement than MAP believed. Public comment from AAMC does not support MAP's conclusion, noting that hospitals electronically reporting the stroke measures should not be compared to those reporting in the original format for payment purposes.
0441 Endorsed	STK-10: Assessed for Rehabilitation	Do Not Support. Measure does not adequately address any current needs of the program.	Performance on this measure is high and MAP recommends the measure set remain parsimonious to avoid diluting incentives.
0434 Endorsed	STK-01: Venous Thromboembolism (VTE) Prophylaxis	Support. NQF-endorsed measure. Addresses program goals/ requirements. Promotes alignment across programs, settings, and public- and private-sector efforts	Stroke is a high-impact condition and there is a need to promote processes closely tied to better outcomes. This measure is associated with an outcome that is difficult to measure directly. Public comment from AAMC does not support MAP's conclusion, noting that for payment purposes, hospitals electronically reporting the stroke measures should not be compared to those reporting in the original format.
0435 Endorsed	STK 02: Discharged on Antithrombotic Therapy	Support. NQF-endorsed measure. Addresses program goals/ requirements. Promotes alignment across programs, settings, and public- and private-sector efforts	Stroke is a high-impact condition and there is a need to promote processes closely tied to better outcomes. This measure is associated with an outcome that is difficult to measure directly. Public comment from AAMC does not support MAP's conclusion, noting that for payment purposes, hospitals electronically reporting the stroke measures should not be compared to those reporting in the original format.

TABLE A7. MAP INPUT ON VBP MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0436 Endorsed	STK-03: Anticoagulation Therapy for Atrial Fibrillation/ Flutter	Do Not Support. Measure does not adequately address any current needs of the program.	Performance on this measure is high and MAP recommends the measure set remain parsimonious to avoid diluting incentives.
0438 Endorsed	STK 05: Antithrombotic Therapy By End of Hospital Day Two	Support. NQF-endorsed measure. Addresses program goals/ requirements. Promotes alignment across programs, settings, and public- and private-sector efforts	Stroke is a high-impact condition and there is a need to promote processes closely tied to better outcomes. Public comment from AAMC does not support MAP's conclusion, noting that for payment purposes, hospitals electronically reporting the stroke measures should not be compared to those reporting in the original format.
0439 Endorsed	STK-06: Discharged on Statin Medication	Do Not Support. Measure does not adequately address any current needs of the program.	MAP recommends that the measure set remain parsimonious to avoid diluting incentives. Statin guidelines have recently been changed.
0440 Not Endorsed	Stroke Education	Do Not Support. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	
0371 Endorsed	Venous Thromboembolism Prophylaxis	Do Not Support. Measure does not adequately address any current needs of the program.	Performance on this measure is high and MAP recommends the measure set remain parsimonious to avoid diluting incentives.
0372 Endorsed	Intensive Care Unit Venous Thromboembolism Prophylaxis	Do Not Support. Measure does not adequately address any current needs of the program.	Performance on this measure is high and MAP recommends that the measure set remain parsimonious to avoid diluting incentives.
0373 Endorsed	Venous Thromboembolism Patients with Anticoagulant Overlap Therapy	Do Not Support. Measure does not adequately address any current needs of the program.	Performance on this measure is high and MAP recommends that the measure set remain parsimonious to avoid diluting incentives.
0376 Not Endorsed	Incidence of Potentially Preventable Venous Thromboembolism	Do Not Support. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	

TABLE A7. MAP INPUT ON VBP MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0374 Not Endorsed	Venous Thromboembolism Patients Recieving Unfractionated Heparin with Dosages/ Platelet Count Monitoring by Protocol or Nomogram	Do Not Support. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	MAP has recommended that this measure be removed from IQR, which would make it unavailable for use in VBP.
0375 Not Endorsed	Venous Thrmoboembolism Warfarin Therapy Discharge Instructions	Do Not Support. NQF endorsement removed (the measure no longer meets the NQF endorsement criteria).	MAP has recommended that this measure be removed from IQR, which would make it unavailable for use in VBP.

TABLE A8. MAP INPUT ON FINALIZED VBP MEASURES

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0527 Endorsed	Prophylactic antibiotic received within 1 hour prior to surgical incision	Remove. Performance on this measure may be topped out.	

Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)

Program Type

Pay for Reporting – Information not publicly reported at this time.

Incentive Structure

The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. For the Medicare Incentive program (hospitals), incentive payments began in 2011 and are comprised of an Initial Amount, Medicare Share, and Transition Factor.[38] The CAH EHR Incentive payment is based on a formula for Allowable Costs and the Medicare Share.[39] The Medicaid Incentive program includes an Overall EHR Amount and Medicaid Share.[40] Medicare payment penalties will take effect in 2015 for providers who are eligible but do not participate. Payment penalties do not apply to Medicaid.[41]

Care Settings Included

Hospitals paid under the Inpatient Prospective Payment System (IPPS), Medicare Advantage, and critical access hospitals.[42]

Statutory Mandate

The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Statutory Requirements for Measures

The program should include measures of processes, experience, and/or outcomes of patient care as well as observations or treatment that relate to one or more quality aims for healthcare, such as effective, safe, efficient, patient-centered, equitable, and timely care. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.[43] Preference should be given to quality measures endorsed by NQF.[44] For Stage 1, eligible facilities must report on all 15 total clinical quality measures.[45] For Stage 2 (2014 and beyond) eligible facilities must report on 16 clinical quality measures that cover 3 of the National Quality Strategy domains. Measures are selected from a set of 29 clinical quality measures that includes the 15 measures from Stage 1.[46]

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A9. MAP INPUT ON MEANINGFUL USE MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDBCB Not Endorsed	Adverse Drug Events - Hyperglycemia	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP recommends close review of the electronic specifications of this measure during the NQF endorsement process. Public comments from Edwards Lifesciences and the Armstrong Institute support MAP's conclusion.
XDBGA Not Endorsed	Adverse Drug Events - Hypoglycemia	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP recommends close review of the electronic specifications of this measure during the NQF endorsement process. Public comments from Edwards Lifesciences and the Armstrong Institute support MAP's conclusion.
0475 Endorsed	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	MAP recommends review of the e-specifications of this measure through the NQF endorsement process.
1659 Endorsed	Influenza Immunization	Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	MAP recommends close review of the electronic specifications of this measure during the NQF endorsement process.
XDEEL Not Endorsed	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP recommends close review of the electronic specifications of this measure during the NQF endorsement process.
0500 Endorsed	Severe Sepsis and Septic Shock: Management Bundle	Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	MAP noted the need for continued development of electronic specifications for NQF #0500 Severe Sepsis and Septic Shock: Management Bundle. While some workgroup members challenged the feasibility and evidence behind this measure, MAP deferred to the recent endorsement review of this measure and conditionally supported it for the Meaningful Use Program. Public comment from Edwards Lifesciences supports MAP's conclusion.

Hospital Readmission Reduction Program

Program Type

Pay for Performance – Hospitals' readmissions information, including their risk adjusted readmission rates, will be made available on the Hospital Compare website.

Incentive Structure

CMS has defined a "readmission" as an admission to an acute-care hospital within 30 days of a discharge from the same or another acute-care hospital. CMS will calculate an excess readmission ratio for each of the applicable conditions selected for the program. These ratios will be measured by the hospital's readmission performance in the previous three years as compared to the national average and adjusted for factors that CMS deems clinically relevant, including patient demographic characteristics, comorbidities, and patient frailty. These ratios will be re-calculated each year using the most recent 3 years of discharge data and no less than 25 cases. DRG payment rates will be reduced based on a hospital's ratio of actual to expected admissions. In FY 2013, the maximum payment reduction is 1%, 2% in FY 2014, and capped at 3% for FY 2015 and beyond.

Care Settings Included

Hospitals paid under the Inpatient Prospective Payment System (IPPS). This includes more than three-quarters of all hospitals.[47]

Statutory Mandate

The Hospital Readmission Reduction Program (HRRP) was mandated by section 3025 of the Affordable Care Act.

Statutory Requirements for Measures

The Affordable Care Act requires that each condition selected by the Secretary of HHS for the Hospital Readmission Reduction Program have measures of readmissions that have been NQF-endorsed and that the endorsed measures have exclusions for readmissions unrelated to the prior discharge.[48] Measures should address conditions and procedures for which readmissions are high volume or high expenditure.[49]

The ACA required the program to begin with the use of the use of the NQF-endorsed readmission measures for acute myocardial infarction (heart attack) (NQF #0505), heart failure (NQF #0330), and pneumonia (NQF #0506). Beginning in FY 2015, the Secretary of HHS can expand the program to include other applicable conditions.[50]

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A10. MAP INPUT ON HRRP MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XBELG Not Endorsed	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP noted a need for additional condition-specific measures in the program so that hospitals can have actionable information about which patient populations to target for improvement efforts. Public comment from the Armstrong Institute supports MAP's conclusion. Public comment from GNYHA does not support MAP's conclusion, noting this measure is not NQF-endorsed.
2027 Not Endorsed	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization	Do Not Support. Measure previously submitted for endorsement and was not endorsed.	MAP expressed concerns over the reliability, validity, and risk adjustment of this measure. More experience with the measure is needed in the IQR program before using it for payment purposes. Public comment from GNYHA supports MAP's conclusion.
1789 Endorsed	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Conditional Support. Not ready for implementation; measure needs further experience or testing before being used in the program.	MAP noted the need to balance improvement for all patients with the risk of unintended consequences for safety net hospitals that may be more likely to experience payment reduction. MAP urged CMS to develop a methodology for how all-cause and condition-specific measures would be used together in the HRRP program and across programs to avoid duplication, as well as to consider recommendations to compare hospitals to peer groups rather than national averages. Public comments from AmeriHealth Caritas and C-P Alliance support MAP's conclusion. Public comments from FAH, ACS, AAMC, AHA, CHA, Florida Hospital, and GNYHA do not support MAP's conclusion, noting limited experience with the measure, inconsistency with the statutory intent of the ACA, concerns about adequate risk adjustment for socioeconomic status and concerns about penalizing a hospital twice for the same readmission. Public comment from AHIP recommends CMS expand its efforts to assess unintended consequences, particularly related to vulnerable populations.

Hospital-Acquired Condition Reduction Program

Program Type

Pay for Performance – Information will be reported on the Hospital Compare website beginning in FY 2015.[51]

Incentive Structure

Hospitals with rates of hospital acquired conditions (HACs) in the top quartile compared to the national average will have their Medicare payments reduced by 1% for all DRGs.[52] Prior to FY 2015 and in each subsequent fiscal year, hospitals will receive confidential reports from HHS on their HAC rates to give them the opportunity to review and submit corrections before the information is made public.

The HAC Reduction program consists of two domains of measures. Domain 1 includes Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) measures. Domain 2 includes measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN). Hospitals will be given a score for each measure within the two domains. A domain score will also be calculated—with Domain 1 weighted at 35 percent and Domain 2 weighted at 65 percent—to determine a total score for each hospital in the program. Risk factors such as patients' age, gender, and comorbidities will be considered in the calculation of the measure rates.

Care Settings Included

Hospitals paid under the Inpatient Prospective Payment System (IPPS). This includes more than three-quarters of all hospitals.[53]

Statutory Mandate

Section 3008 of the Affordable Care Act requires HHS to establish a program for IPPS hospitals to improve patient safety by imposing financial penalties on hospitals that perform poorly with regard to hospital-acquired conditions.

Statutory Requirements for Measures

The conditions addressed by this program are the same as those for the policy that mandates no additional payment for treatment of HACs (HAC Payment Provision Program).[54] It can also include any other conditions acquired during a hospital stay that the Secretary deems appropriate. The conditions currently included are:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burn
  - Other Injuries
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity
  - Laparoscopic Gastric Bypass
  - Gastroenterostomy
  - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures:
  - Spine
  - Neck
  - Shoulder
  - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
  - Total Knee Replacement
  - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A11. MAP INPUT ON HAC REDUCTION PROGRAM MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0349 Endorsed	Transfusion Reaction (PSI 16)	Support. NQF-endorsed measure. Addresses program goals/ requirements.	Transfusion reactions are straightforward, preventable events. Public comments from C-P Alliance and UHC support MAP's conclusion. Public comment from AAMC disagrees with MAP's conclusion, noting measures for the HAC Reduction Program should be publicly reported before they are implemented. Public comments from Highmark and AHIP disagree with MAP's additional findings, noting blood transfusion reactions are not always due to the infusion of incompatible blood and recommend the measure be stratified for emergency and non-emergent care.
0533 Endorsed	Postoperative Respiratory Failure Rate (PSI 11)	Support. NQF-endorsed measure. Addresses program goals/ requirements.	MAP discussed whether this measure could be incorporated into the PSI-90 composite measure. Public comment from UHC supports MAP's conclusion. Public comment from AAMC does not support MAP's conclusion, noting measures for the HAC Reduction Program should be publicly reported before they are implemented.
XAFLG Not Endorsed	PSI 9: Perioperative Hemorrhage or Hematoma Rate	Do Not Support. Not endorsed.	Measure specifications too vague for implementation in a high stakes payment program. Public comment from UHC does not support MAP's conclusion, noting the need for the addition of outcome measures indicating potentially defective care for certain inpatient conditions and procedures.
XDDLA Not Endorsed	PSI 10: Postoperative Physiologic and Metabolic Derangement Rate	Do Not Support. Not endorsed. A "Supported" measure under consideration addresses a similar topic and better addresses the needs of the program.	Measure is vague and addresses too many conditions. Public comment from UHC does not support MAP's conclusion, noting the need to add outcome measures indicating potentially defective care for certain inpatient conditions and procedures.

PPS-Exempt Cancer Hospital Quality Reporting Program

Program Type

Required Public Reporting – Information will be reported on the CMS website.[55]

Incentive Structure

The Prospective Payment System-Exempt Cancer Hospital (PCH) Quality Reporting Program does not currently include an incentive or a penalty for failing to report quality measures. CMS plans to address incentives for the PCH Quality Reporting Program in future rulemaking.[56]

Care Settings Included

Hospitals that are exempt from the Prospective Payment System (PPS) because they primarily provide care for persons with cancer, as described in Section 1866(k)(1) of the Social Security Act.

Statutory Mandate

Section 3005 of the Affordable Care Act (ACA) requires CMS to establish a quality reporting program for PCHs beginning in FY 2014.

Statutory Requirements for Measures

The program measure set should include structure, process, outcome, patients' perspectives on care, efficiency, and costs-of-care measures. The measure set should also include measures that reflect the level of care and most important aspects of care furnished by PCHs, in addition to the gaps in the quality of cancer care. The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

Future rulemaking will consider measures of clinical quality of care, care coordination, patient safety and experience, population health, and efficiency. PPS-exempt cancer hospitals will also be measured in the future on informed decisionmaking and quality improvement programs.[57]

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A12. MAP INPUT ON PCHQR MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
1822 Endorsed	External Beam Radiotherapy for Bone Metastases	Support. NQF-endorsed measure. Addresses program goals/ requirements.	MAP noted the importance of this therapy in controlling pain for patients with advanced cancer. Public comments from AAHPM and ADCC support MAP's conclusion. ADCC recommends a sampling methodology or adoption of a patient-reported outcome instrument as an alternative. Public comment from GNYHA does not support MAP's conclusion, noting data extraction for this measure exceeds the measure's value.
XDCFE Not Endorsed	Initiation of Osteoclast Inhibitors for Patients with Multiple Myeloma or Bone Metastases Associated with Breast Cancer, Prostate Cancer, or Lung Cancer	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP noted the need for this measure to be submitted for and receive NQF endorsement to address concerns about the measure reflecting current evidence and the potential unintended consequence of measuring use of one class of medication. Public comments from ADCC, Amgen, and GNYHA support MAP's conclusion.
1628 Endorsed	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Conditional Support. Not ready for implementation; measure concept is promising but requires modification or further development.	MAP noted that this measure involves repeated patient screenings and expressed concern that this measure would be especially burdensome and costly to implement. A sampling methodology may be more feasible than collecting data on all patients at all visits. MAP noted that this measure may be redundant with finalized measures NQF #0383 and NQF #0384 and encouraged CMS to take the most parsimonious approach when implementing measures for the program. Public comment from GNYHA supports MAP's conclusion. Public comments from AAHPM and MITA do not support MAP's conclusion. AAHPM notes this measure addresses a critical measure gap and should be fully supported. Public comment from ADCC does not support MAP's conclusion, noting a sampling methodology or PRO instrument should be adopted instead. ADCC further notes that this measure should be harmonized with other finalized pain-related measures.

TABLE A12. MAP INPUT ON PCHQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDBLG Not Endorsed	Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement,	MAP noted that preventing overuse is important to address waste in the system was well as to improve patient safety. This measure is consistent with current guidelines. MAP recommended that overuse measurement be tied more closely to shared decisionmaking between providers and patients. Patient-centered care is a crucial part of cancer treatment because the science is constantly evolving and patients need to feel comfortable discussing treatment options with their providers. Public comments from ADCC, MITA, UHC and GNYHA support MAP's conclusion.
0450 Endorsed	Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12)	Support. NQF-endorsed measure. Addresses program goals/ requirements.	MAP noted that this measure is included in the Safety Family of Measures and addresses an important patient safety concern. Public comment from UHC supports MAP's conclusion. Public comments from ADCC and GNYHA urge CMS to include risk-adjustment for this measure to account for cancer-specific risks.
XDDAF Not Endorsed	Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy	Conditional Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	Public comments from ADCC, Eisai, and GNYHA support MAP's conclusion. Public comment from Amgen does not support MAP's conclusion, noting the causes for admissions and ED visits in cancer patients are not exclusive sequelae of outpatient chemotherapy; therefore the measure may not be a sensitive nor specific indicator of physician practice in prevention of these potential complications.

TABLE A13. MAP INPUT ON HOSPICE AND PALLIATIVE MEASURES TO ADDRESS GAPS IN PCHQR

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
1634 Endorsed	Hospice and Palliative Care -- Pain Screening	Support. NQF-endorsed measure. Addresses program goals/ requirements.	Applies to all patients/settings. There is a question of whether these data can be recorded electronically. Public comment from AAHPM supports MAP's conclusion. Public comment from ADCC does not support MAP's conclusion, noting a sampling methodology or PRO instrument should be adopted instead. ADCC further notes that this measure should be harmonized with other finalized pain-related measures.
1637 Endorsed	Hospice and Palliative Care -- Pain Assessment	Support. NQF-endorsed measure. Addresses program goals/ requirements.	Applies to all patients/settings. Public comment from AAHPM supports MAP's conclusion. Public comment from ADCC does not support MAP's conclusion, noting a sampling methodology or PRO instrument should be adopted instead. ADCC further notes that this measure should be harmonized with other finalized pain-related measures.
0326 Endorsed	Advance Care Plan	Support. NQF-endorsed measure. Addresses program goals/ requirements.	Applies to all patients/settings. Public comments from AAHPM and ADCC support MAP's conclusion. ADCC notes a sampling methodology should be adopted for this measure and the measure should be modified to include all adult patients.
1641 Endorsed	Hospice and Palliative Care – Treatment Preferences	Support. NQF-endorsed measure. Addresses program goals/ requirements.	Public comments from ADCC and AAHPM support MAP's conclusion.

Inpatient Psychiatric Facilities Quality Reporting Program

Program Type

Pay for Reporting – Information will be reported on the Hospital Compare website.[58]

Incentive Structure

Nonparticipating inpatient psychiatric hospitals or psychiatric units will receive a reduction of 2.0% of their annual market basket update (the measure of change in costs of goods and services used by hospitals in treating Medicare patients) to the Prospective Payment System (PPS).[59]

Care Settings Included

Inpatient Psychiatric Facilities (IPFs) required to report in the program include inpatient psychiatric hospitals or psychiatric units paid under the IPF PPS. The IPF Quality Reporting Program applies to freestanding psychiatric hospitals, government-operated psychiatric hospitals, and distinct psychiatric units of acute-care hospitals and critical-access hospitals. The IPF Quality Reporting Program does not apply to children's hospitals, which are paid under a different system.

Statutory Mandate

Section 1886(s)(4) of the Social Security Act as amended by sections 3401(f) and 10322(a) of the Affordable Care Act (ACA) and requires CMS to establish quality measures for the IPF Quality Reporting Program.

Statutory Requirements for Measures

The program measure set should include structure, process, outcome, patients' perspectives on care, efficiency, and costs-of-care measures. The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all facilities are effectively in compliance or measures do not represent best practice).

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A14. MAP INPUT ON IPFQR MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0028 Endorsed	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Do Not Support. A different NQF-endorsed measure better addresses the needs of the program.	MAP found that this screening measure did not meet the needs of the program. While MAP found the one-day screening window to be an improvement over other measures that have a three-day window, the group expressed concerns that these may be setting a low bar. As an alternative, MAP encouraged the inclusion of measures from the Joint Commission's tobacco, substance abuse, and hospital-based inpatient psychiatric services suites, noting that these are currently used in the field and are in the final stages of the NQF endorsement process. Public comments from FAH and TJC support MAP's conclusion. Public comment from CHA does not support the inclusion of tobacco or substance use measures in inpatient programs.
XCAEA Not Endorsed	IPF Metabolic Screening	Do Not Support. A different NQF-endorsed measure better addresses the needs of the program.	MAP found that this screening measure did not meet the needs of the program. While MAP found the one-day screening window to be an improvement over other measures that have a three-day window, the group expressed concerns that these may be setting a low bar. As an alternative, MAP encouraged the inclusion of measures from the Joint Commission's tobacco, substance abuse, and hospital-based inpatient psychiatric services suites, noting that these are currently used in the field and are in the final stages of the NQF endorsement process. Public comments from FAH and TJC support MAP's conclusion.

TABLE A14. MAP INPUT ON IPFQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDCBA Not Endorsed	IPF Suicide Risk Screening completed within one day of admission	Do Not Support. A different NQF-endorsed measure better addresses the needs of the program.	MAP found that this screening measure did not meet the needs of the program. While MAP found the one-day screening window to be an improvement over other measures that have a three-day window, the group expressed concerns that these may be setting a low bar. As an alternative, MAP encouraged the inclusion of measures from the Joint Commission's tobacco, substance abuse, and hospital-based inpatient psychiatric services suites, noting that these are currently used in the field and are in the final stages of the NQF endorsement process. Public comments from FAH and TJC support MAP's conclusion.
XDCFD Not Endorsed	IPF Violence Risk Screening completed within one day of admission	Do Not Support. A different NQF-endorsed measure better addresses the needs of the program.	MAP found that this screening measure did not meet the needs of the program. While MAP found the one-day screening window to be an improvement over other measures that have a three-day window, the group expressed concerns that these may be setting a low bar. As an alternative, MAP encouraged the inclusion of measures from the Joint Commission's tobacco, substance abuse, and hospital-based inpatient psychiatric services suites, noting that these are currently used in the field and are in the final stages of the NQF endorsement process. Public comments from FAH and TJC support MAP's conclusion.

TABLE A14. MAP INPUT ON IPFQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFGC Not Endorsed	IPF Drug Use Screening completed within one day of admission	Do Not Support. A different NQF-endorsed measure better addresses the needs of the program.	MAP found that this screening measure did not meet the needs of the program. While MAP found the one-day screening window to be an improvement over other measures that have a three-day window, the group expressed concerns that these may be setting a low bar. As an alternative, MAP encouraged the inclusion of measures from the Joint Commission's tobacco, substance abuse, and hospital-based inpatient psychiatric services suites, noting that these are currently used in the field and are in the final stages of the NQF endorsement process. Public comments from FAH and TJC support MAP's conclusion. Public comment from CHA does not support the inclusion of tobacco or substance use measures in inpatient programs.
XDFGD Not Endorsed	IPF Alcohol Use Screening completed within one day of admission	Do Not Support. A different NQF-endorsed measure better addresses the needs of the program.	MAP found that this screening measure did not meet the needs of the program. While MAP found the one-day screening window to be an improvement over other measures that have a three-day window, the group expressed concerns that these may be setting a low bar. As an alternative, MAP encouraged the inclusion of measures from the Joint Commission's tobacco, substance abuse, and hospital-based inpatient psychiatric services suites, noting that these are currently used in the field and are in the final stages of the NQF endorsement process. Public comments from FAH and TJC support MAP's conclusion. Public comment from CHA does not support the inclusion of tobacco or substance use measures in inpatient programs.

TABLE A14. MAP INPUT ON IPFQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0431 Endorsed	Influenza Vaccination Coverage Among Healthcare Personnel	Conditional Support. Not ready for implementation; measure needs further experience or testing before being used in the program.	MAP noted that influenza vaccination is important for healthcare personnel and patients and an important public health concern. However, MAP cautioned that CDC and CMS need to collaborate on adjusting specifications for reporting from psych units before these measures can be included in the reporting program. Public comments from the Armstrong Institute support MAP's conclusion.
1659 Endorsed	Influenza Immunization	Conditional Support. Not ready for implementation; measure needs further experience or testing before being used in the program.	MAP noted that influenza vaccination is important for healthcare personnel and patients and an important public health concern. However, MAP cautioned that CDC and CMS need to collaborate on adjusting specifications for reporting from psych units before these measures can be included in the reporting program.
XDEGE Not Endorsed	IPF Use of an electronic health record meeting Stage 1 or Stage 2 Meaningful Use criteria	Do Not Support. Measure does not adequately address any current needs of the program.	MAP noted that psychiatric hospitals were excluded from the EHR Incentive Program and imposing these criteria is not realistic. MAP also expressed concerns about using quality reporting programs to collect data on systems and infrastructure and suggested that the American Hospital Association's survey of hospitals may be a better source for this type of data.
XDFGE Not Endorsed	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	Support. Promotes person- and family-centered care.	MAP noted the potential of this measure to improve patient and family engagement and experience but cautioned that this measure should eventually be replaced with a patient-reported measure of experience of care. Public comments from the Armstrong Institute support MAP's conclusion.

Hospital Outpatient Quality Reporting

Program Type

Pay for Reporting – Information is reported on the Hospital Compare website.[60]

Incentive Structure

Nonparticipating hospitals will receive a 2.0% reduction in their annual market basket payment update (the measure of change in costs of goods and services used by hospitals in treating Medicare patients).[61] Hospitals providing outpatient services such as clinic visits, emergency department visits, or critical care services (including trauma team activation) that do not meet the minimum Outpatient Quality Reporting Program (OQR) requirements will not receive the Outpatient Prospective Payment System (OPPS) payment updates for the calendar year, which may result in a reduction in the OPPS payments.

Care Settings Included

Hospitals providing outpatient services such as clinic visits, emergency department visits, and critical care services paid under the OPPS.

Statutory Mandate

The OQR Program was first established in the Balanced Budget Act of 2007. The program was mandated by Congress to replace Title XVIII of the Social Security Act reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 2007 established PPS for outpatient services rendered on or after August 2010.[62] The Affordable Care Act of 2010 established the role of the OQR Program as a pay-for-reporting program for hospitals.

Statutory Requirements for Measures

The OQR program measure set should include structure, process, outcome, patients' perspectives on care, efficiency, and costs-of-care measures. The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

Future rulemaking will consider measures of clinical quality of care, care coordination, patient safety and experience, population health, and efficiency.[63]

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A15. MAP INPUT ON OQR MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEMA Not Endorsed	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Conditional Support. Should be submitted for and receive NQF endorsement; Measure is promising but needs further development.	Measure would provide valuable outcome information to inform consumer decision and drive quality improvement. Measure addresses an important quality and safety issue with incidence ranging from 10 to 22 per 1,000 after risk adjustment. The NQF endorsement process would resolve questions about the reliability and validity of the measure and about the feasibility of the algorithm for attributing claims data in light of possible effects of the Medicare three-day payment window. Public comments from the Armstrong Institute and UHC support MAP's conclusion. Public comments from the ASC Quality Collaboration and ASGE do not support MAP's conclusion, noting concerns about the impact of the Medicare three-day payment window on the measure.
XDFMH Not Endorsed	30-Day Readmissions	Do Not Support. Measure does not adequately address any current needs of the program.	While MAP supports the inclusion of readmissions measures as part of a broader approach to measuring performance and improving care, MAP was unable to support the 30-Day Readmissions measure under consideration as the measure was not well defined. Public comment from FAH supports MAP's conclusion.

TABLE A15. MAP INPUT ON OQR MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDFMF Not Endorsed	No Individual Psychotherapy	Do Not Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP members wanted evidence on the relative value of individual versus group therapy and recommended that these measures be submitted for NQF endorsement to better understand their merit before they are implemented. MAP recognized the need for individualized psychotherapy services, particularly for vulnerable populations, and these measures conceptually have face validity; however, the measures have more to do with previously identified billing issues than they do with quality of care or patient outcomes. Public comments from FAH and the Armstrong Institute support MAP's conclusion.
XDFMG Not Endorsed	Group Therapy	Do Not Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP members wanted evidence on the relative value of individual versus group therapy and recommended that these measures be submitted for NQF endorsement to better understand their merit before they are implemented. MAP recognized the need for individualized psychotherapy services, particularly for vulnerable populations, and these measures conceptually have face validity; however, the measures have more to do with previously identified billing issues than they do with quality of care or patient outcomes. Public comments from FAH and the Armstrong Institute support MAP's conclusion.
XDEMB Not Endorsed	High-Acuity Care Visits after Outpatient Cataract Procedure	No longer under consideration per HHS.	Public comment from UHC supports the inclusion of outcome measures indicating issues in care for common outpatient procedures.
XDELM Not Endorsed	High-Acuity Care Visits after Outpatient Endoscopy Procedure	No longer under consideration per HHS.	Public comment from UHC supports the inclusion of outcome measures indicating issues in care for common outpatient procedures.

Ambulatory Surgical Centers Quality Reporting Program

Program Type

Pay for Reporting – Information is reported to the Centers for Medicare & Medicaid Services (CMS).[64]

Incentive Structure

Beginning in CY 2014, ambulatory surgical centers (ACSs) that treat Medicare beneficiaries and fail to report data will receive a 2.0% reduction in their annual market basket payment update (the measure of change in costs of goods and services used to treat Medicare patients).[65] Data collection for the ASC Quality Reporting Program began in 2012; most measures collected are to be used for payment determination beginning in 2014.

Care Settings Included

The program includes ASCs operating exclusively to provide surgical services to patients not requiring hospitalization. The expected duration of services would not be expected to exceed 24 hours following admission to the ASC facility.[66]

Statutory Mandate

CMS is authorized, but not required, to implement a reduction in annual payment updates for facilities failing to report on quality measures under the Medicare Improvements and Extension Act of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006.

Statutory Requirements for Measures

The ASC Quality Reporting Program may include the same or similar measures reported in the Hospital Outpatient Quality Reporting (OQR) or Inpatient Quality Reporting (IQR) Programs.

The program measure set should include structure, process, outcome, patients' perspectives on care, efficiency, and costs-of-care measures. To the extent feasible, outcome and patient experience measures should be risk adjusted. The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all facilities are effectively in compliance or measures do not represent best practice).

In order to reduce the burden of measurement for smaller ASCs, CMS finalized only claims-based measures for the first year of the program and only structural measures for the second year of the program.

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A16. MAP INPUT ON ASCQR MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEMA Not Endorsed	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Conditional Support. Should be submitted for and receive NQF endorsement; Measure is promising but needs further development.	Measure would provide valuable outcome information to inform consumer decision and drive quality improvement. Measure addresses an important quality and safety issue with incidence ranging from 10 to 22 per 1,000 after risk adjustment. The NQF endorsement process would resolve questions about the reliability and validity of the measure and about the feasibility of the algorithm for attributing claims data in light of possible effects of the Medicare three-day payment window. Public comments from the Armstrong Institute and UHC support MAP's conclusion. Public comments from the ASGE and ASC Quality Collaboration do not support MAP's conclusion, noting measure development and testing should be completed before a measure is conditionally supported.
XDEMB Not Endorsed	High-Acuity Care Visits after Outpatient Cataract Procedure	No longer under consideration per HHS.	
XDELM Not Endorsed	High-Acuity Care Visits after Outpatient Endoscopy Procedure	No longer under consideration per HHS.	

TABLE A17. MAP INPUT ON FINALIZED ASCQR MEASURES

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0658 **Endorsed**	Endoscopy Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	Retain.	MAP discussed the difficulty in attributing this measure to the ASC facility given that much of the decisionmaking of colonoscopy timing is under the purview of the primary care provider. However, MAP also noted that this is an important measure of overuse and ASCs should share responsibility for ensuring that their clinicians are not performing procedures more often than necessary. Public comment from ASGE does not support MAP's conclusion, noting questions about the feasibility of implementing this measure at the facility level.
0659 **Endorsed**	Endoscopy Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	Retain.	MAP discussed the difficulty in attributing this measure to the ASC facility given that much of the decisionmaking of colonoscopy timing is under the purview of the primary care provider. However, MAP also noted that this is an important measure of overuse and ASCs should share responsibility for ensuring that their clinicians are not performing procedures more often than necessary. Public comment from ASGE does not support MAP's conclusion, noting questions about the feasibility of implementing this measure at the facility level.

MAP Input on Post-Acute and Long-Term Care Programs

Inpatient Rehabilitation Facility Quality Reporting

Program Type

Pay for Reporting, Public Reporting.

Incentive Structure

For the fiscal year of 2014, and each year thereafter, Inpatient Rehabilitation Facility providers (IRFs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive annual payment updates. Failure to report quality data will result in a 2% reduction in the annual increase factor for discharges occurring during that fiscal year.[67] The data must be made publicly available, with IRF providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[68]

Care Settings Included

Inpatient Rehabilitation Facilities.

Statutory Mandate

Section 3004(b) of the Affordable Care Act (ACA) directs the Secretary to establish quality reporting requirements for IRFs.

Statutory Requirements for Measures

Measures should align with the National Quality Strategy (NQS), be relevant to the priorities of IRFs (such as patient safety, reducing adverse events, better coordination of care, and person- and family-centered care), and address the primary role of IRFs—meeting the rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community post-discharge.[69]

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A18. MAP INPUT ON INPATIENT REHABILITATION FACILITY QUALITY REPORTING MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0674 Endorsed	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Conditionally Support. Not ready for implementation; data sources do not align with program's data sources. Not ready for implementation; measure needs further experience or testing before being used in the program.	Measure should be modified to clarify the scale of the injury, consider where falls occur in the facility, and distinguish between assisted falls and unassisted falls. Public comment from AMRPA supports MAP's conclusion.
1716 Endorsed	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Conditionally Support. Not ready for implementation; measure concept is promising but requires modification or further development.	MAP suggests exploring whether this measure could be harmonized with other infection measures. Public comment from AMRPA supports MAP's conclusion. Public comments from ARN and UDSMR do not support MAP's conclusion, noting that incidence of this condition occurring in rehabilitation facilities is very low.
1717 Endorsed	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Support. NQF-endorsed measure. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set. Addresses program goals/ requirements. Addresses a measure type not adequately represented in the program measure set.	MAP notes that this is an important concept that can prevent patients' participation in rehab. Public comment from AMRPA supports MAP's conclusion. Public comments from ARN and UDSMR do not support MAP's conclusion, noting that incidence of this condition occurring in rehabilitation is very low.
0676 Endorsed	Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)	Conditionally Support. Not ready for implementation; measure concept is promising but requires modification or further development.	MAP notes this is an important concept as pain can interfere with patients' ability to participate in rehab. Public comment from AMRPA supports MAP's conclusion.

TABLE A18. MAP INPUT ON INPATIENT REHABILITATION FACILITY QUALITY REPORTING MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCFFL Not Endorsed	Functional Outcome Measure: Change in Mobility Score	Conditionally Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; data sources do not align with program's data sources.	Public comments from AMRPA, CHA, and ARN support MAP's conclusion. UDSMR urges MAP to consider the FIM® instrument to measure functional quality and outcomes in post-acute care, noting that the FIM® instrument has been used across all post-acute care settings and is already being used by CMS for the IRF Prospective Payment System.
XCFFM Not Endorsed	Functional Outcome Measure: Change in Self-Care Score	Conditionally Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; data sources do not align with program's data sources.	Public comments from AMRPA, CHA, and ARN support MAP's conclusion. UDSMR urges MAP to consider the FIM® instrument to measure functional quality and outcomes in post-acute care, noting that the FIM® instrument has been used across all post-acute care settings and is already being used by CMS for the IRF Prospective Payment System.
XDDCA Not Endorsed	Functional Outcome Measure: Discharge mobility score	Conditionally Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; data sources do not align with program's data sources.	Public comments from AMRPA, CHA, and ARN support MAP's conclusion. UDSMR urges MAP to consider the FIM® instrument to measure functional quality and outcomes in post-acute care, noting that the FIM® instrument has been used across all post-acute care settings and is already being used by CMS for the IRF Prospective Payment System.
XDDCB Not Endorsed	Functional Outcome Measure: Discharge self-care score	Conditionally Support. Not ready for implementation; measure concept is promising but requires modification or further development. Not ready for implementation; data sources do not align with program's data sources.	Public comments from AMRPA, CHA, and ARN support MAP's conclusion. UDSMR urges MAP to consider the FIM® instrument to measure functional quality and outcomes in post-acute care, noting that the FIM® instrument has been used across all post-acute care settings and is already being used by CMS for the IRF Prospective Payment System.

Long-Term Care Hospital Quality Reporting

Program Type
Pay for Reporting, Public Reporting.

Incentive Structure
For fiscal year 2014, and each year thereafter, Long-Term Care Hospital providers (LTCHs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive full annual payment updates; failure to report quality data will result in a 2% reduction in the annual payment update.[70] The data must be made publicly available, with LTCH providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[71]

Care Settings Included
Long-Term Care Hospitals.

Statutory Mandate
Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for LTCHs.

Statutory Requirements for Measures
Measures should align with the National Quality Strategy (NQS), promote enhanced quality with regard to the priorities most relevant to LTCHs (such as patient safety, better coordination of care, and person- and family-centered care), and address the primary role of LTCHs—furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).[72]

MAP Pre-Rulemaking 2014 Input
The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A19. LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCBBF Not Endorsed	Percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function	Conditionally Support. Not ready for implementation; measure concept is promising but requires modification or further development.	
XCFGB Not Endorsed	Functional Outcome Measure: change in mobility among patients requiring ventilator support	Conditionally Support. Not ready for implementation; measure concept is promising but requires modification or further development.	Measure addresses a critical area of measurement; however, functional outcome measures should be broader than patients requiring ventilation.
XDDCC Not Endorsed	Ventilator-Associated Event	Support. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set. Addresses program goals/ requirements.	Measure provides useful information for healthcare facilities to monitor ventilator use.

End Stage Renal Disease Quality Incentive Program

Program Type

Pay for Performance, Public Reporting.

Incentive Structure

Starting in 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions will be on a sliding scale, which could amount to a maximum of 2% per year.[73] Performance is reported on the Dialysis Facility Compare website.

Care Settings Included

Dialysis Providers/Facilities.

Statutory Mandate

The ESRD Quality Incentive Program (QIP), required by section 1881 (h) of the Social Security Act and added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c), was developed by CMS to be the first pay-for-performance (also known as "value-based purchasing") model quality incentive program.[74]

Statutory Requirements for Measures

Measures of anemia management that reflect labeling approved by the Food and Drug Administration (FDA), dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access.[75]

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A20. END-STAGE RENAL DISEASE QUALITY INCENTIVE PROGRAM MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0029 Endorsed	Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	Support. NQF-endorsed measure. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set. Promotes person- and family-centered care.	Measure should go beyond assessment, including a plan for follow-up. The denominator for this measure is individuals age 65 years and older; the measure should be expanded to include adults and children. Public comments from ASN, KCP, and NKF do not support MAP's conclusion. ASN notes the measure is poorly defined and, as worded, seems to require an additional patient survey, and is beyond the scope of dialysis facilities. NKF and KCP question its impact.
0260 Endorsed	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Do not Support. Measure does not adequately address any current needs of the program.	KDQOL is collected for dialysis facilities certification; MAP prefers measures that go beyond assessment by including follow-up and intervention. Public comments from NKF, ASN, and KCP support MAP's conclusion. Public comment from the Armstrong Institute also notes that the measure has been implemented in most dialysis facilities under the Medicare Conditions for Coverage.
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Support. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set. Promotes person- and family-centered care. Promotes alignment across programs, settings, and public- and private-sector efforts.	MAP notes that this measure includes follow-up assessment and an action plan. Public comments from KCP, NKF, and ASN do not support MAP's conclusion, noting that the measure is endorsed for use at the health plan and population levels and that the measure is not feasible since facilities do not collect this data. Public comment from the Armstrong Institute also raises concerns regarding the measure, noting that requiring documentation of referrals is beyond the scope of care for facilities.

TABLE A20. END-STAGE RENAL DISEASE QUALITY INCENTIVE PROGRAM MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0418 Endorsed	Screening for Clinical Depression	Support. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set. Promotes person- and family-centered care.	Depression is common in dialysis patients. The Beck Depression Index has been validated in the dialysis population, and it has been correlated with mortality. Dialysis facilities have multiple providers, including social workers, who are equipped to deal with depression; accordingly the measure is actionable. Public comments from the Armstrong Institute and NKF support MAP's conclusion. Public comments from ASN and KCP do not support MAP's conclusion, noting that the measure is endorsed as a clinician-level measure and is not appropriate for use in dialysis facilities.
0420 Endorsed	Pain Assessment and Follow-Up	Support. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set. Promotes person- and family-centered care.	Pain is important to assess as it can be a sign of more severe problems. Public comment from NKF supports MAP's conclusion. Public comments from ASN and KCP do not support MAP's conclusion, noting that the measure was endorsed as a clinician-level measure and is not appropriate for use in dialysis facilities. Public comment from the Armstrong Institute also raises concerns regarding the measure, noting that the lack of clarity of the timing and frequency of pain assessment would place a significant burden on facilities.
0393 Endorsed	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	Support. NQF-endorsed measure. Addresses program goals/ requirements.	Measure is important in this population as 14% of dialysis patients have Hepatitis C, which is 10 times more than the general population. It would be important to consider antiviral therapy before kidney transplant, because Hepatitis C is difficult to treat post-transplant. Public comment from NKF supports MAP's conclusion. Public comments from ASN and KCP do not support MAP's conclusion, noting that the measure is endorsed at the clinician level and has not been tested in dialysis facilities.

TABLE A20. END-STAGE RENAL DISEASE QUALITY INCENTIVE PROGRAM MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0431 Endorsed	Influenza Vaccination Coverage Among Healthcare Personnel	Support. NQF-endorsed measure.	Public comment from NKF supports MAP's conclusion. Public comments from ASN and KCP do not support MAP's conclusion, citing concerns about implementation and feasibility.
XDEFH Not Endorsed	Pneumococcal Vaccination Measure (PCV13)	Do Not Support. Measure does not adequately address any current needs of the program. A "Supported" measure under consideration addresses a similar topic and better addresses the needs of the program.	This measure assesses whether patients received one pneumococcal vaccine. It may be challenging for facilities to understand which vaccination (PCV13 or PCV23) a patient may have received in a previous setting. MAP recommends modifying NQF #1653 or XDGBA to address pneumococcal vaccinations in this setting. Public comments from ASN and KCP support MAP's conclusion. Public comment from NKF does not support MAP's conclusion, noting the measure should align with the CDC Advisory Committee on Immunization Practices (ACIP) recommendation. Public comment from the Armstrong Institute raises concern regarding the implementation of this measure which could be difficult and potentially lead to inappropriate or repeat immunization.
XDEFL Not Endorsed	ESRD Vaccination - Pneumococcal Vaccination (PPSV23)	Do Not Support. Measure does not adequately address any current needs of the program. A "Supported" measure under consideration addresses a similar topic and better addresses the needs of the program.	This measure assesses whether patients received one pneumococcal vaccine. It may be challenging for facilities to understand which vaccination (PCV13 or PCV23) a patient may have received in a previous setting. MAP recommends modifying NQF #1653 or XDGBA to address pneumococcal vaccinations in this setting. Public comments from ASN, the Armstrong Institute, and KCP support MAP's conclusion. Public comment from NKF does not support MAP's conclusion, noting the measure should align with the CDC Advisory Committee on Immunization Practices (ACIP) recommendation.

TABLE A20. END-STAGE RENAL DISEASE QUALITY INCENTIVE PROGRAM MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEFM Not Endorsed	Full-Season Influenza Vaccination (ESRD Patients)	Conditionally Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP notes that influenza vaccination is very important for dialysis patients; however, it is unclear how this measure will drive improvement compared to another NQF-endorsed measure #0226 Influenza Immunization in the ESRD Population. Public comments from the Armstrong Institute and NKF support MAP's conclusion. Public comments from ASN and KCP do not support MAP's conclusion, noting that the measure is currently vague and is not aligned with the NQF-endorsed standardized specifications for influenza immunization measures.
XDEGA Not Endorsed	ESRD Vaccination - Timely Influenza Vaccination	Do Not support: A "Supported" measure under consideration addresses a similar topic and better addresses the needs of the program.	MAP prefers XDEFM, which assesses vaccination for the full flu season, rather than a measure that assesses vaccinations for a limited time period. Additionally, the shorter time period is not supported by evidence. Public comments from the Armstrong Institute, KCP, NKF, and ASN support MAP's conclusion.
XDGAF Not Endorsed	Hepatitis B vaccine coverage in hemodialysis patients	Support. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set.	Public comments from ASN and KCP do not support MAP's conclusion, noting that they cannot adequately evaluate the technical aspects of the measure as currently written. Public comment from the Armstrong Institute and NKF raises concerns regarding the measure's ability to drive improvement.
XDGBA Not Endorsed	ESRD Vaccination – Lifetime Pneumococcal Vaccination	Conditionally Support. Not ready for implementation; measure concept is promising but requires modification or further development.	The evidence supporting this measure is still developing. Additionally, this measure should align with CDC guidelines. Public comments from ASN, the Armstrong Institute, and NKF support MAP's conclusion. Public comment from KCP does not support MAP's conclusion, noting that the measure has not been tested for reliability or validity.

TABLE A20. END-STAGE RENAL DISEASE QUALITY INCENTIVE PROGRAM MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCBMM Not Endorsed	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/ V	Conditionally Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP supports continued development of this measure. MAP will consider this measure for inclusion in the program once it has been reviewed for endorsement. Public comments from the Armstrong Institute, ASN, NKF, and KCP support MAP's conclusion.
XDGAM Not Endorsed	Pediatric Peritoneal Dialysis Adequacy: Frequency of Measurement of Kt/ V	Conditionally Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP supports continued development of this measure. MAP will consider this measure for inclusion in the program once it has been reviewed for endorsement. Public comments from the Armstrong Institute, ASN, NKF, and KCP support MAP's conclusion.
XDEGB Not Endorsed	Percentage of Dialysis Patients with Dietary Counseling	Conditionally Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP supports continued development of this measure. MAP will consider this measure for inclusion in the program once it has been reviewed for endorsement. Public comments from the Armstrong Institute and NKF support MAP's conclusion. Public comments from ASN and KCP do not support MAP's conclusion, noting that the measure has not been tested for reliability or validity.
XAHMH Not Endorsed	Ultrafiltration Rate (UFR)	Conditionally Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP supports continued development of this measure. MAP will consider this measure for inclusion in the program once it has been reviewed for endorsement. Public comments from the Armstrong Institute support MAP's conclusion. Public comments from ASN, NKF, and KCP do not support MAP's conclusion, noting the paucity of evidence to support this measure.
XDEFE Not Endorsed	Surface Area Normalized Kt/ V	Conditionally Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP supports continued development of this measure. MAP will consider this measure for inclusion in the program once it has been reviewed for endorsement. Public comments from ASN, NKF, and KCP do not support MAP's conclusion, noting that the measure has not been tested for validity.

TABLE A20. END-STAGE RENAL DISEASE QUALITY INCENTIVE PROGRAM MEASURES UNDER CONSIDERATION (continued)

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XDEFF Not Endorsed	Standardized Kt/ V	Conditionally Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP supports continued development of this measure. MAP will consider this measure for inclusion in the program once it has been reviewed for endorsement. Public comments from ASN, NKF, and KCP do not support MAP's conclusion, noting that the measure has not been tested for validity.
XDEGC Not Endorsed	Measurement of Plasma PTH Concentration	Conditionally Support. Not ready for implementation; should be submitted for and receive NQF endorsement.	MAP supports continued development of this measure. MAP will consider this measure for inclusion in the program once it has been reviewed for endorsement. Public comments from the Armstrong Institute and NKF support MAP's conclusion. Public comment from Amgen supports the immediate inclusion of this measure into the program, noting that no quality measures under the ESRD QIP assess monitoring clinical or biochemical outcomes related to secondary hyperparathyroidism (SHPT). Public comments from ASN and KCP do not support MAP's conclusion, noting that the measure has not been tested for validity and reliability.
N/A Not Endorsed	Comorbidity Report	Do Not Support. Measure does not adequately address any current needs of the program.	Facilities are required to report this information; it is unclear how this information will be used as a performance measure. Public comments from KCP and NKF support MAP's conclusion.

Home Health Quality Reporting

Program Type

Pay for Reporting, Public Reporting.

Incentive Structure

Medicare-certified[76] home health agencies (HHAs) are required to collect and submit the Outcome Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.[77] Home health agencies meet their quality data reporting requirements through the submission of OASIS assessments and Home Health CAHPS. HHAs that do not submit data will receive a 2% reduction in their annual HHS market basket percentage increase.

Subsets of the quality measures generated from OASIS are reported on the Home Health Compare website, which provides information about the quality of care provided by HHAs throughout the country.[78] Currently, 23 of the 97 OASIS measures are finalized for public reporting on Home Health Compare.

Care Settings Included

Medicare-certified home health agencies.

Statutory Mandate

Section 1895(b)(3)(B)(v)(I) of the Social Security Act, as amended by section 5201 of the Deficit Reduction Act, established the requirement that HHAs that do not report quality data would not receive the full market basket payment increase.

Statutory Requirements for Measures

None.

MAP Pre-Rulemaking 2014 Input

The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A21. HOME HEALTH QUALITY REPORTING PROGRAM MEASURES UNDER CONSIDERATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
XCHGG Not Endorsed	Rehospitalization During the First 30 Days of Home Health	Support. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set.	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population. Noting the challenges to the development of such a measure, MAP supports the revisions to this measure to include a hierarchal risk-adjustment model. Public comments from the Armstrong Institute and the C-P Alliance support MAP's conclusion.
XDAEH Not Endorsed	Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health	Support. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set.	A consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population. Noting the challenges to the development of such a measure, MAP supports the revisions to this measure to include a hierarchal risk-adjustment model. Public comments from the Armstrong Institute and the C-P Alliance support MAP's conclusion.
XDFFA Not Endorsed	Depression Screening Conducted and Follow-Up Plan Documented	Support. Promotes person- and family-centered care. Addresses program goals/ requirements.	MAP notes that this measure includes an element of follow-up and would be preferable to the current depression assessment measure in the HHQR set. Public comment from the Armstrong Institute support MAP's conclusion.
XDFGB Not Endorsed	New or Worsened Pressure Ulcers	Support. Addresses National Quality Strategy aim or priority not adequately addressed in program measure set. Addresses program goals/ requirements.	MAP notes that this measure addresses the PAC/LTC core concept of pressure ulcers and raised concern over risk-adjustment issues for this measure. Public comment from the Armstrong Institute support MAP's conclusion.

Hospice Quality Reporting Program

Program Type
Pay for Reporting, Public Reporting.

Incentive Structure
Failure to submit required quality data, beginning in FY 2014 and for each year thereafter, shall result in a 2% reduction to the market basket percentage increase for that fiscal year.[79] The data must be made publicly available, with Hospice Programs having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of hospice quality data. [80]

Care Settings Included
Multiple; hospice care can be provided in inpatient and outpatient settings.

Statutory Mandate
Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Programs.[81]

Statutory Requirements for Measures
None.

MAP Pre-Rulemaking 2014 Input
The following are MAP's recommendations on measures under consideration and finalized measures, as applicable.

TABLE A22. HOSPICE QUALITY REPORTING PROGRAM FINALIZED MEASURES WITH A MAP RECOMMENDATION

Measure # and NQF Status	Measure Title	MAP Conclusion and Rationale	Additional Findings
0209 Endorsed	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	N/A	This measure will be removed from the Hospice Quality Reporting Program in 2015. MAP highly values this measure, yet recognizes that there are implementation issues. MAP encourages continued development of pain outcome measures for the hospice population.

ENDNOTES

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10 CMS. Medicare and Medicaid HER Incentive Program Basics website. Available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html. Last accessed January 2014.

11 CMS. HER Incentive Programs Getting Started website. Available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Getting_Started.html. Last accessed January 2014.

12 CMS HER Incentive Programs. website. Available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/. Last accessed January 2014.

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APPENDIX B:
MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[1]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that HHS will receive varied and thoughtful input on performance measure selection. In particular, the ACA-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a more global and strategic way.

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable.[2] Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP's objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families**. MAP encourages the use of the best available measures that are high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared decisionmaking.
2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value**. MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden**. MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology (health IT) to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure

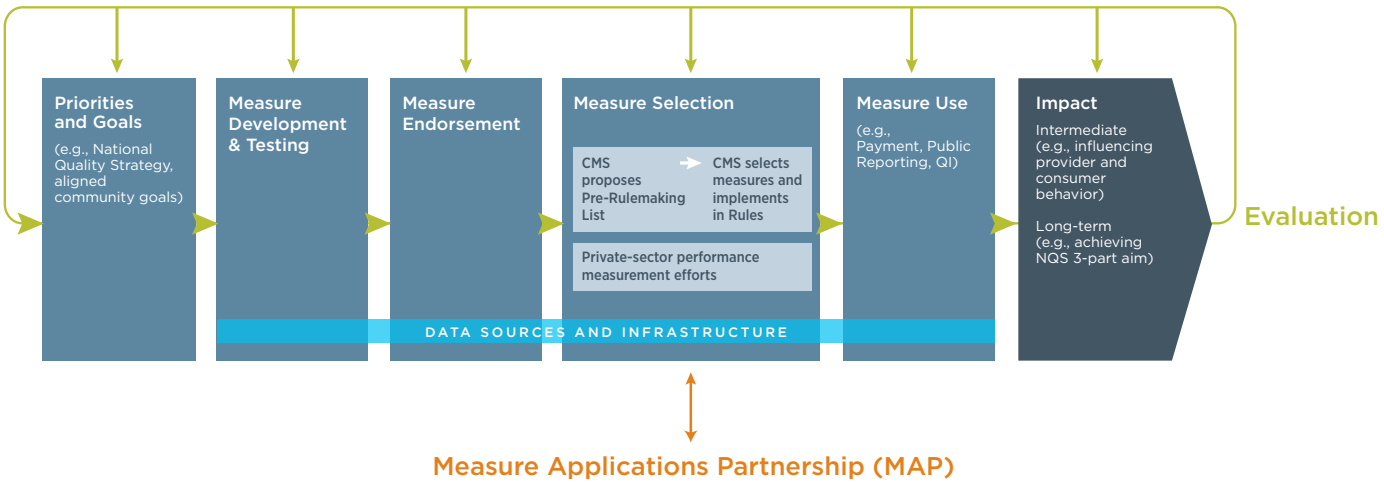
developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust Quality Enterprise (see Figure 1) that includes:

- **Setting priorities and goals.** The work of the Measure Applications Partnership is predicated on the National Quality Strategy and its three aims of better care, affordable care, and healthy people/healthy communities. The NQS aims and six priorities provide a guiding framework for the work of the MAP, in addition to helping align it with other quality efforts.
- **Developing and testing measures.** Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).
- **Endorsing measures.** NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.
- **Measure selection and measure use.** Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the Quality Enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.
- **Impact.** Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate if measures are having their intended impact and are driving improvement, transparency, and value.
- **Evaluation.** Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements.

MAP seeks to engage in bidirectional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

FIGURE B1. QUALITY MEASUREMENT ENTERPRISE



Structure

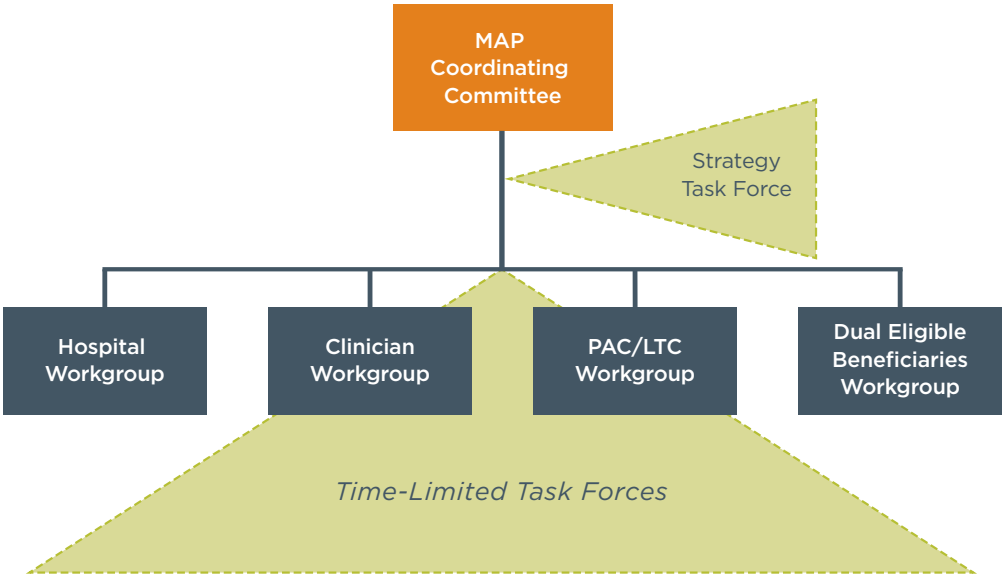
MAP operates through a two-tiered structure (see Figure 2). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing "families of measures"—related measures that cross settings and populations—and a multiyear strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

The NQF Board of Directors oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness, but will not review the Coordinating Committee's input to HHS. The Board selected the Coordinating Committee and workgroups based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups also was imperative.

All MAP activities are conducted in an open and transparent manner. The appointment process includes open nominations and a public comment period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decisionmaking is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the NQF-endorsed Patient-Focused Episodes of Care framework,[3] the HHS Partnership for Patients safety initiative,[4] the HHS Prevention and Health Promotion Strategy, [5] the HHS Disparities Strategy,[6] and the HHS Multiple Chronic Conditions framework.[7]

FIGURE B2. MAP STRUCTURE



Additionally, the MAP Coordinating Committee has developed Measure Selection Criteria (see Appendix D) to help guide MAP decisionmaking. The MAP Measure Selection Criteria are intended to build on, not duplicate, the NQF endorsement criteria. In 2013, MAP updated the MSC to incorporate lessons learned from the previous pre-rulemaking cycles and to incorporate the Guiding Principles that the Clinician and Hospital Workgroups had developed during their 2012-2013 pre-rulemaking input.

The Measure Selection Criteria provide decisionmaking guidance for MAP members as they are considering the appropriateness of measures for specific programs. They call attention to aspects of the measure such as endorsement status, alignment with an NQS aim or priority, alignment with other programs (if applicable), whether it is disparities sensitive, and other important considerations. The criteria are intended to act as guidance, rather than absolute rules.

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see **MAP 2012 Pre-Rulemaking Report** submitted to HHS February 1, 2012 and **MAP 2013 Pre-Rulemaking Report** submitted to HHS February 1, 2013).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP's pre-rulemaking input. To date MAP has:

- Engaged in **Strategic Planning** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.
  - **MAP Approach to the Strategic Plan**, submitted to HHS on June 1, 2012
  - **MAP Strategic Plan**, submitted to HHS on October 1, 2012
- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities and high-impact conditions—to facilitate coordination of measurement efforts.
  - **MAP Families of Measures: Safety, Care Coordination, Cardiovascular Conditions, Diabetes**, submitted to HHS on October 1, 2012
- Provided input on **program considerations and specific measures** for federal programs that are not included in MAP's annual pre-rulemaking review.
  - **MAP Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults**, submitted October 15, 2013
  - **Input on the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces**, submitted January 24, 2014
- Provided a measurement strategy and best available measures for evaluating the quality of care provided to Medicare/Medicaid **Dual Eligible Beneficiaries**.
  - **Measuring Healthcare Quality for the Dual Eligible Beneficiary Population**, submitted to HHS on June 1, 2012
  - **Further Exploration of Healthcare Quality Measurement for the Dual Eligible Beneficiary Population**, submitted to HHS on December 21, 2012
- Developed **Coordination Strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives. Each coordination strategy addresses measures,

gaps, and measurement issues; data sources and health information technology implications; alignment across settings and across public- and private-sector programs; special considerations for dual eligible beneficiaries; and the path forward for improving measure application.

- **Coordination Strategy for Clinician Performance Measurement**, submitted to HHS on October 1, 2011
- **Readmissions and Healthcare-Acquired Conditions Performance Measurement Strategy Across Public and Private Payers**, submitted to HHS on October 1, 2011
- **MAP Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement**, submitted to HHS on February 1, 2012
- **Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals**, submitted to HHS on June 1, 2012
- **Performance Measurement Coordination Strategy for Hospice and Palliative Care**, submitted to HHS on June 1, 2012

ENDNOTES

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6 HHS. National Partnership for Action to End Health Disparities website, Available at http://minorityhealth.hhs.gov/npa/. Last accessed March 2012.

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APPENDIX C:
Approach to Pre-Rulemaking

MAP continued to enhance its pre-rulemaking process for the 2013-2014 pre-rulemaking cycle by utilizing the following step-wise approach.

Build on MAP's Prior Recommendations

MAP's prior strategic input and pre-rulemaking decisions provide important building blocks for MAP's ongoing deliberations. MAP's prior inputs and how they contributed to the pre-rulemaking process are described below (also see Table C1).

Coordination Strategies elucidated opportunities for public and private stakeholders to accelerate improvement and alignment of measurement initiatives. Each coordination strategy addresses available measures, gaps, and measurement issues; data sources and health information technology implications; alignment opportunities across settings and across public- and private-sector programs; special considerations for dual eligible beneficiaries; and approaches for improving measure application. The recommendations provided setting-specific considerations that served as background information for MAP's pre-rulemaking deliberations.

2012 and **2013** Pre-Rulemaking Reports provided program-specific input that included recommendations about measures previously finalized for various programs and about measures on the list of measures under consideration for future implementation by HHS. Previous measure-specific recommendations were incorporated into the measure-by-measure deliberations.

Families of Measures facilitate coordination of measurement efforts. Families of Measures are composed of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities (i.e., safety, care coordination), vulnerable populations (i.e., dual eligible beneficiaries, hospice), and high-impact conditions (i.e., cardiovascular, diabetes, cancer).

Table C1 below illustrates how MAP's prior work served as an input to MAP's pre-rulemaking deliberations.

TABLE C1. USING MAP'S PRIOR WORK IN PRE-RULEMAKING

MAP's Prior Efforts	Pre-Rulemaking Use
Coordination Strategies (i.e., Safety, Clinician, PAC-LTC, Dual Eligible Beneficiaries cross-cutting input)	• Provided topic- and setting-specific considerations that served as background information for MAP's pre-rulemaking deliberations. • Key recommendations from each coordination strategy were compiled in background materials.
Families of Measures NQS priorities (safety, care coordination) Vulnerable populations (dual eligible beneficiaries, hospice) High-impact conditions (cardiovascular, diabetes, cancer)	• Represented a starting place for identifying the highest-leverage opportunities for addressing performance gaps within a particular content area. • Served as a basis for determining alignment between public and private sectors.
Decisions from 2012 and 2013 Pre-Rulemaking Reports	• Provided historical context and represented a starting place for pre-rulemaking discussions. • Prior MAP decisions were noted with the individual measure information in background materials.
Gaps identified across all MAP efforts	• Provided historical context of MAP measure gap identification. • Served as a foundation for measure gap prioritization. • A list of MAP's previously identified gaps was compiled and included in background materials.

Using MAP Measure Selection Criteria and Additional Information to Evaluate Program Measure Sets

The MAP Measure Selection Criteria (MSC) (see Appendix C) are intended to facilitate structured discussion and decisionmaking processes. MAP made enhancements to the MSC in 2013 for the 2013-2014 pre-rulemaking cycle. Key changes and highlights included: adding a preamble to emphasize that the criteria are meant as guidance rather than rules; balancing the need for strong measure standards with the priority of filling important measure gaps and promoting alignment within and across program measure sets; integrating content from the guiding principles previously developed by the Clinician and Hospital Workgroups; and taking a more inclusive approach to person- and family-centered care and services. Table C2 below identifies inputs available to MAP to evaluate program measure sets against the MSC.

TABLE C2. EVALUATING PROGRAM MEASURE SETS AGAINST THE MAP MEASURE SELECTION CRITERIA

Measure Selection Criterion	Information Available and Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	NQF endorsement status was noted for each measure, along with links to additional measure details via NQF's Quality Positioning System (QPS).
2. Program measure set adequately addresses each of the National Quality Strategy's three aims	Provided for each individual measure. MAP discussion determined adequacy of each program measure set in addressing each of the National Quality Strategy (NQS) aims and corresponding priorities.
3. Program measure set is responsive to specific program goals and requirements	For each program, a program information sheet was provided covering: • Statutory requirements • Program goals provided by CMS • Additional information provided in federal rules • MAP's prior key recommendations regarding the program For individual measures, the following information was also provided: • MAP decision history (e.g., supported/not supported, included in a family of measures) • Measure use in private-sector initiatives (where available) • Measure use in public programs (where available) • Measure performance (where available)
4. Program measure set includes an appropriate mix of measure types	Measure type provided for each individual measure. MAP discussion determined whether the mix of measure types is appropriate for each program.
5. Program measure set enables measurement of person- and family-centered care and services	MAP discussion informed whether the program measure set addresses access, choice, self-determination, and community integration.
6. Program measure set includes considerations for healthcare disparities and cultural competency	Provided for each individual measure, based on NQF's Disparities Consensus Development Project. MAP discussion determined the adequacy of each program in promoting equitable access and treatment by considering healthcare disparities.
7. Program measure set promotes parsimony and alignment	Parsimony reflects the quantity, as well as the adequacy, of the measure set for each program. Alignment is evaluated through consideration of available information, such as where measures under consideration are used or being considered for other federal and private programs.

Evaluate Currently Finalized Program Measure Sets Using MAP Measure Selection Criteria

MAP used the MSC to evaluate each finalized program measure set (see Appendix D). During the past two years of providing pre-rulemaking input, HHS has asked MAP to review a large number of measures under consideration, under challenging time constraints, for various performance measurement programs. During this pre-rulemaking cycle, MAP reviewed currently finalized measure sets before reviewing measures under consideration to make the winter pre-rulemaking meetings more efficient. Information relevant to assessing the adequacy of the finalized program measure sets was provided to MAP members. This assessment led to the identification of measure gaps, measures for potential inclusion, measures for potential removal, and other issues regarding program structure.

In reviewing currently finalized program measure sets, MAP provided rationales for one of the following recommendations for each finalized measure:

- **Retain** indicates measures that should remain in the program measure set.
- **Remove** indicates measures that should be removed from a program measure set, according to a justifiable timeline.

Evaluating Measures Under Consideration

The evaluation of each finalized program measure set served as a starting point for reviewing the measures under consideration. Next, MAP determined whether the measures under consideration enhanced the program measure sets. For each measure under consideration, MAP indicated a decision and rationale as well as noted any additional comments or considerations. Table C3 below lists MAP's decision categories and potential rationales.

TABLE C3. MAP DECISION CATEGORIES AND RATIONALE EXAMPLES

MAP Decision Category	Decision Description	Rationale (Examples)
Support	Indicates measures under consideration that should be added to the program measure set during the current rulemaking cycle	• NQF-endorsed measure. • Addresses National Quality Strategy aim or priority not adequately addressed in program measure set. • Addresses program goals/requirements. • Addresses a measure type not adequately represented in the program measure set. • Promotes person- and family-centered care. • Provides considerations for healthcare disparities and cultural competency. • Promotes parsimony. • Promotes alignment across programs, settings, and/or public- and private-sector efforts. • Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries. • Included in a MAP family of measures.

MAP Decision Category	Decision Description	Rationale (Examples)
Do Not Support	Indicates measures, measure concepts, or measure ideas that that are not recommended for inclusion in the program measure set	• Measure does not adequately address any current needs of the program. • A finalized measure addresses a similar topic and better addresses the needs of the program. • A "Supported" measure under consideration addresses a similar topic and better addresses the needs of the program. • NQF endorsement removed (the measure no longer meets the NQF endorsement criteria). • NQF endorsement retired (the measure is no longer maintained by the steward). • NQF endorsement placed in reserve status (performance on this measure is topped out). • Measure previously submitted for endorsement and was not endorsed.
Conditionally Support	Indicates measures, measure concepts, or measure ideas that should be phased into program measure sets over time, subject to contingent factor(s)	• Not ready for implementation; measure concept is promising but requires modification or further development. • Not ready for implementation; should be submitted for and receive NQF endorsement. • Not ready for implementation; data sources do not align with program's data sources. • Not ready for implementation; further experience or testing needed before being used in the program.

To support MAP's pre-rulemaking review of measures, NQF staff identified information for each measure under consideration. The information noted in Table C2 assisted MAP in determining whether the measures under consideration would enhance the finalized program measure sets. Additionally, MAP utilized other information about measures—such as performance results, unintended consequences, impact, and implementation experiences—that NQF staff included in pre-rulemaking measure tables.

To assist MAP's systematic review of the measures under consideration, NQF staff prepared discussion guides for each meeting. The discussion guides facilitated MAP's response to the following questions regarding measures under consideration:

- Is there sufficient information to make a decision?
- Does the measure contribute to the program set (e.g., addresses a gap, advances programmatic goals)?
- Is the measure ready for implementation in a program (e.g., tested for that setting, data sources align with the program's structure)?

The discussion guides allowed MAP to revisit the previously finalized measures and determine whether any measures should be removed from programs. Additionally, the discussion guides provided context for how measures under consideration may enhance program measure sets.

Finally, prior to MAP's deliberation on measures under consideration, MAP offered an opportunity for the public to comment on the measures under consideration for 2014 rulemaking. Comments received provided early input to the MAP workgroups and Coordinating Committee. To guide comments, MAP asked the following questions:

- Would the measure add value to the program measure set? Is a better measure available, or is a measure addressing the particular program objective already in the measure set?
- If the measure is being used, for what purpose? Are there implementation challenges?

The information was then shared with the workgroups at the December in-person meetings and is available on the MAP website.

Identifying High-Priority Measure Gaps

After reviewing the measures under consideration and making recommendations about which new measures to include in programs, MAP reassessed the program measure sets for remaining high-priority gaps. In addition, MAP highlighted barriers to gap-filling and suggested potential solutions to those barriers.

TABLE C4. FEDERAL PROGRAMS FOR PRE-RULEMAKING AND CORRESPONDING MAP WORKGROUP

Federal Program	Number of Measures Under Consideration[a]	Workgroup
Ambulatory Surgical Center Quality Reporting	3	Hospital
End Stage Renal Disease Quality Improvement Program	20	PAC/LTC
Home Health Quality Reporting	4	PAC/LTC
Hospice Quality Reporting	0	PAC/LTC
Hospital-Acquired Condition Reduction Program	4	Hospital
Hospital Inpatient Quality Reporting	11	Hospital
Hospital Outpatient Quality Reporting	6	Hospital
Hospital Readmission Reduction Program	3	Hospital
Hospital Value-Based Purchasing	14	Hospital
Inpatient Psychiatric Facility Quality Reporting	10	Hospital
Inpatient Rehabilitation Facility Quality Reporting	8	PAC/LTC
Long-Term Care Hospital Quality Reporting	3	PAC/LTC
Medicare and Medicaid EHR Incentive Program (Meaningful Use) for Eligible Professionals	37	Clinician
Medicare and Medicaid EHR Incentive Program (Meaningful Use) for Hospitals and CAHs	6	Hospital
Medicare Physician Quality Reporting System[b]	110	Clinician
Medicare Shared Savings Program	100	Clinician, Hospital
Physician Feedback/Quality and Resource Utilization Reports[c]	161	Clinician
Physician Value-Based Modifier Program[c]	161	Clinician
Physician Compare[c]	110	Clinician
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	6	Hospital

a A single measure may be under consideration for multiple programs.

b All quality measures under consideration for PQRS were also under consideration for the Physician Feedback/QRUR, Physician Value-Based Payment Modifier, and Physician Compare programs.

c Measures already finalized and remaining current for the Medicare Physician Quality Reporting System, Hospital Inpatient Quality Reporting, and Hospital Outpatient Quality Reporting programs that were not specifically included on the MUC list may also be considered for the Physician Feedback/QRUR, Physician-Value Based Payment Modifier, and Physician Compare programs.

APPENDIX D:
MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

Sub-criterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Sub-criterion 2.3 Affordable care

3. Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is "fit for purpose" for the particular program.

Sub-criterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

Sub-criterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

4. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program.

Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs

Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Sub-criterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Sub-criterion 5.2 Measure set addresses shared decision-making, such as for care and service planning and establishing advance directives

Sub-criterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

6. Program measure set includes considerations for healthcare disparities and cultural competency

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Sub-criterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Sub-criterion 6.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Sub-criterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

Sub-criterion 7.2 Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

APPENDIX E:
MAP Previously Identified Measure Gaps

This appendix synthesizes previously identified measure gaps compiled from all prior MAP reports. The gaps are grouped by NQS priority.

Safety

- Composite measure of most significant Serious Reportable Events

Healthcare-Associated Infections

- Ventilator-associated events for acute care, post-acute care, long-term care hospitals and home health settings
- Pediatric population: special considerations for ventilator-associated events and C. difficile
- Infection measures reported as rates, rather than ratios (more meaningful to consumers)
- Sepsis (healthcare-acquired and community-acquired) incidence, early detection, monitoring, and failure to rescue related to sepsis
- Post-discharge follow-up on infections in ambulatory settings
- Vancomycin Resistant Enterococci (VRE) measures (e.g., positive blood cultures, appropriate antibiotic use)

Medication and Infusion Safety

- Adverse drug events
  - Injury/mortality related to inappropriate drug management
  - Total number of adverse drug events that occur within all settings (including administration of wrong medication or wrong dosage and drug-allergy or drug-drug interactions)
- Potentially inappropriate medication use
  - Polypharmacy and use of unnecessary medications for all ages, especially high-risk medications
  - Antibiotic use for sinusitis
  - Use of sedatives, hypnotics, atypical-antipsychotics, pain medications (consideration for individuals with dementia, Alzheimer's, or residing in long-term care settings)
- Medication management
  - Patient-reported measures of understanding medications (purpose, dosage, side effects, etc.)
  - Medication documentation, including appropriate prescribing and comprehensive medication review
  - Persistence of medications (patients taking medications) for secondary prevention of cardiovascular conditions
  - Role of community pharmacist or home health provider in medication reconciliation
- Blood incompatibility

Perioperative/Procedural Safety

- Air embolism
- Anesthesia events (inter-operative myocardial infarction, corneal abrasion, broken tooth, etc.)
- Perioperative respiratory events, blood loss, and unnecessary transfusion
- Altered mental status in perioperative period

Venous Thromboembolism

- VTE outcome measures for ambulatory surgical centers and post-acute care/long-term care settings
- Adherence to VTE medications, monitoring of therapeutic levels, medication side effects, and recurrence

Falls and Immobility

- Standard definition of falls across settings to avoid potential confusion related to two different fall rates
- Structural measures of staff availability to ambulate and reposition patients, including home care providers and home health aides

Obstetrical Adverse Events

- Obstetrical adverse event index
- Measures using National Health Safety Network (NHSN) definitions for infections in newborns

Pain Management

- Effectiveness of pain management balanced by monitoring for potentially inappropriate use of opioids
- Assessment of depression with pain

Patient & Family Engagement

Person-Centered Communication

- Information provided at appropriate times
- Information is aligned with patient preferences
- Patient understanding of information, not just receiving information (considerations for cultural sensitivity, ethnicity, language, religion, multiple chronic conditions, frailty, disability, medical complexity)
- Outreach to patients to ensure they have the tools and resources needed to self-manage their care

Shared Decisionmaking and Care Planning

- Person-centered care plan, created early in the care process, with identified goals for all people
- Integration of patient/family values in care planning
- Plan agreed to by the patient and provider and given to patient, including advanced care plan
- Plan shared among all providers seeing the patient (integrated); multidisciplinary
- Identified primary provider responsible for the care plan
- Fidelity to care plan and attainment of goals
  - Treatment consistent with advanced care plan
- Social care planning addressing social, practical, and legal needs of patient and caregivers
- Grief and bereavement care planning

Advanced Illness Care

- Symptom management (pain, nausea, shortness of breath)
- Comfort at end of life

Patient-Reported Measures

- Functional status
  - Particularly for individuals with multiple chronic conditions
  - Optimal functioning (e.g., improving when possible, maintaining, managing decline)
- Pain and symptom management
- Health-related quality of life
- Patient activation/engagement

Healthy Living

- Well-being
- Healthy lifestyle behaviors
- Social and environmental determinants of health
- Social connectedness for people with long-term services and supports needs
- Sense of control/autonomy/self-determination
- Safety risk assessment

Care Coordination

Communication

- Sharing information across settings
  - Address both the sending and receiving of adequate information
  - Sharing medical records (including advance directives) across all providers
  - Documented consent for care coordination
  - Coordination between inpatient psychiatric care and alcohol/substance abuse treatment
- Effective and timely communication (e.g., provider-to-patient/family, provider-to-provider)
  - Survey/composite measure of provider perspective of care coordination
- Comprehensive care coordination survey that looks across episode and settings (includes all ages; recognizes accountability of the multidisciplinary team)
- Care Transitions
- Measures of patient transition to next provider/site of care across all settings, beyond hospital transitions (e.g., primary care to specialty care, clinician to community pharmacist, nursing home to home health) as well as transitions to community services
- Timely communication of discharge information to all parties (e.g., caregiver, primary care physician)
- Transition planning
  - Outcome measures for after care
  - Primary care follow-up after discharge measures (e.g., patients keeping follow-up appointments)
  - Access to needed social supports

System and Infrastructure Support

- Interoperability of EHRs to enhance communication
- Measures of "systemness," including accountable care organizations and patient-centered medical homes
- Structures to connect health systems and benefits (e.g., coordinating Medicare and Medicaid benefits, connecting to long-term supports and services)

Avoidable Admissions and Readmissions

- Shared accountability and attribution across the continuum
- Community role; patient's ability to connect to available resources

Affordability

- Ability to obtain follow-up care
- Utilization benchmarking (e.g., outpatient/ED/nursing facility)
- Total cost of care
- Consideration of patient out of pocket cost
- Appropriateness for admissions, treatment, over-diagnosis, under-diagnosis, misdiagnosis, imaging, procedures
- Chemotherapy appropriateness, including dosing

- Ensuring end-of-life care that is consistent with patient preferences
- Use of radiographic imaging in the pediatric population

Prevention and Treatment for the Leading Causes of Mortality

Primary and Secondary Prevention

- Lipid control
- Outcomes of smoking cessation interventions
- Lifestyle management (e.g., physical activity/exercise, diet/nutrition)
- Cardiometabolic risk
- Modify Prevention Quality Indicators (PQI) measures to assess accountable care organizations; modify population to include all patients with the disease (if applicable)

Cancer

- Cancer- and stage-specific survival as well as patient-reported measures
- Complications such as febrile neutropenia and surgical site infection
- Transplants: bone marrow and peripheral stem cells
- Staging measures for lung, prostate, and gynecological cancers
- Marker/drug combination measures for marker-specific therapies, performance status of patients undergoing oncologic therapy/pre-therapy assessment
- Disparities measures, such as risk-stratified process and outcome measures, as well as access measures
- Pediatric measures, including hematologic cancers and transitions to adult care

Cardiovascular Conditions

- Appropriateness of coronary artery bypass graft and PCI at the provider and system levels of analysis
- Early identification of heart failure decompensation
- ACE/ARB, beta blocker, statin persistence (patients taking medications) for ischemic heart disease

Depression

- Suicide risk assessment for any type of depression diagnosis
- Assessment and referral for substance use
- Medication adherence and persistence for all behavioral health conditions

Diabetes

- Measures addressing glycemic control for complex patients (e.g., geriatric population, multiple chronic conditions) at the clinician, facility, and system levels of analysis
- Pediatric glycemic control
- Sequelae of diabetes

Musculoskeletal

- Evaluating bone density, and prevention and treatment of osteoporosis in ambulatory settings

APPENDIX F:
Clinician Workgroup's Guiding Principles for Applying Measures to Clinician Programs

Excerpted from: **MAP Pre-Rulemaking Final Report - February 2013**

The MAP Clinician Workgroup developed these principles to serve as guidance for applying performance measures to specific clinician measurement programs. The principles are not absolute rules; rather, they are meant to guide measure selection decisions. The principles are intended to complement program-specific statutory and regulatory requirements and the MAP Measure Selection Criteria. These principles will inform future revisions to the MAP Measure Selection Criteria.

Physician Quality Reporting System (PQRS)

- For endorsed measures, whether currently finalized or under consideration:
  - Include NQF-endorsed measures relevant to clinician reporting to encourage engagement (the endorsement process addresses harmonization of competing measures)
- For measures that are not endorsed:
  - Measures currently finalized for the program:
    - » Remove measures that have had endorsement removed or have been submitted for endorsement and were not endorsed
    - » Remove measures that are in endorsement reserve status (i.e., topped out), unless the measures are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures
  - Include measures under consideration that are fully specified and that:
    - » Support alignment (e.g., measures used in MOC programs, registries)
    - » Are outcome measures that are not already addressed by outcome measures included in the program
    - » Are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures
- Measures selected for the program that are not NQF-endorsed should be submitted for endorsement

Physician Compare

- NQF-endorsed measures are preferred for public reporting programs over measures that are not endorsed or are in reserve status (i.e., topped out); measures that are not NQF-endorsed should be submitted for endorsement or removed
- Include measures that focus on outcomes and are meaningful to consumers (i.e., have face validity) and purchasers
- Focus on patient experience, patient-reported outcomes (e.g., functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care measures
- To generate a comprehensive picture of quality, measure results should be aggregated

(e.g., composite measures), with drill-down capability for specific measure results

Value-Based Payment Modifier (VBPM)

- NQF-endorsed measures are strongly preferred for pay-for-performance programs; measures that are not NQF-endorsed should be submitted for endorsement or removed
- Include measures that have been reported in a national program for at least one year (e.g., PQRS) and ideally can be linked with particular cost or resource use measures to capture value
- Focus on outcomes, composites, process measures that are proximal to outcomes, appropriate care (e.g., overuse), and care coordination measures (measures included in the MAP Families of Measures generally reflect these characteristics)
- Monitor for unintended consequences to vulnerable populations (e.g., through stratification)

Medicare and Medicaid EHR Incentive Program for Eligible Professionals (Meaningful Use)

- Include endorsed measures, whether currently finalized for the program or under consideration, that have eMeasure specifications available (the endorsement process addresses issues of harmonization and competing measures)
- Over time, as health IT becomes more effective and interoperable, focus on:
  - Measures that reflect efficiency in data collection and reporting through the use of health IT
  - Measures that leverage health IT capabilities (e.g., measures that require data from multiple settings/providers, patient-reported data, or connectivity across platforms to be fully operational)
  - Innovative measures made possible by the use of health IT

General Considerations

- Work toward a core set of measures that all clinicians, regardless of specialty, can report across all programs. The core set should focus on patient experience and engagement, patient-reported outcomes, other outcomes, care coordination, appropriate care, and population health (e.g., health risk assessment, prevention)
- To promote parsimony and alignment, the same measures should serve multiple programs, where possible (e.g., Meaningful Use and PQRS; Medicare Shared Savings and Medicare Advantage)
- Measures should be tested at the appropriate level of analysis (e.g., individual, group, system) before inclusion in public reporting or payment programs. PQRS can serve as a mechanism for testing measures

APPENDIX G:
MAP Rosters

Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Gerry Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip Kahn
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National Partnership for Women and Families	Alison Shippy
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American Occupational Therapy Association	Pamela Roberts, PhD, OTR/L, SCFES, CPHQ, FAOTA
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
American Society of Consultant Pharmacists	Jennifer Thomas, PharmD
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
Kidney Care Partners	Allen Nissenson, MD, FACP, FASN, FNKF
Kindred Healthcare	Sean Muldoon, MD
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD

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Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN
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APPENDIX H:
Glossary

AAA: Abdominal Aortic Aneurysms

AAHPM: American Academy of Hospice and Palliative Medicine

AAMC: Association of American Medical Colleges

AANS: American Association of Neurological Surgeons

ABMS: American Board of Medical Specialties

ABS: American Board of Surgery

ACA: Affordable Care Act

ACE: Angiotensin-Converting Enzyme

ACG: American College of Gastroenterology

ACIP: Advisory Committee on Immunization Practices

ACO: Accountable Care Organizations

ACS: Acute Coronary Syndrome

ACS: American College of Surgeons

ADCC: Alliance of Dedicated Cancer Centers

ADD: Attention Deficit Disorder

ADR: Adenoma Detection Rate

AF: Atrial Fibrillation

AGA: American Gastroenterological Association

AGIS: Advanced Glaucoma Intervention Study

AHA: American Hospital Association

AHRQ: Agency for Healthcare Research and Quality

AKI: Acute Kidney Injury

AMA: American Medical Association

AMD: Age-Related Macular Degeneration

AMGA: American Medical Group Association

AMI: Acute Myocardial Infarction

ANC: Absolute Neutrophil Count

ARB: Angiotensin Receptor Blockers

AREDS: Age-Related Eye Disease Study

Armstrong Institute: Armstrong Institute for Patient Safety and Quality at Johns Hopkins University

ARRA: American Recovery and Reinvestment Act of 2009

ART: Antiretroviral therapy

ASCQC: ASC Quality Collaboration

ASC: Ambulatory Surgical Center

ASCQR: Ambulatory Surgical Center Quality Reporting

ASGE: American Society for Gastrointestinal Endoscopy

ASN: American Society of Nephrology

AV: Arteriovenous

BBPS: Boston Bowel Prep Score

BMD: Bone Mineral Density

BMI: Body Mass Index

C: Clopidogrel

CABG: Coronary Artery Bypass Graft

CAD: Coronary Artery Disease

CAHPS®: Consumer Assessment of Healthcare Providers and Systems

CAHs: Critical Access Hospitals

CAP: Community-Acquired Pneumonia

CAS: Carotid Artery Stenting

CDC: Centers for Disease Control and Prevention

CDI: *Clostridium difficile* Infection

CDP: Consensus Development Process

CfC: Conditions for Coverage

CG-CAHPS: Clinician-Group—Consumer Assessment of Healthcare Providers and Systems

CIED: Cardiac Implantable Electronic Device

CINV: Chemotherapy Induced Nausea and Vomiting

CKD: Adult Kidney Disease

CKD: Chronic Kidney Disease

CLABSI: Central Line-Associated Bloodstream Infection

CLL: Chronic Lymphocytic Leukemia

CMS: Centers for Medicare & Medicaid Services

CNS: Congress of Neurological Surgeons

COPD: Chronic Obstructive Pulmonary Disease

C-P Alliance: Consumer-Purchaser Alliance

CRBSI: Catheter-Related Bloodstream Infections

CT: Computerized Tomography

CVC: Central Venous Catheter

CY: Calendar Year

DMARD: Disease Modifying Anti-Rheumatic Drug

DR: Diabetic retinopathy

DSH: Disproportionate Share Hospital

DVT: Deep Vein Thrombosis

ECG: Electrocardiogram

eCQMs: Electronic Clinical Quality Measures

EGD: Esophagogastroduodenoscopy

EHR: Electronic Health Record

EPs: Eligible Professionals

ESA: Erythropoiesis-Stimulating Agent

ESRD QIP: End Stage Renal Disease Quality Incentive Program

EVAR: Endovascular Aortic Repair

FAH: Federation of American Hospitals

FDA: Food and Drug Administration

FFS: Fee-For-Service

FOBT: Fecal Occult Blood Test

FY: Fiscal Year

GNYHA: Greater New York Hospital Association

GPRO: Group Practice Reporting Option

GSK: GlaxoSmithKiline

HAC: Hospital-Acquired Condition

HAP: The Hospital & Healthsystem Association of Pennsylvania

HbA1c: Hemoglobin A1c

HCC: Hepatocellular Carcinoma

HCC: Hierarchical Condition Categories

HCP: Healthcare Personnel

HCV: Hepatitis C Virus

HER2: Human Epidermal Growth Factor Receptor 2 Testing

HF: Heart Failure

HH: Home Health

HHA: Home Health Agency

HHS: Department of Health and Human Services

HITECH: Health Information Technology for Economic and Clinical Health Act

HQR: Hospice Quality Reporting

HRRP: Hospital Readmissions Reduction Program

HRS: Heart Rhythm Society

HRSA: Health Resources and Services Administration

HVBP: Hospital Value-Based Purchasing

HWR: Hospital-Wide All-Cause Unplanned Readmission Measure

IBD: Inflammatory Bowel Disease

ICD: Implantable Cardioverter-Defibrillator

IHC: Immunohistochemical

IMA: Internal Mammary Artery

IOP: Intraocular Pressure

IPF: Inpatient Psychiatric Facility

IPFQR: Inpatient Psychiatric Facility Quality Reporting

IPPS: Inpatient Prospective Payment System

IQR: Inpatient Quality Reporting

IRFQR: Inpatient Rehabilitation Facility Quality Reporting Program

IRF: Inpatient Rehabilitation Facility

IRH/Us: Inpatient Rehabilitation Hospitals and Units

IVD: Ischemic Vascular Disease

KCP: Kidney Care Partners

KDIGO: Kidney Disease Improving Global Outcomes

KDQOL: Kidney Disease Quality of Life

LBP: Low Back Pain

LDL: Low Density Lipoprotein

LDL-C: Low Density Lipoprotein Control

LEB: Lower Extremity Bypass

LHS: Learning Health System

LTCH: Long-Term Care Hospital

LVEF: Left Ventricular Systolic Dysfunction

LVF: Left Ventricular Function

LVS: Left Ventricular Systolic

MA: Medicare Advantage

MAP: Measure Applications Partnership

MDD: Major Depressive Disorder

MDS: Minimum Data Sets

MDS: Myelodysplastic Syndrome

MI: Myocardial Infarction

MIEA-TRHCA: Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006

MIPPA: Medicare Improvements for Patients and Providers Act of 2008

MITA: Medical Imaging and Technology Alliance

MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003

MMSEA: Medicare, Medicaid, and SCHIP Extension Act of 2008

MOC: Maintenance of Certification

MRI: Magnetic Resonance Imaging

MRSA: Methicillin-resistant *Staphylococcus aureus*

MSC: MAP Measure Selection Criteria

MSK: Memorial Sloan Kettering Cancer Center

MSPB: Medicare Spending per Beneficiary

MSSP: Medicare Shared Savings Program

MU: Meaningful Use

MUC: Measures Under Consideration

MWM: Measuring What Matters

NAQC: Nursing Alliance for Quality Care

NH: Nursing Home

NHSN: National Healthcare Safety Network

NIHSS: National Institutes of Health Stroke Scale

NKF KDOQI: NKF Kidney Disease Outcomes Quality Initiative

NKF: National Kidney Foundation

NPP: National Priorities Partnership

NQF: National Quality Forum

NQME: National Quality Measurement Enterprise

NQS: National Quality Strategy

NSQIP: National Surgical Quality Improvement Program

OA: Osteoarthritis

OASIS: Outcome Assessment Information Set

OI: Osteoclast inhibitors

ONC: Office of the National Coordinator for Health Information Technology

OPM: Office of Personnel Management

OPPS: Outpatient Prospective Payment System

OQR: Hospital Outpatient Quality Reporting

OTC: Over-The-Counter

PCA: Patient-Controlled Analgesia

PCH: Prospective Payment System-Exempt Cancer Hospital

PCHQR: PPS-Exempt Cancer Hospital Quality Reporting

PCI: Percutaneous Coronary Intervention

PCP: Pneumocystis jiroveci pneumonia

PCPI®: Physician Consortium for Performance Improvement®

PE: Pulmonary Embolism

PET: Positron Emission Tomography

PhRMA: Pharmaceutical Research and Manufacturers of America

POAG: Primary Open Angle Glaucoma

PONV: Post-Operative Nausea and Vomiting

POV: Post-Operative Vomiting

PPAI: Practice Performance Assessment and Improvement

PPS: Prospective Payment System

PQI: Prevention Quality Indicator

PQRS: Physician Quality Reporting System

PROMS : Patient Reported Outcomes Measures

PSI: Patient Safety Indicator

PTH: Parathyroid Hormone

QCDR: Qualified Clinical Data Registries

QIP: Quality Incentive Program

QOPI: Quality Oncology Practice Initiative

QPS: Quality Positioning System

RA: Rheumatoid Arthritis

RE-AIM: Reach, Effectiveness, Adoption, Implementation, Maintenance

Rhogam: Rh Immunoglobulin

RNA: Ribonucleic Acid

RPA: Renal Physicians Association

RRR: Relative Risk Reduction

RSCR: Risk-Standardized Complication Rate

RSMR: Risk-Standardized Mortality Rate

RSRR: Risk-Standardized Readmission Rate

S-CAHPS : Patient Experience with Surgical Care Based on the Surgical Care Survey CAHPS

SCIP: Surgical Care Improvement Project

SES: Socioeconomic Status

SHPT: Secondary Hyperparathyroidism

SHR: Standardized Hospitalization Ratio

SLNB: Sentinel Lymph Node Biopsy

SMR: Standardized Mortality Ratio

SSI: Supplemental Security Income

SSI: Surgical Site Infection

T: Ticagrelor

TEP: Technical Expert Panel

THA: Total Hip Arthroplasty

TJC: The Joint Commission

TKA: Total Knee Arthroplasty

TRHCA: 2006 Tax Relief and Healthcare Act

UDSmr: Uniform Data System for Medical Rehabilitation

UFR: Ultrafiltration Rate

UKPDS: UK Prospective Diabetes Study

UM-KECC: University of Michigan Kidney and Epidemiology Cost Center

URI: Upper Respiratory Infection

USPSTF: U.S. Preventive Services Task Force

UTI: Urinary Tract Infection

VBP: Value-Based Purchasing

VBPM: Value-Based Payment Modifier

VEGF: Vascular Endothelial Growth Agents

VHA: Veterans Health Administration

VRE: Vancomycin Resistant Enterococci

VTE: Venous Thromboembolism

APPENDIX I:
Public Comments

Section 1: Progress on Measure Alignment and High-Priority Measure Gaps

Abbott

Danna Caller

Abbott commends the MAP on efforts to identify and prioritize critical gap areas in quality measurement across various Federal programs and welcomes the opportunity to provide input to the Final Report for HHS.

Although evidence shows that decline in nutritional status impacts patient outcomes, resource use and costs, there are currently no quality measures to address gaps in management of malnutrition through screening, assessment, nutritional intervention, execution of nutritional treatment plan, and care coordination.

Given the critical role of nutrition in improving outcomes and reducing costs and the lack of an associated quality measure, Abbott recommends that MAP consider adding Malnutrition to the list of High-Priority quality gap areas in the Final MAP Pre-Rulemaking Report for HHS.

Malnutrition is a leading cause of morbidity and mortality, especially among the elderly. Studies estimate that 20-50% of hospital inpatients are either malnourished or at risk for malnutrition upon admission, depending on the particular patient population and the criteria used to assess the patients. As many as 31% of malnourished patients and 38% of well-nourished patients will experience nutritional decline during their hospital stay due to multiple factors. In addition, many patients continue to lose weight after discharge and patients with weight loss are at increased risk for readmission.

Nutrition intervention can significantly improve patient outcomes with

25% reduction in pressure ulcer incidence[1]

28% decrease in avoidable readmissions[2]

14% fewer overall complications[3

Reduced average length of stay by approximately 2 days[4],[5]

Decreased mortality[6],[7],[8],[9],[10],[11]

Improved quality of life.[12],[13],[14],[15],[16],[17],[18]

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American Academy of Hospice and Palliative Medicine

Amy Abernethy, MD PhD, FACP, FAAHPM

The biggest ongoing concern of the American Academy of Hospice and Palliative Medicine (AAHPM) is that despite the increasing number of measures available for federal quality reporting programs, there are still very few measures that are directly relevant to palliative care and that meaningfully address the unique needs of patients with advanced illness who are in all healthcare settings. These gaps are present across settings - in both hospital and clinical-level reporting programs, which makes it very challenging for our members to satisfy federal reporting requirements and track the quality of their care. Given this lack of relevant measures, AAHPM greatly appreciates that the topics of "Advanced Illness Care" and "Pain Management" were included on the MAP's list of measure gaps. "Advanced Illness Care" measures, in particular, represent a significant gap in measurement and should be a very high priority in terms of future development and incorporation into federal quality programs. Persons with advanced illness have priorities that differ from those with less serious illness. Effective quality measurement for this population requires several important innovations - 1) identification of persons with advanced or serious illness across settings, 2) measures focused on relief from pain and other symptoms, function, shared decision-making, care coordination, and family supportive needs, and 3) exclusion from quality measures addressing prevention or disease-specific care designed for less advanced illness. AAHPM also has some questions about specific measure gaps identified by MAP. For one, we question why, on pg. 282, the MAP lists "nutrition" as a symptom management gap (along with pain, nausea, and shortness of breath) for "Advanced Illness Care." We request that the MAP remove it from this list. Nutrition is a supportive treatment, but not a symptom. Standards for nutrition treatment can harm palliative care patients whose illness course includes a natural cessation of oral intake. Also, on pg. 280, the "Inappropriate Medication Use" specifically cites "use of sedatives, hypnotics, atypical anti-psychotics, [and] pain medications." AAHPM is concerned that an unintended consequence of this measure concept could be barriers to the appropriate use of pain medications. The under treatment of pain is already a significant problem in certain patient populations. Patients in pain due to serious illness should not be denied access to critical treatments due to inappropriate management of pain medications in other unrelated populations.

American Hospital Association

Linda Fishman

Enhancing the MAP's Approach to Alignment

The AHA strongly believes that all federal quality measurement and reporting programs should be aligned around a common set of national priorities for quality improvement.The MAP's statutory mandate to review all quality measures being considered for federal programs affords it a unique opportunity to look across programs and measures, identifying the health care delivery system's best opportunities for aligned measurement. In this year's pre-rulemaking report, the MAP bases much of its assessment of progress on achieving alignment on the number of measures currently finalized in CMS programs and on the MUC list that appears in multiple programs. We agree that this type of analysis can signal whether federal programs are focusing on the same quality topics and issues.

However, the analysis provides limited indication of whether the measures are actually focused on the highest priority areas that must be improved across the health care system. Moreover, this type of analysis fails to consider whether measures selected for each setting are aligned to achieve an overall improvement goal. Indeed, each provider along the care continuum often contributes to an overall improvement goal in a different way. For example, while a hospital's role in improving heart attack outcomes is to provide acute interventions (e.g., surgery), an inpatient rehabilitation facility's work will be oriented toward restoring daily activities and functions (e.g., ability to walk). For that reason, while overall quality improvement goals may be the same, the measures used in each care setting may need to vary to account for the different goals of care in each setting, as well as differences in data collection processes.

Thus, the AHA urges the MAP to broaden its

assessment of alignment to consider whether measures in programs address a consistent set of measurement and improvement priorities across the health care system. The key to making such an assessment possible is the prioritization of several tightly scoped, actionable areas for improvement in which strong, measures appropriate to the care setting are available to drive improvement across care settings and programs.

We also recommend that the MAP work with the National Priority Partnership, CMS and others to identify the top three to five priority areas for measurement each year. These priorities would provide more focus and direction for the MAP's measure selection efforts, and help it identify whether existing measures and measures under consideration are addressing the most important issues. High-level quality measurement and improvement priorities have been outlined in the National Quality Strategy (NQS). However, we recommend that the MAP select a limited number of elements within a priority area to address aggressively each year with available measures.

American Medical Association

James L. Madara, MD

Affordability: The MAP identified "affordability" as a gap area in its 2012-2013 Strategic Plan, and created a task force to address the issue. Cost containment is a necessary priority for the Medicare program, but affordability is subjective by nature. Also, the current tools for measuring and comparing health outcomes and provider resources are rather weak. Strategic plans should identify gap areas. But this is not an appropriate way to adequately fix or address the problem.

The definition and interpretation of affordability differ between physicians, patients, insurers, and purchasers. Even within cohorts, affordability can be measured and defined differently. Payment methodologies and site of service also influence affordability in ways that may not be readily apparent and that may be outside the control of the health care system. For example, a procedure performed in an ambulatory surgical center (ASC) may have a lower associated cost than the same procedure when performed in the hospital outpatient or inpatient setting. But state law may prohibit or discourage creating or operating ASCs in some regions. Medicare rules also determine which procedures may be safely performed and reimbursed in an ASC. Similarly, the cost of care for most services is lower in a physician's office than a hospital outpatient department. But a variety of Medicare payment policies are driving more and more physicians to affiliate with hospitals, thereby raising costs to both Medicare and patients. Some physicians practice in areas or facilities where state or federal laws and regulations have led to higher costs.

Equitable measurement of affordability also requires CMS to consider who is incurring costs and over what period of time. Variations exist within health care due to patient mix, provider distribution, community characteristics, and a variety of other factors that drive the availability and use of health care resources. In addition, what appears to be more "affordable" in the short term may not be the most efficient or effective treatment over the long term. For instance, medical management versus surgery may seem more "affordable" in the short term, but the medical management may indeed end up more costly in the long term. In most cases, however, the answer is likely to be "it depends." This is because for any given patient, the calculus will be affected by the individual's projected life span and ability to withstand surgery, or tolerate a particular drug, as well as the availability of the appropriate surgical or medical specialist to provide the chosen course of care.

As demonstrated in the development of the Value-Based Payment Modifier (VBM), current efforts to calculate resource use, patient outcomes, and value of a service to an individual patient are not yet mature enough to be accurate or useful. Current measures are too rudimentary to accurately reflect patient, provider, and community differences in any meaningful way. This deficiency is true even at the hospital or regional level, let alone at the level of an individual physician practice or an individual patient. Much work is needed to refine the VBM calculations, and in our view, the NQF and CMS should complete this work before moving to the "affordability" issue. Areas where additional effort is warranted include: improvement of Medicare's risk adjustment method; development of a more granular specialty

list; refinement of the specialty mix adjustments; completion of a robust Medicare-specific episode grouper; and development and piloting of cost measures that are appropriate for use at the physician level, to replace current measures designed for the population or hospital level.

American Medical Group Association

Donald W. Fisher, PhD

Third, we recognize that the crux of MAP's contributions for the past three years has rested within the expected actions and deliverables of the selection, comparison, and harmonization of common clinical performance measures. However, what we particularly appreciate is MAP's astuteness in taking on the difficult task of seeking out and addressing measurement gaps that will encourage the development of performance measures that are currently lacking. From our perspective, in this current MAP draft Report, there are two critical topics referenced as current gaps in the myriad of clinical measures: "systemness" and "outcomes". We would like to comment on these and suggest further elucidation in the draft Report.

As an extension of our January 28, 2013 comments to you regarding MAP's 2013 pre-rulemaking draft Report, we now applaud MAP for initiating a focus on "systemness" by its discussion of a Federal program that promotes attributes of "systemness," that leads to the formation of accountable care organizations (ACO), enhanced levels of patient experience and has a strong emphasis upon meaningful outcomes via the ACO/Medicare Shared Savings Program (MSSP). (It should be noted that AMGA is the foremost authority on the legislative intent of the MSSP, having helped draft the original ACO legislative language.) In the context of the MSSP, MAP's current draft Report is accurate with regard to its comments incorporating measures that reflect both individual performance measures as well as patient-reported outcome measures.

Moreover, MAP's current position on "systemness" would be enhanced by an added comment in this draft Report for the expanded need for measures of systemic parameters that promote and encourage the delivery of evidence-based quality care, the attainment of meaningful clinical outcomes and the efficient and the thoughtful parsimonious use of limited resources to carry out the other two attributes. Such measures are in preliminary phases of development, will represent an ultimate hybrid of the three parameters of quality – infrastructure, process, and outcomes, and will address attributes of high-performance "systemness". As we delineated in January, 2013, these attributes of high-performing "systemness" include: (i) team-based, efficient provision of services; (ii) organized entity of care; (iii) quality measurement and improvement activities; (iv) care coordination; (v) use of information technology and evidence-based medicine; (vi) compensation practices that promote harmonization and parsimony; and, (vii) accountability.

The rationale for this Report to elaborate upon this gap is that the current body of MAP's work and harmonized recommendations unfortunately requires that the patient pull together disparate elements of his or her care, leading to fragmentation of care, given there is no discourse about real-time or virtual contexts in which MAP's recommended clinical measures can be practiced and assessed. Variation exists between different clinical determinants of care delivery, in addition to variation between the settings providing that care. In other words, the context of health care influences quality and outcomes. The ACO/MSSP concept is a first step towards recognizing and advocating for quality care within an established and organized context, but that substrate of "systemness" will need continued definition, refinement and expansion.

Therefore, we would suggest the following clarifying sentence be added under the draft Report Section on "System Performance Measurement Programs" as well as a further elaboration in "Appendix E: Previously Identified Measure Gaps" :

"While clinical measures for organized systems of care are not distinct from those for individual performance measures, MAP recognizes that performance measures are also needed to assess the context in which care is given, such as the appropriateness, efficiency and accountability of established organized systems of care. Without measures for assessing the integrity of systems of care, clinical measures, absent an accountable systemic context, isolate patients from a coordinated

care process and contribute to the fragmentation of their health care. MAP encourages further development, testing and assessment of needed measures of 'systemness'".

Thank you for this opportunity to comment and, again, thank you for the hard work and dedication to this directive of the ACA.

American Nurses Association

Maureen Dailey

ANA applauds MAP's work to identify families of measures and core sets in alignment with the National Quality Strategy (NQS) aims and priorities. ANA agrees with multiple comments made at MAP meetings that alignment of the three-part aim, better care, more affordable care, and healthier people, would be best served by a balanced portfolio of measures that includes team-based measures. MAP members have identified that there are barriers that must be negotiated to develop team-based measures. These measures should reflect the contributions of interprofessional health care teams and include both shared accountability and attribution. They are important to inform a Learning Health System to ascertain the best mix of clinicians and staffing to yield the best outcomes for specific populations at risk. For example, MAP has identified that there is a persistent gap in robust team-based coordination measure gaps related to multiple barriers that must be negotiated. ANA's Framework for Measuring Nurses' Contribution to Care Coordination provides a dynamic roadmap that should be used across the National Quality Measurement Enterprise (NQME) to broaden existing low bar measures and fill theses gaps. Specifically, ANA Framework is a rubric that is appropriate for the NQME to use to identify prioritized measures of care coordination as well as concepts for new measure development which reflect nurses' unique roles, strengthen system accountabilities, and benefit patients and the health system.

ANA also supports the expedited gap filling of team-based safety measures for hospital acquired conditions which are important to patients and families, in particular measure gaps in the areas outlined by ANA in the Hospital comments section. These gaps in robust safety metrics have been identified by multiple MAP workgroups. Specifically, gaps in measures for healthcare acquired conditions are high cost in both dollars and human suffering.

Patient/Family-centered care and engagement is another persistent measure gap area that the MAP identified. These measures should include patient reported outcome measures (PROMs) and team-based measures, including shared accountability and attribution. The Nursing Alliance for Quality Care (NAQC), managed by ANA, stands ready to support the gap-filling efforts. NAQC has published several documents supporting patient/family engagement to inform the NQME.

ANA agrees with MAP that a more systematic assessment of progress on gap-filling is needed. This assessment should include consideration of innovative, state of the science outcome measures that are high impact and important to patients and families. It is also important that the right mix of structure, process, and outcome measures are needed, as indicated in the MAP's Measure Selection Criteria.

American Society of Anesthesiologists

Jane C. K. Fitch, MD

ASA appreciates the work of the MAP in addressing measure alignment and measure gaps. We recognize this is a challenging task for quality measurement organizations and the MAP.

ASA cautions the MAP against overvaluing measures based upon their inclusion in multiple CMS quality programs. In particular, we are concerned that the focus on this type of analysis may not take into full consideration the diversity of patient care provided by medical specialties, including anesthesiologists who work in a multitude of settings. In addition, we are concerned that the trend toward supporting measures that span multiple programs may undermine important measure development that may be focused on a subset of patients and their physicians.

While the ASA understands the value MAP places on the National Quality Strategy priorities, MAP should recognize that many specialties do not align well with all of priorities of the NQS. For instance, anesthesiology aligns well with the patient safety priority but does not

fit the paradigm of the healthy living priority. We urge MAP to facilitate each specialty's ability to align its measures appropriately within the NQS for maximum impact on quality of care.

The ASA notes that the MAP is concerned with the relatively small number of patient- and family-centered care measures. ASA requests the MAP expand their scope of review in consideration of specialty society measure submissions. In recent years, ASA introduced several measures for CMS and MAP consideration related to person- and family-centered care. Two measures in particular have been submitted by ASA and have yet to receive support from either the MAP or CMS – Prevention of Post-Operative Nausea and Vomiting (PONV) Combination Therapy for Adults at High Risk for PONV and Prevention of Post-Operative Vomiting (POV) – Combination Therapy for Pediatric Patients at High Risk for POV. Both measures span multiple IOM and NQS domains and are aimed at providing and measuring person- and family-centered care. Reporting on the prophylactic treatment for patients with severe risk of PONV is necessary to improve a patient's experience with anesthesia and to prevent the increased suffering and costs associated with extended postoperative stay, unanticipated admissions, and patient complications.

These two measures are part of a growing body of measures, not yet endorsed on a national level, that are used to improve patient care locally by focusing on patient and family-centered care. The PONV and POV measures provide an opportunity for physician anesthesiologists to address important clinical problems while targeting critical key processes of care. Although ASA acknowledges that the measures are process measures, the measures nonetheless contribute to improving patient outcomes and satisfaction – thus filling critical gaps identified by the IOM and the MAP.

America's Health Insurance Plans

Carmella Bocchino

We agree with the concepts of measuring coordination of care and using families of measures to align multiple stakeholders. However, the accountability for each measure must be placed where there is the greatest opportunity to impact care. For example, health plans should be held more accountable for population health than for individual provider process measures. Additionally, a greater emphasis should be placed on community and population health measures in order to truly measure health care outcomes for patients with multiple comorbid conditions, as this remains a measure gap.

We also encourage measure alignment efforts across CMS's various programs, and specifically with the Medicare Advantage (MA) Stars program and Medicare fee-for-service. Many measures are being removed from PQRS, Physician Compare, and Value Based Payment Modifier programs, while being retained by MA Stars. This creates a discordance between health plan and provider measures thereby making it more difficult for health plans to collaborate with and support their network providers in quality improvement efforts.

AmeriHealth Caritas

Andrea Gelzer

AmeriHealth Caritas Family of Companies agrees with the concepts of measuring coordination of care and using families of measures to align multiple stakeholders, but believe that accountability must be placed where there is the opportunity to impact care. This puts health plans much more account for population health and less so for the process measures of individual providers. Additionally, we believe there should be greater emphasis on community and population health measures in order to truly measure health care outcomes for patients with multiple comorbid conditions, as this remains a measure gap.

California Hospital Association

Alyssa Keefe

CHA urges CMS and the MAP to separate and further differentiate input by the MAP on measures that are ready for implementation (i.e. appropriately specified, tested and under some level of review by the NQF) versus measure concepts that are in early development and may or may not address measure gaps. Finally, CHA asks that every measure that received a support or conditional support that was still in development be brought back to

the MAP for re-review before CMS considers the MAP recommendation for inclusion in a federal program final. The measure development process, the endorsement process and selection process for inclusion in federal program must be connected, but must also be afforded the appropriate consideration at each level of input.

California Hospital Association

Alyssa Keefe

CHA supports the continued consultation of the MAP by CMS in identifying measurement gaps, prioritizing those gaps and in promoting measure alignment across federal programs We believe that the process overall has improved each year since its inception and we applaud the NQF and CMS efforts in making continuous improvements to the process. In particular, we commend the MAP for allowing continuous public comment of the measures throughout the process. In addition the revisions to the measurement selection criteria and in redefining the "support direction" recommendation to "conditional support" were important changes While these changes have provided improvements to the process, they also raise additional questions for consideration.

CHA asks that the MAP consider an additional process improvement. CHA supports many of the sentiments expressed by the American Hospital Association regarding the intended purpose of the MAP in selection of measures for inclusion in public reporting and performance based payment and or penalty programs. We were struck by the number of measures that have been put forward for MAP consideration that had not yet completed an NQF review, or that provided no more information than a measurement description and a brief synopsis by the CMS contractor during the workgroup discussion. CHA understands the desire that CMS has expressed to receive early direction from the MAP regarding measures under development, but the current criteria used by the MAP workgroups in making their recommendations is not the appropriate construct in which to make these recommendations and or conclusions.

CHA appreciates the opportunity CMS is providing to the MAP in allowing the opportunity for early comments, but a conditional support recommendation contingent on NQF endorsement of a measure description – not a measure - with little to no additional information provided to the MAP undermines the MAPs ability to make informed decisions on the task at hand – whether or not the measure should be included in a public reporting or payment program. There are several factors that arise during the NQF endorsement process that may raise questions regarding the usability and feasibility of a measure that are critical to know when deciding to put the measure into a program. We believe it's premature to finalize a MAP recommendation until such time as more information is known and has gone through an NQF process.

Center to Advance Palliative Care

Emily Warner, JD

The Center to Advance Palliative Care appreciates the MAP's excellent work in defining measure gaps and working toward aligning measures across quality programs. As an organization that works to improve access to patient-centered palliative care for all people with serious illness, regardless of treatment setting, we have particular interest in aligning measurement to improve quality of care for the sickest, most vulnerable patients.

We appreciate the MAP's efforts to grapple with the concept of alignment and what it may mean in different contexts. We suggest an additional framework for alignment: aligning measures across settings to improve care for the highest-risk, highest-need populations that would most benefit from quality improvement initiatives, i.e. those with functional limitations and complex conditions. This population accounts for 61% of the top 5% of Medicare spenders, and are most at risk for uncoordinated, poor quality care.

People with functional limitations and complex conditions face tremendous disease burden, untreated pain and symptoms, poorly coordinated care, and a failure of their care teams to ensure that the care provided is concordant with the patient's values and goals. Further, the caretakers and loved ones of this population face tremendous stress from which there is no respite. All these factors contribute to not only poor quality care and needless suffering,

but also repeat utilization of emergency interventions that place additional stress on patients and families, and additional strain on an overtaxed system.

One alignment strategy is therefore to work across settings toward the goal of improved patient and family-centered care for this population. What is unique about this goal, and about this alignment strategy, is that it is not disease-specific, and the responsibility for care is not setting specific. All individuals in this high risk group need coordinated care, goals of care planning, and excellent pain and symptom management, and while different settings take responsibility for different aspects of disease-directed care, all settings can be measured on their attention to goal-concordant care and pain and symptom management.

This alignment strategy points to the glaring dearth of measures to support such a strategy. A quality measurement strategy aimed at improving care for a population based need and risk, and not on diagnosis, demands a denominator that can address this population. Functional limitation, a growing body of evidence suggests, is one of the best predictors of healthcare utilization and risk of unnecessary emergency interventions and poor quality care. Therefore we are in support of efforts to measure this important marker of risk, and for the healthcare system to increase its attunement to functional status. In the meantime, we suggest a goal-oriented framework for alignment: improved patient-centered care for individuals with functional limitations and complex conditions.

Edwards Lifeciences

Reginald Lavender

Edwards supports the Measures Application Partnership's (MAP) recognition of measures addressing sepsis beyond post-operative infections as a gap area for the Hospital Acquired Conditions (HAC) Payment Reduction Program. Sepsis is a high-impact condition that may affect patients throughout the hospital stay. Measures that address sepsis rates beyond post-operative infections will help drive further implementation of sepsis management interventions that have proven to be effective.

GlaxoSmithKline

Deborah Fritz

MAP has made good progress toward aligning measures across the healthcare delivery system and federal reporting programs. We are especially pleased with MAP's progress on families of measures. GSK supports the recommendations to include tobacco screening and cessation as a prevention measure across CMS programs (Medicare and Medicaid EHR Incentive Program, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System).

GSK recommends that, in the report, MAP highlight the development of new families of measures specifically recommend adoption of measures from the COPD family of measures when MAP completes it. CMS has recognized COPD as a priority condition for emphasis in coming years. While CMS did not propose COPD measures for consideration in 2014 proposed rules, MAP should recommend CMS draw from the COPD Family of Measures and identified gaps. GSK supports recommendations for gap areas identified by MAP and the need for further development, as noted by PhRMA. GSK supports the use of patient-reported outcomes at the clinician level and in performance measures across the continuum of care. GSK is a leader in development and use of PROs and in clinical trials and agrees that collaborative measure development initiatives should include clinical trial expertise and experience. GSK strongly recommends development of a family of measures for comprehensive medication management that could include existing NQF and PQA endorsed medication management measure. We also strongly recommend support for development of additional medication management measure that are patient centered, apply across settings and time, and support monitoring and adjusting medication use against clinical goals (e.g. blood pressure control) and personal goals (e.g. ability to walk around the block).

Greater New York Hospital Association

Lorraine Ryan

Greater New York Hospital Association (GNYHA) commends MAP on its efforts to assess measure

alignment and gaps. Ensuring measures are meaningful is critical to the integrity of Federal quality reporting programs. While GNYHA agrees with some of MAP's recommendations, we have concerns with certain measure alignment decisions:

Gaps in Hospital-Acquired Conditions (HACs) to be Publicly Reported

MAP made recommendations on gaps in HAC measures that are publicly reported on Hospital Compare. GNYHA strongly urges MAP and CMS to be cautious when selecting measures for public reporting. Publicly reporting inadequately vetted measures, including non-NQF-endorsed, inappropriately risk adjusted, or rare occurrences do not accurately portray quality of care, can mislead patients health care decisions, and therefore are not appropriate for public reporting.

Excluding HAC Measures from the Hospital Value-Based Purchasing (VBP) Program

We urge CMS and MAP to view the Readmissions and HAC Reduction programs as created separately from the budget-neutral VBP program in the ACA. Thus, readmission and HAC measures do not belong in VBP and GNYHA does not support MAP's recommendation to include NQF #0351 PSI-4; and NQF #1550 - Hip/Knee Complications in VBP.

MAP's List of IQR Measures to Priorioritize for VBP

As CMS strives to align quality measures across programs, GNYHA urges CMS to be mindful of measure-related quality improvement efforts, and ensure that the burden of quality measurement does not hinder these efforts or exceed the measures' potential value. CMS should also not transition measures from pay-for-reporting to pay-for-performance programs prematurely and before they have been field tested to ensure sufficient reliability for use in pay-for-performance programs. GNYHA considers MAP's list of recommended gap-filling measures for the VBP among the measures that should not yet be considered for such a transition.

Alignment with the Inpatient Quality Reporting Program and Medicare and Medicaid EHR Incentive Program

GNYHA supports a thoughtful transition to eCQMs and is pleased that CMS asked MAP to include these measures in its assessment. One of the benefits to transitioning to EHRs is the timely and effective use of information for performance improvement efforts. However, as MAP's discussion highlighted, hospitals continue to struggle with generating accurate and reliable measures from their EHRs. The readiness of eCQMs for use in public policy programs is uncertain. Hospitals' experience thus far with eCQMs in meaningful use has demonstrated that more time and testing is necessary to generate accurate results comparable to chart-abstracted measures. eCQMs must also go through the same rigor of the NQF endorsement process as manually abstracted measures and should be vetted independent of their corresponding manually abstracted measure for scientific validity.

Highmark, Inc.

Deborah Donovan

General: Promotion of Alignment Across CMS Programs

Throughout the NQF and MAP process a common goal has been the alignment and consolidation of measures to one day allow a meaningful quality assessment of population health. Highmark is concerned with the potential direction which may disregard alignment efforts and cause inconsistent measurement within CMS programs. Noted throughout our review of the physician measure sets is lack of alignment with the CMS Stars quality measurement program. There are many examples of measures being removed from the PQRS, Physician Compare and Value Based Payment Modifier Program that are active measures within the CMS Stars measure sets to evaluate health plans with Medicare Advantage plans. One significant component of a health plan Star performance ratings is directly dependent upon their network providers' compliance with the specifications of these measures. Health plans all over the country are actively advancing physician profiling and improvement programs and engaging with our providers to promote improved clinical care with an assessment of performance on the CMS Star measures. We strongly request consideration for including the established measure set as foundational measures within all of the physician programs in the

promotion of collaboration, alignment and support to improve population health. Creating significant variation within measures sets sends a message of inconsistency and scattered focus.

National Coalition for Hospice and Palliative Care

Amy Melnick

The National Coalition for Hospice and Palliative Care appreciates the opportunity to provide comments on the performance measure recommendations made by the Measure Applications Partnership (MAP) in its 2014 pre-rulemaking report to the U.S. Department of Health and Human Services (HHS). The Coalition is comprised of organizations dedicated to the specialized care of patients with serious and often life-threatening illness who require relief from the symptoms, pain, and stress of a serious illness. These patients have a myriad number of diagnoses and are present in multiple health care settings. Palliative care in particular is appropriate at any age and at any stage of a serious illness and can be provided along with curative treatment. Coalition Member Organizations represent hospice and palliative care physicians, nurses, allied health professionals, social workers, researchers and palliative care program directors.

The Members (American Academy of Hospice and Palliative Medicine, Center to Advance Palliative Care, Hospice and Palliative Nurses Association and the National Palliative Care Research Center) have expertise in patient-centered measure development, evaluation and implementation. The Coalition urges both the National Quality Forum and HHS to work closely with our Member organizations and to seek their expertise throughout the year as performance measures are reviewed for potential use in federal public reporting and performance-based payment programs.

The Coalition supports the comments submitted by the American Academy of Hospice and Palliative Medicine and the Center to Advance Palliative Care and urges the MAP to revise its Pre-Rulemaking Report to reflect these comments. The Coalition would like to emphasize the following:

Measure Gaps

1) The Coalition is extremely interested in the inclusion of measures in federal programs that address the needs of and improve the quality of life for patients facing life-threatening or serious conditions. Few measures address quality of life for this population, and those that do only address very specific disease based populations. Measures are needed that measure pain and symptom management, care coordination, care planning, and caregiver support for individuals with serious illness.

2. Despite the increasing number of measures available for federal reporting programs, there are still very few measures that address the unique needs of patients with functional limitations with complex conditions such as pain and symptom management, care coordination, patient and family engagement around care planning, and caregiver support. These gaps are present across settings - in both hospital and clinician-level reporting programs. All individuals in this high risk group need coordinated care, care planning, and superior pain and symptom management. Although different settings take responsibility for different aspects of disease directed care, all settings can be measured on their attention to goal-concordant care and pain and symptom management. The goal to increase alignment across quality programs is laudable but the focus should be to improve the quality of care for the highest risk, highest need population.

3. The Coalition greatly appreciates that the topics of "Advanced Illness Care" and "Pain Management" were included on the MAP's list of measure gaps, However, it is important to note that "Advanced Illness Care" is a relatively nebulous term. To be precise, patients with "functional limitations and complex conditions" more accurately reflects this patient population. This topic however does represent a significant gap in measurement and should be a high priority for future development and incorporation into federal quality programs. Persons with functional limitations and complex conditions have priorities that differ from those with less serious illness. Effective quality measurement for this population requires several important changes. A) Identification of person with serious illness across health settings, B) Measures focused on relief from pain and other symptoms, function, shared decision making, care coordination, and family supportive needs and C) Exclusion from quality measures addressing prevention or disease

specific care designed for less advanced illness.

Previously Identified Measure Gaps - Medication and Infusion Safety - Inappropriate Medication Use

On page 280, the "Inappropriate Medication Use" specifically cites "use of sedatives, hypnotics, atypical anti-psychotics, and pain medications". The Coalition is concerned that an unintended consequence of this measure could be barriers to the appropriate use of pain medications, sedatives for relief of severe anxiety or insomnia, and use of atypical anti-psychotics for hyperactive delirium and for anti-emetic benefits. The Coalition is extremely concerned that this measure would lead to increased and unnecessary barriers to appropriate prescribing of these medications in situations where they can provide much needed relief of suffering.

Patients in pain due to advanced and other serious illnesses should not be denied access to critical and necessary pain relief due to the inappropriate management of pain medications in other patient populations.

Measure Families

The Coalition would also like to voice its support for the MAP's Families of Measures concept. The American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association recently partnered on a new initiative called Measuring What Matters (MWM), a consensus project aimed at identifying a recommended portfolio of cross-cutting performance measures for all hospice and palliative care programs. We very strongly urge the MAP to consider this effort as the foundation for a Measure Family related to Palliative Care and would greatly appreciate the NQF's assistance in developing a strategy to ensure Palliative Care measures are cross-cutting and applicable across health care settings.

The Coalition appreciates the opportunity to provide these comments and welcomes any further dialogue with the MAP or CMS related to providing and measuring quality of care for hospice and palliative care patients and their families.

National Partnership for Women & Families

Alison Shippy

The Consumer-Purchaser Alliance (C-P Alliance) believes filling high-priority measure gaps as an essential aspect to the success of the performance measurement enterprise. As such, it is critical that MAP participants, NQF members, and the public be aware of the progress. For example, the Hospital Workgroup had a calculable success in the area of gap filling and illustrates the information that should be highlighted. Cost/affordability was previously identified by MAP as a gap area and noted to be a priority for expedient filling, especially related to condition-specific costs. This year, the Hospital Workgroup supported two measures for the Inpatient Quality Reporting (IQR) program (Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia and heart failure) – a demonstration that MAP was making some progress, as a gap was identified and subsequently filled the next year.

C-P Alliance requests that NQF (in concert with their federal partners) provide more quantitative feedback/assessments to the various committee participants so they can be better equipped to make decisions on particular measures/federal programs. Additionally, this information should also be shared with other NQF members and the public, so that MAP's successes and areas for improvement are transparent and can possibly incite focused attention by measure developers.

Pharmaceutical Research and Manufacturers of America

Kelsey Lang

(1)

B. Progress Toward Aligned Measurement and Filling Measure Gaps

Alignment of Measures Across Programs

PhRMA supports MAP's progress in aligning measures across the healthcare delivery system and federal reporting programs. This alignment is key to making advances in quality improvement and being able to demonstrate system-wide improvements. Further, alignment is important in

the drive toward high-value, parsimonious measure sets to evaluate the care provided to beneficiaries in federal programs. We believe the creation and use of additional families of measures will aid in this endeavor.

Gaps in Clinician-Level Measures: Adapting Hospital Measures for Use at the Clinician Level

PhRMA appreciates the need to fill gaps in measures for clinician programs. In the draft report, MAP discusses two potential options for the application of hospital-based measures to clinician reporting. The options include (1) re-specifying hospital-level measures; and (2) applying hospital performance rates. PhRMA supports the first option. Measures specified at the hospital level have not been reviewed for their validity, feasibility and useability for clinician reporting. Application of hospital rates for clinician accountability would likely misrepresent the quality of care provided by the clinician and could lead users of the measure to draw inappropriate conclusions from the results. PhRMA recommends that measures be re-specified at the clinician level and submitted for NQF review. Measuresshould not be supported by the MAP or used by HHS until they are NQF endorsed.

Additional Gap Areas

PhRMA supports recommendations for gap areas identified by MAP in previous reports, and appreciates MAP's work to fill these gaps in the 2014 draft recommendations. PhRMA also agrees that there are priority gap areas where significant progress has not been made as quickly as needed to meet the goals of various federal programs. In order to continue to make progress on filling these gaps, collaborations between stakeholders, including the pharmaceutical industry, must be stronger. For example, while the draft report includes patient-reported outcomes that are supported by MAP, additional efforts are needed to meet demands for these types of measures. Research-based pharmaceutical companies have extensive experience in the use of patient-reported outcomes measures in clinical trials. This type of expertise should be tapped within a measure development collaboration In addition to the gaps in patient-reported outcomes and other gaps identified by the MAP, we point out a number of others:

- Measures to evaluate multiple co-morbidities
- Measures to address weight management/ obesity, such as counseling on multi-component interventions (including behavioral and pharmacological therapies)
- Measures that address appropriate care and outcomes for cognitive impairment/dementia, multiple sclerosis and epilepsy
- Additional measures to address care and outcomes for depression, particularly in the areas of daily functioning and productivity, residual symptoms, side effects, and care coordination
- Measures to assess primary non-adherence to medications
- Measures related to prescription abandonment

We also suggest development of a family of measures for comprehensive medication management that could include measures about primary nonadherence, prescription abandonment, secondary adherence, medication safety, medication reconciliation, and other medication management activities.

PhRMA appreciates that due to the urgency of CMS programmatic needs, measures are often reviewed by MAP before they have been reviewed by NQF. Thus, MAP has developed the recommendation category of "conditional support." Given the significant questions raised about attribution and risk adjustment for the episode grouper measures under consideration, we do not believe that MAP has sufficient information available to conditionally support these measures.

Measures of Medication Adherence

MAP previously identified medication management and, in particular, medication adherence as a quality measure gap area. PhRMA commends MAP for its recommendation to support the CG-CAHPS Supplemental Item: Educating Patient about Medication Adherence in the Medicare Shared Savings Program. MAP's support for this measure is consistent with its effort to fill measure gaps related to patient-centered measures and measures of medication management.

There are several instances where MAP recommends removal of measures of medication adherence

from federal programs and expresses a preference for outcomes measures. PhRMA agrees that meaningful outcome measures are needed to assess quality of care provided in federal programs. In recognition of the importance of medication adherence to improving patient health for a wide range of conditions including cardiovascular disease, diabetes, COPD and others prevalent in the Medicare population, we urge MAP to consider the value of retaining measures of adherence and medication management where such measures complement outcome measures.

The Advanced Medical Technology Association

Steven Brotman

Progress on High Priority Measure Gaps (Part 1)

AdvaMed applauds MAPS's efforts to constantly identify and discuss ways to address remaining critical gap areas in quality measurement and alignment of these across various programs. We believe that the identification of measure gaps is essential, especially in broad areas where there are a minimal number, or complete absence, of measures currently available to fulfil these voids.

To this end, AdvaMed would recommend that the MAP include two additional areas as "high-priority quality gap areas" in the "Final MAP Pre-Rulemaking Report" to HHS on February 1, 2014. These are the need for measures related to management of: (1) Wounds and; (2) Malnutrition.

Although evidence shows that wounds and the decline in nutritional status across all settings impacts patient outcomes, resource use and costs, there are currently no quality measures to address gaps in management of wounds and malnutrition through screening, assessment, intervention, execution of care (treatment) plan, and care coordination.

Accordingly, AdvaMed wishes to provide the following example of a potential composite measure that we propose as a starting point for interested measure developers to advance such quality measures in these two areas:

1. A screening measure to identify patients currently with wounds/malnutrition or those at-risk for developing wounds/malnutrition;

2. Subsequent measure of assessment by a trained professional of patients currently with wounds/malnutrition or at-risk of developing wounds/malnutrition;

3. A measure dealing with the documentation and implementation of a care plan to include wound care/malnutrition intervention; and

4. A continuity of care measure involving communication of the wound/nutritional care plan to discharge provider(s).

Importantly, a comprehensive set of Wound and/or Malnutrition measures, such as presented above, would address many of the aims and priorities of the NQS Priority Areas including:

Patient Safety;

Effective Clinical Care;

Efficiency and Cost Reduction;

Community/Population Health; and

Communication and Care Coordination.

AdvaMed requests that MAP include our recommendation to identify the management of Wounds and Malnutrition as high priority gap areas — as well as the composite quality measure example provided above — in the MAP's "Final MAP Pre-Rulemaking Report" to HHS on February 1, 2014.

In "Parts 2 & 3" of these comments, we provide some additional background on the impact of wounds and malnutrition to underscore the need for designation of these areas as high priority gap areas.

Progress on High Priority Measure Gaps (Part 2)

Wound Care: In the United States, chronic wounds affect around 6.5 million patients and an excess of $25 billion is spent annually on treatment of chronic wounds.[1] These wounds usually do not close without interventions. The annual incidence of chronic wounds is expected to increase with the growing elderly, diabetic and obese populations. In addition, there are special populations that are more "at-risk" than others for developing acute or chronic wounds. These include diabetics, ICU patients, bariatric patients, patients with spinal cord injuries, neonatal/pediatric patients and geriatric patients. The following few examples highlight the need for

measure developers to focus their attention on this area:

1/3 of people admitted to a critical care unit develop a pressure ulcer[2]

Nearly 15% of hospitalized patients age 65 or older developed a pressure ulcer during a 5-day stay or longer[3]

It is estimated that up to 25% of all diabetics will develop a foot ulcer[4]

The financial burden of venous ulcers is estimated to be $2 billion per year in the United States.[5]

[1]Human Skin Wounds: A Major and Snowballing Threat to Public Health and the Economy. Sen CK, Gordillo GM, Roy S, et ad. Wound Repair Regen., Nov-Dec, 2009; (17)6:763 771. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2810192/[Accessed[online]: 23 Jan. 2014].

[2]Bergstrom N, et. al. Pressure ulcers in adults: Prediction and Prevention, AHCPR Clinical Practice Guideline # 3,and Treatment of Pressure Ulcers, AHCPR Clinical Guideline # 15 Publication No. 95-0652Dept. of Health and Human Services, Public Health Services, Agency for Health Care Policy and Research, 1994. Bethesda, Md.

[3]Connecticut Peer Review Organization Inc. Medicare Quality Indicator System: Pressure Ulcer Prediction and Prevention Module Final Report. February, 1998.

[4]Singh N, Armstrong DG, Lipsky BA. Preventing foot ulcers in patients with diabetes. Jama 2005; 293:217–28.

[5]Collins L. Seraj S. Diagnosis and Treatment of Venous Ulcers. Am Fam Physician. 2010 Apr 15; 81(8):989-996.

Progress on High Priority Measure Gaps (Part 3)

Malnutrition: Malnutrition is a leading cause of morbidity and mortality, especially among the elderly. Increasing the risk of malnutrition in older patients is the presence of comorbidities (cardiovascular disease, stroke, cancer, COPD, renal disease, depression, and dementia[1],[2]). Evidence suggests that 20-50% of patients in the hospital setting are either malnourished or at risk for malnutrition upon admission.[3] As many as 31% of malnourished patients — and 38% of well-nourished patients — will experience nutritional decline during their hospital stay.[4] In addition:

Malnourished patients are 2 times more likely to develop a pressure ulcer[5];

Patients with malnutrition / weight loss have 3 times the risk for surgical site infection[6];

45% percent of patients who fall in the hospital are malnourished[7]; and

Malnutrition has been recently identified as the strongest independent risk factor predicting short-term mortality in elderly patients visiting the Emergency Department[8]

[1]Jensen GL, et al. J Parenter Enteral Nutr. 2010; 34:156-159.

[2]NQF Committee Report, May 2010

[3]Barker LA, et al. Int J Environ Res Public Health. 2011; 8:514-527.

[4]Braunschweig C et al. J Am Diet Assoc 2000; 100 (11): 1316-1322.

[5]Banks M et al. Nutrition 2010; 26:896–901.

[6]Fry DE, et al. Arch Surg. 2010; 145:148-151.

[7]Bauer, JD et al. J Hum Nutr Diet. 2007:20:558-

[8]Gentile S, et al. J Nutr Health Aging 2013 Apr; 17 (4):29

The Leapfrog Group

Melissa Danforth

First, Leapfrog supports the MAPs recommendation to include PSI 5 as a replacement for the HAC Object Retained After Surgery measure which was removed from the IQR program in 2013. Leapfrog strongly supports this recommendation as the PSI 5 measure is readily available and endorsed.

However, though the measure gaps cited in the MAP report regarding hospital-acquired conditions acknowledges the crtical gap in publicly available information on hospital-acquired air emboli, the report inaccurately notes that publically reported information on falls and trauma is addressed by the comment: “finalized measure addresses this issue.”

This statement is not accurate. There are no measures proposed in either the IQR, VBP, or HAC reduction programs that remotely or adequately address this gap in publicly reported information on incidences of hospital-acquired falls and trauma. This is very converning.

Since the 8 HAC measures have already been removed from the IQR program, Leapfrog would urge the MAP, and CMS, to replace these measures quickly and adequately. In regards to replacing the HAC Falls and Trauma measure, there are existing NQF-endorsed falls (#0141) and injuries (#0202) measures developed by NDNQI. These existing mesaures have previously been recommended by MAP in the patient safety family of measures (NQF #0141 and #0202), and we were disappointed that the report does not reflect the recommendation made during the MAP proceedings that it be added to the IQR program this year.

Notably, measure 0141 would address a broader set of outcomes that are more understandable to patients than the postoperative hip fracture rate measure currently included in IQR, VBP and HAC Reduction Programs as part of PSI-90.

Section 2: Pre-Rulemaking Input on System Performance Measurement Programs

American Association of Neurological Surgeons

Katie Orrico

In regards to patient-reported outcome measures,the AANS/CNS does not believe that federal policy should not mandate the use of a closed system when non-proprietary, free options are available. We appreciate that the MAP encouraged other nonproprietary tools to be considered such as the "VR-12" and "PROMIS." However, we remind the MAP that the PROMIS system is still under development, and has not been validated across the variety of clinical pathologies that neurosurgeons see. For instance, while low back pain (LBP) is one of the most common complaints leading to a primary care visit, PROMIS has not been evaluated as a metric for assessing LBP patients. It is a developing system but may require further refinement prior to being tied to payer policy.

American Nurses Association

Maureen Dailey

High-impact, system-level measures are important to a Learning Health System (LHS). ANA supports MAP's recommendations that system-level program measure sets align with measures used for setting-specific performance measurement programs. Harmonized measures can enhance focus and achievement of care delivery goals and reduce data collection burden. ANA is taking a lead in coordinating harmonization of falls definitions as requested by the NQF during the Patient Safety Complications project in 2012. ANA urges MAP to consider innovations in measurement that don't add additional burden to front line clinicians. Increased burden related to data entry can have the unintended consequence of reduced patient/family access to high-value face-to-face time with clinicians. It is essential that data from risk screenings and assessments conducted by nurses are collected in data warehouses that are employed in essential analyses to inform a LHS.

ANA supports system-level measures including patient reported outcomes measures (PROM). ANA also supports NQF work on population health measures through the multiple committees/task forces convened by NQF. As population health experts shared with the MAP, these measures are likely not to have NQF endorsement. MAP's conditional support voting category is an appropriate mechanism to introduce innovative measures recommended by using the NQF Population Health Framework and the MAP's Population Health Task Force Family of Measures.

American Society of Anesthesiologists

Jane C. K. Fitch, MD

The ASA supports the decision of the MAP to continue its support of the Patient Experience with Surgical Care Based on the Surgical Care Survey CAHPS (S-CAHPS). We encourage the MAP to consider the development of local quality improvement programs that use patient and family-centered tools to measure quality and satisfaction. By further embracing these practice or facility-based programs, the MAP, along with CMS, may be able to produce a flexible yet meaningful approach to balancing national measures with community and facility-focused quality-related priorities.

The ASA agrees with MAP that the Medicare Shared Savings Program Measure Set could be enhanced with the addition of acute and post-acute care measures, but such measures have not yet been included. In addition, anesthesiologists who are ACO participants have no choice but to have their quality data submitted by the ACO and cannot seek to qualify for incentive under traditional quality reporting, yet none of the ACO-reported Shared Savings Program measures relate in any way to quality of anesthesia care.

America's Health Insurance Plans

Carmella Bocchino

While we support MAP's efforts to increase patients' adherence to medication, measures such as #0543 Adherence to Statin Therapy for Individuals with Coronary Artery Disease are better at assessing

medication adherence than #0005 CG CAHPS Supplemental Item: Educating Patient about Medication Adherence. We believe the adherence to statin therapy is a better assessment of medication adherence as it could be viewed as an outcome measure of adherence, than a CAHPS question that asks if a provider has explained medication adherence.

Also, we are supportive of the SF-36 survey, as it is a well-proven, valid, and reliable tool to assess a patient's health status. Measures that are derived from the data generated by this tool should be tested for reliability and validity and address quality improvement.

Amgen, Inc

Jason Spangler

Amgen does not support MAP's recommendation of "do not support" Measures 0046 "Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older" and 0053 "Osteoporosis management in women who had a fracture" for inclusion in the Medicare Shared Savings Program (MSSP). Instead, we recommend that one or both measures be included in the program.

Amgen supports performance measures that encourage post-fracture diagnosis, treatment, and coordination of care because these are critical for ensuring that individuals who suffer a fracture have the best opportunity to avoid a subsequent fracture and its complications, which may lead to a diminished quality of life as well as increased healthcare costs. Improving the quality of care for osteoporosis patients pre- and post-fracture must be a priority for the Medicare program due to known gaps in care, and the enormous impact on patient outcomes and costs to the program. Although MAP supports future inclusion of these measures in MSSP, once ACOs are able to overcome implementation issues with the current finalized measure set, NQF has highlighted osteoporosis in the past as a high-impact Medicare condition that is currently challenged with important quality measurement gaps. Additionally, the goal of the MSSP is to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Fractures caused by osteoporosis place an enormous medical burden on Medicare patients (most of whom are women) and caregivers and have a significant economic impact on the Medicare system, as reported by the Surgeon General in 2012. Osteoporosis is an important chronic condition within the Medicare population, and Medicare has committed to screening bone mass in appropriate patients at risk for osteoporosis. Given the importance of these measures, an exception should be made for the recommendation that the MSSP measure set should only be expanded for cross-cutting measures. Consistent with the current quality measure benchmarks in the MSSP that address major chronic diseases, one or both osteoporosis quality measures should be included within the program.

Armstrong Institute for Patient Safety and Quality at Johns Hopkins University

Matt Austin

E0576: While the MAP recommended supporting this measure, we do have the following concerns: The major issue has to do with how often we properly diagnose depression (or other MI) in non psych settings and how often we give PHQ or other outcome scales. If we adopt these, we need to commit to a better job at detection and diagnosis. It is hard for us to say if these are the best metrics as there are no mentions of obesity, smoking, or other behaviors, or regarding the several addiction outcomes. Also, nothing was included on dementia.

E0053: While the MAP recommended suporting this measure, we have the following concerns: Disease specific guidelines focus physician/patient effort too narrowly for a population that is heterogeneous with respect to function and goals. Furthermore, the absolute benefit to burden ratio for an individual patient for this particular recommendation is small in study populations and unknown in multi-morbid individuals.

E0555: While the MAP did not support this measure, we do believe this measure is reasonable.

E0556: While the MAP did not support this measure, we do believe this measure is reasonable.

E0046: We concur with the MAP's recommendation of not suporting this measure and offer the following comments: Disease specific guidelines focus

physician/patient effort too narrowly for a population that is heterogeneous with respect to function and goals. Furthermore, the absolute benefit to burden ratio for an individual patient for this particular recommendation is small in study populations and unknown in multi-morbid individuals.

XDAEB: We concur with the MAP's recommendation of conditional support and offer the following comments: Annual wellness visit is good; focus should be on patient-identified goals, with screening and behavioral counseling tailored to meet those goals. Accomplishing immunizations is good, but insufficient. Health outcomes should be the yardstick.

E0005: While the MAP recommended supporting this measure, we do offer the following concern: The measure needs to consider more specific parameters for the denominator (i.e., specific to patients in need of specified preventive or high risk test reminders); otherwise the measure might result in nuisance reminders about unimportant tests and dilute potential importance of important or targeted reminders.

E0543: While the MAP did not support this measure, we do believe this measure is reasonable.

California Hospital Association

Alyssa Keefe

CHA remains concerned that due to the lack of time afforded this process to deliberate on measures and the programs that for which they are being considered, that the MAP has defaulted to selecting measures in multiple programs as a definition for measure alignment. Where this is most concerning is the MAPs recommendation to support the all-cause all-condition readmission measure for inclusion in the readmissions payment penalty program. This program is only a penalty program. There are not points or payment incentives for improving your readmissions rates. By including measures that are duplicative of the current measure while leaving in the condition specific readmissions measures, the MAP has supported a recommendation that penalizes a hospital twice for the same readmission, rather than promoting a recommendation that would further drive improvement. This type of recommendation is takes double the resources away from hospitals, resources that could be used to improve readmissions rates by implementing any one of a number of quality improvement efforts that are costly to implement and then sustain over time.

CHA urges the MAP to reexamine its goals for measure alignment and to allow more time for shared understanding of the consequences of duplication of measurement in performance and penalty programs. CHA urges NQF to undertake additional analysis that more fully illustrates these types of interactions so that the MAP can fully consider any unintended consequences.

Society of Hospital Medicine

Eric Howell, MD

SHM supports the following measures for inclusion in the Medicare Shared Savings Program:

MUC ID E0543: Adherence to Statin Therapy for Individuals with Coronary Artery Disease. SHM supports this measure to affect the consistent use of statin therapy in appropriate patients with coronary artery disease.

MUC ID E0576: Follow-up after Hospitalization for a Mental Illness. SHM supports the timely mental health follow-up within 30 days after an acute hospitalization with a principal mental health diagnosis.

MUC ID E0053: Osteoporosis Management in Women who had a Fracture. This measure highlights the evidence-based need to screen and treat women with acute fractures for osteoporosis. Of note, the exclusion criteria should include patients who have been unable to tolerate or have other contraindications to the FDA-approved medications: hormone replacement (risk of DVT, estrogen-sensitive cancer history), bisphosphonates (esophagitis, renal failure).

Section 3: Pre-Rulemaking Input on Clinician Performance Measurement Programs

American Academy of Hospice and Palliative Medicine

Amy Abernethy, MD PhD, FACP, FAAHPM

"ALS Patient Care Preferences" measure: The MAP recommended conditional support for this measure in PQRS, but did not support it for Physician Compare and the VBM. Although the MAP feels it is a promising concept, they feel it also requires further development, is not yet ready for implementation, and should be submitted for and receive NQF endorsement. The MAP's main concern was that care planning for ALS patients should occur more than once annually and recommended that further development of the measure should explore more frequent care planning or shorter intervals of measurement. AAHPM continues to urge the MAP to support this measure for use in PQRS. Many patients live for years with ALS and are able to create care plans early in their illness, so more frequent care planning may not be necessary for all patients. This measure addresses a critical gap in care and measurement by encouraging the adoption of palliative care at the time of diagnosis and targeting patients who are currently not adequately informed of their treatment options. Since many patients do not even receive care planning once a year, we encourage the MAP to recommend the use of this measure and re-address more frequent care planning in the future once the most basic gap in care is adequately addressed. Adoption of a care plan early in a patient's diagnosis is so critical that AAHPM urges the MAP to make a recommendation to CMS about the need to broaden this measure in the future so that it captures even larger populations of patients with serious conditions.

American Academy of Ophthalmology

William Rich

AAO on MAP 2014 Pre-rulemaking

Part I.a of VI—Introduction

We recommend that the MAP reconsider its proposals regarding several eye care measures. The conditions these measures capture constitute significant burden and causes of visual impairment/blindness in the Medicare population. Elimination of these measures would mean performance of eye care provided to these large patient groups, often consisting of racial/ethnic groups at higher disease risk, is not evaluated. In the US, 1.75 million people age 40 yrs or older have neovascular age-related macular degeneration (AMD) and 7.3 million have large drusen (≥125 microns) in one or both eyes.[1] AMD causes 46% of cases of severe visual loss (visual acuity 20/200 or worse) in Americans older than 40 yrs.[2] Diabetic retinopathy (DR) is a leading cause of legal blindness among working Americans. The prevalence rate for retinopathy for adults aged 40 and older in the US is 3.4% (4.1 million persons); the prevalence rate for vision-threatening retinopathy is 0.75% (899,000 persons).[3] African Americans and Mexican descendants have a disproportionately high diabetes prevalence compared with European Americans (11%, 10.4%, 5.2%, respectively).[4] In 2011, 2.71 million persons in the US had primary open-angle glaucoma (POAG) and the largest demographic group is non-Hispanic white women. By 2050, an estimated 7.32 million persons will have POAG, with the largest demographic group shifting to Hispanic men.[5] Overall, there is a threefold higher prevalence of OAG in African Americans relative to non-Hispanic Whites[6]. Recent evidence suggests that Hispanics have prevalence rates comparable to African Americans.[7]

[1]Friedman DS, O'Colmain BJ, Munoz B, et al. Prevalence of age-related macular degeneration in the US. Arch Ophthalmol 2004;122:564-72

[2]Congdon N, O'Colmain B, Klaver CC, et al. Causes and prevalence of visual impairment among adults in the US. Arch Ophthalmol 2004;122:477-85

[3]Kempen JH, O'Colmain BJ, Leske MC, et al. The prevalence of diabetic retinopathy among adults in the US. Arch Ophthalmol 2004;122:552-63

[4]Cowie CC, Rust KF, Byrd-Holt DD, et al. Prevalence of diabetes and impaired fasting glucose in US adults: National Health And Nutrition Examination Survey 1999-2002. Diabetes Care 2006;29:1263-8.

[5]Vajaranant TS, Wu S, Torres M, Varma R. The changing face of primary open-angle glaucoma in the US: demographic changes from 2011 to 2050.Am J Ophthalmol. 2012;154:303-314.e3.

[6]Sommer A, Tielsch JM, Katz J, et al. Racial differences in the cause-specific prevalence of blindness in east Baltimore. N Engl J Med 1991;325:1412-7

[7]Varma R, Ying-Lai M, Francis BA, et al, Los Angeles Latino Eye Study Group. Prevalence of open-angle glaucoma and ocular hypertension in Latinos: the Los Angeles Latino Eye Study. Ophthalmology 2004;111:1439-48

American Academy of Ophthalmology Comments on MAP 2014 Pre-rulemaking

Part I.b of VI—Introduction

Finally, the eliminated process measures are part of developing measure groups (that include stratified outcomes) for AMD, DR, POAG and all are in the top 25 disease conditions in Medicare cost. All the glaucoma, macular degeneration and diabetic retinopathy measures excluded in the MAP recommendations are based on solid Level 1 evidence and impact the outcomes and cost burden to society for these three chronic diseases. Our comments will show how adherence to these trial metrics of staging has lead to significant changes in eye health over the past decade. These address current gaps in care, and promote delivery of efficacious care, leading to cost savings to the health care system. There are still problems with physician adherence to these guidelines so there is room for further improvement. All these measure are endorsed by the AAO and the American Board of Ophthalmology for inclusion in our new longitudinal ophthalmic registry, IRIS (Intelligent Research in Sight ®) which will give eye care providers real time feedback on their adherence to these measures.

Furthermore, the Academy developed new ICD-10CM codes to identify chronic disease stages associated with easily defined criteria to improve care quality. We are also identifying typical resource use for each stage, so it is consistent to maintain quality measures that match episodes for the same diseases. Robust, risk adjusted, stratified outcomes measures for all ophthalmic specialties are being developed by the IRIS registry measure development group which has met four times a month for the last two years. These measures are close to being mapped into our registry and will supplement these meaningful PQRS approved measures.

American Academy of Ophthalmology Comment on 2014 NQF MAP Pre-rulemaking

Part II.a of VI—Support for Age-related Macular Degeneration (AMD) Measures:

NQF 0087--AMD: Dilated Macular Exam

A documented complete macular exam is necessary to determine the presence or absence of thickening or hemorrhage, and the severity of AMD, so that a decision can be made as to the benefits of prescribing antioxidants. Periodic assessment is also necessary to determine whether there is progression of the disease and to plan ongoing treatment. Three randomized clinical trials (ANCHOR[1], MARINA[2], and PIER[3]) found that with effective treatment at the appropriate stage of disease, 90-96% of patients lost less than 15 letters of visual acuity, and 33 – 40% of patients gained more than 15 letters of visual acuity. Based on this evidence, timely and effective treatment can be provided to patients who are staged accurately, thus avoiding the blindness/visual impairment associated with the natural progression of disease. No data exists on the identification and documentation of the severity of macular degeneration and presence or absence of macular thickening but parallel data for key structural assessments for glaucoma and cataract and diabetic retinopathy suggest that significant gaps are likely.

[1]Brown DM, Kaiser PK, Michels M, et al. ANCHOR Study Group. Ranibizumab versus verteporfin for neovascular age-related macular degeneration. N Engl J Med 2006;355:1432-44.

[2]Rosenfeld PJ, Brown DM, Heier JS, et al. MARINA Study Group. Ranibizumab for neovascular AMD. N Engl J Med 2006;355:1419-31.

[3]Abraham P, Yue H, Wilson L. Randomized, double-masked, sham-controlled trial of ranibizumab for neovascular AMD: PIER study year 2. Am J Ophthalmol 2010; 150:315-324.

American Academy of Ophthalmology Comment on 2014 NQF MAP Pre-rulemaking

Part II.b of VI—Support for Age-related Macular Degeneration (AMD) Measures

NQF 0566 AMD: Counseling on Anti-Oxidant Supplement

A National Eye Institute-funded study, Age-Related Eye Disease Study (AREDS), showed that antioxidant supplements help to reduce the rate of progression to advanced AMD by 25% for those patients with intermediate or advanced AMD in one eye.[1] If all the people with intermediate AMD or advanced AMD in one eye received AREDS supplements, more than 300,000 (95% confidence interval, 158 000–487000) of them would avoid advanced AMD and any associated vision loss during the next 5 years.[2] Based on average costs for treating advanced AMD for five years, this would result in savings of $2.1–$14 billion dollars.[3] From the same AREDS study, there is no evidence that the use of antioxidants for patients with mild AMD alters the natural history of mild AMD. A study found that there is a significant gap in current patterns of care: more than one third of patients who should be taking antioxidant supplements are not or are not taking it in the correct dosage and another 20% taking the supplements but should not be. Counseling is necessary to explain to patients why treatment is not indicated as well as to warn of risks of treatment to patients who smoke or have other contraindications.

[1]Age-Related Eye Disease Study Research Group. A randomized, placebo-controlled, clinical trial of high-dose supplementation with vitamins C and E, beta carotene, and zinc for AMD and vision loss: AREDS report number 8. Arch Ophthalmol 2001;119:1417-36.

[2] Age-Related Eye Disease Study Group: Potential Public Health Impact of Age-Related Eye Disease Study Results: AREDS Report No. 11. Arch Ophthalmol 2003; 121:1621–1624

[3] Charkoudian LD, Gower EW, Solomon SD et al. Vitamin usage patterns in the prevention of AMD. Ophthalmology 2008; 115:1032-8.

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Part III – Support for Diabetic Retinopathy Measures

Part III.a of VI: NQF 0088-- Diabetic Retinopathy: Documentation of Macular Edema/Severity of Retinopathy

The natural progression of this disease advances with age and severity of diabetes mellitus resulting in visual impairment and blindness. Several level 1 randomized controlled trials demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study,[1] Early Treatment Diabetic Retinopathy Study[2]). Treatment of diabetic macular edema, a common cause of visual impairment, has been significantly enhanced with the advent of anti-vascular endothelial growth agents (VEGF). The Diabetic Retinopathy Clinical Research Network study found that the mean change in visual acuity was significantly greater in patients receiving ranibizumab plus prompt/deferred laser surgery (+9 letters) compared to treatments without anti-VEGF agents.[3] A key prerequisite to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination.[4] Thus, ensuring timely treatment that could prevent 90% of the blindness due to diabetes[5] requires the performance and documentation of these key examination parameters. Panretinal photocoagulation use for advanced proliferative retinopathy in the Medicare population has decreased 24% in the last ten years despite greater numbers of Medicare beneficiaries with diabetes because of improved detection and effective treatment in earlier stages of disease—reducing overall healthcare costs.

[1]Diabetic Retinopathy Study Research Group. Indications for photocoagulation treatment: Study report no. 14. Int Ophthalmol Clin 1987;27:239-53.

[2]Early Treatment Diabetic Retinopathy Study Research Group. Early photocoagulation for diabetic retinopathy. Report no. 9. Ophth 1991;98:766-85.

[3]Elman MJ, Bressler NM, Qin H, et al. Expanded 2-Yr Follow-up of Ranibizumab Plus Prompt or Deferred Laser or Triamcinolone Plus Prompt Laser for Diabetic Macular Edema. Ophth. Apr 2011;118(4):609-14.

[4] McGlynn EA, Asch SM, Adams J et al. The quality of health care delivered to adults in the US. N Engl J Med.2003;348:2635-4

[5]Ferris FL, III. How effective are treatments for diabetic retinopathy? JAMA 1993;269:1290-1.

American Academy of Ophthalmology Comment on 2014 NQF MAP Pre-rulemaking Document

Part III – Support for Diabetic Retinopathy Measures

Part III.b: NQF 0089-- Diabetic Retinopathy: Communication with Physician Managing Diabetes Care

It is important that the primary care physician be aware of the patient's dilated eye exam and severity of retinopathy to manage the ongoing diabetes care. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease (Diabetes Control and Complications Trial-DCCT ,[1] UK Prospective Diabetes Study [2]). The impact of the counseling (HgA1C levels and lipids -part of the diabetic yearly exam) dictated by the DCCT trial and the ACCORD study[3] have resulted in slowing of the progression of retinopathy and dramatic decreases in the need for more expensive treatments. This addresses an important quality domain: Coordination of Care.

[1]Diabetes Control and Complications Trial Research Group. Progression of retinopathy with intensive versus conventional treatment in the Diabetes Control and Complications Trial. Ophth 1995;102:647-61.

[2]UK Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylurea insulin compared with conventional treatment and risk of complications with type 2 diabetes (UKPDS 33). Lancet 1998;352:837

[3]The ACCORD Study Group, ACCORD Eye Study Group . Effects of medical therapies on retinopathy progression in type 2 diabetes. N Engl J Med 2010 ; 363 :233–244.

American Academy of Ophthalmology Comment on 2014 NQF MAP Pre-rulemaking

Part IV—Support for Primary Open-Angle Glaucoma (POAG) Measures

Part IV.a of VI: NQF 0086-- Primary Open-Angle Glaucoma: Dilated Exam

Changes in the optic nerve are one of two characteristics which currently define progression and worsening of glaucoma disease status. There is a significant gap in documentation patterns of the optic nerve for both initial and follow-up care. [1] [2] Examination of the optic nerve head and retinal nerve fiber layer provides valuable structural information about glaucomatous optic nerve damage and can occur prior to visual field defects. A detailed examination of the optic nerve greatly improves the sensitivity of detecting glaucoma in patients at risk. Glaucoma is an asymptomatic disease where simple measurement of IOP will not detect 20% of glaucoma patients. A careful, dilated exam of the optic nerve and managing the disease appropriately, the 20 year probability of blindness from glaucoma has been reduced from 26% of patients diagnosed between 1965 – 1980 to 13.5% for patients diagnosed from 1981-2000.[3]

The value of a dilated optic nerve evaluation on was recognized with the Congressional passage and CMS implementation of the Glaucoma Detection Benefit for African Americans, Hispanics and those with a family history. This preventive benefit was designed by the AAO, the American Glaucoma Society and the National Eye Institute and the scientific validity of this exam was affirmed by CMS, and CBO. The cost savings were scored positively by the Congressional Budget Office.

[1]Fremont AM, et al. Patterns of Care for Open-angle Glaucoma in Managed Care. Arch Ophthalmol. 2003;121:777-783.

[2]Lee PP, et al. A Multicenter, Retrospective Pilot Study of Resource Use and Costs Associated With Severity of Disease in Glaucoma. Arch Ophthalmol. 2006;124:12-19.

[3] Malihi M, Filho ERM, Hodge DO, Sit AJ. Long term trends in glaucoma-related blindness in Olmsted County, Minnesota. Ophthalmology 2014;121:134-41.

AAO Comment on 2014 MAP Pre-rulemaking

Part IV—Support for Primary Open-Angle Glaucoma (POAG) Measures

Part IV.b of VI: NQF 0563-- Primary Open-Angle

Glaucoma(POAG): Reduction of Intraocular Pressure (IOP) by 15%

The rationale for a failure indicator (NOT achieving at least a 15% IOP reduction) with this key outcome measure are that 1) different studies results lead experienced clinicians to believe that different levels of IOP reduction are appropriate; 2) minimize the impact of adverse selection for those patients whose IOPs are more difficult to control; and 3) because each patient's clinical course may require IOP reduction that may vary. In addition, several studies have demonstrated that the prevalence of POAG, as well as the incidence of POAG,increases as IOP increases.[1] [2] [3]These studies provide strong evidence that IOP plays a key role in the neuropathy of POAG. Studies have demonstrated that reduction in IOP lessens the risk of visual field progression in glaucoma.[4] [5] [6] [7] In addition, treated eyes that have a greater IOP fluctuation are at increased progression risk and therefore at higher blindness risk.[8]

[1] Sommer A, et al. Relationship between IOP and POAG among white and black Americans. The Baltimore Eye Survey. Arch Ophthalmol. 1991;109:1090-1095

[2] Quigley HA, West SK, Rodriguez J, et al. The prevalence of glaucoma in a population-based study of Hispanic subjects: Proyecto VER. Arch Ophthalmol. 2001;119:1819-1826.

[3] Klein BE, et al. Prevalence of glaucoma. The Beaver Dam Eye Study. Ophthalmol 1992;99:1499-1504.

[4]The Advanced Glaucoma Intervention Study (AGIS): 7. The relationship between control of IOP and visual field deterioration.The AGIS Investigators. Am J Ophthalmol 2000;130:429-40.

[5]Heijl A, Leske MC, Bengtsson B, et al. Reduction of IOP and glaucoma progression: results from the Early Manifest Glaucoma Trial. Arch Ophthalmol 2002;120:1268-79.

[6]Collaborative Normal-Tension Glaucoma Study Group. The effectiveness of IOP reduction in the treatment of normal-tension glaucoma. Am J Ophthalmol 1998;126:498-505.

[7]Leske MC, Heijl A, Hussein M, et al. Factors for glaucoma progression and the effect of treatment: the Early Manifest Glaucoma Trial. Arch Ophthalmol 2003;121:48-56.

[8]Asrani S, et al. Large diurnal fluctuations in IOP are an independent risk factor in patients with glaucoma. J Glaucoma, 2000;9:134-142.

AAO Comment on 2014 MAP Pre-rulemaking

Part IV—Support for Primary Open-Angle Glaucoma (POAG) Measures

Continuation of Part IV.b of VI: NQF 0563-- Primary Open-Angle Glaucoma(POAG): Reduction of Intraocular Pressure (IOP) by 15%

A plan of care option reflects the dilemma of trying to fit a quantitative outcome measure like IOP reduction into a quality system that uses G codes. The lowering of IOP should be much lower for some and may be too aggressive for other populations, resulting in unnecessary resource use. The plan of care option addresses the patient-centered needs of various populations that could not be stratified using G codes.

Studies reviewing documented IOP achieved under care, show the gap could be as great as 50% or more in the providers treating patients with POAG. Based on criteria for control, IOP was controlled in 66% of follow-up visits for mild glaucoma patients and 52% of visits for moderate to severe glaucoma patients. Another comprehensive insurance plan study suggested that a large proportion of patients felt to require treatment for glaucoma or suspect glaucoma are falling out of care and are being monitored at rates lower than the recommendations of published guidelines.[1]

[1]Friedman DS, Nordstrom B, Mozaffari E, Quigley H. Glaucoma management among individuals enrolled in a single comprehensive insurance plan. Ophthalmol. 2005 Sep;112(9):1500-4.

American Academy of Ophthalmology Comment on NQF MAP 2014 Pre-rulemaking Document

Part V—Support for Cataract Patient Satisfaction Survey

Part V of VI XBAAG-- 304 Cataracts: Patient Satisfaction Following Cataract Surgery

The MAP is recommending that this patient participation survey be eliminated from the Value-based Modifier. This measure is a registry reported measure that is only reported as part of the cataract measure group within PQRS. Further, the survey instrument used for the cataract patient satisfaction survey was developed from the Surgical-CAHPS that is approved both by AHRQ and the NQF.

Eliminating this measure from the VBM could mean that many ophthalmologists are subjected to a negative VBM because one of the most logical ways that ophthalmologist will likely be participating in PQRS and therefore the VBM (+/-) adjustment would be through successfully reporting the cataract group measure. By law, the VBM is supposed to be used for all physicians and eligible providers by 2017 and for many ophthalmologists, applicability for the VBM begins this year and they will be seeking to demonstrate value through reporting the cataract group measure. This recommendation conflicts with current public goals and the CMS/HHS emphasis on patient participation and patient centered care.

American Academy of Ophthalmology Comments on the NQF 2014 Draft Pre-rulemaking Report

Part VI of VI— Episode Groupers

The Academy would recommend against the NQF recommendation of "conditional support" for these groupers and is perplexed why NQF would support something that has not been made public or reviewed by NQF. We are on record opposing the Brandeis/AMA PCPI/AHRQ Episode Grouper project related to all of the eye conditions that were reviewed. Treatment for all chronic eye disease depends on staging and acuity. Such diseases are also very likely bilateral with each eye having a different stage of disease. Our surgical codes and some but not all of the testing service codes will have Right/ Left/Bilateral modifiers.

Furthermore chronic costs will always be higher in patients who require multiple meds to control the disease, but this does not always translate to a more severe stage of disease, because severity stages are based on functional visual field loss. We have no confidence that the costs associated with these chronic diseases can be assessed/attributed using the Brandeis/PCPI grouper to ensure appropriate modeling. Our confidence in these groupers working even for acute conditions with a defined global period such as cataract surgery is low based on what our volunteers have reported. The likelihood costs not associated with the specific surgery will be attributed to the cataract or other surgical episode appears to be very high.

Furthermore, this effort was rushed through without formal input from any of the physician organizations who were asked to supply volunteers; work group meetings were held on short notice during daytime/ patient care hours; and most importantly, none of the workgroup members were allowed to view the final product to ensure that their concerns, objections and structural problems were addressed. Finally, the meetings which were federally funded in part were not transparent and in fact were closed to anyone but workgroup members despite the objections of organizations and the request to be able to assist our members all of whom are actively practicing with this project. A significant number of concerns were raised during the process yet we have no way to determine whether or not they were appropriately addressed.

American Association of Neurological Surgeons

Katie Orrico

The AANS/CNS is concerned about the MAP's recommendation that perioperative measures not be included in the VBM and Physician Compare. The perioperative set represents one of the most common measure sets available for proceduralists and is one of the most meaningful and relevant measures available to many surgeons, in particular. We request further consideration of the implications of not offering this measure under a program that adjusts payments based on measure performance.

In regards to the CAHPS survey measures, the AANS/CNS reminds the MAP to consider the relevancy and administrative burden of administering this survey. We do not support using the CAHPS for public reporting or payment adjustments linked to performance. We appreciate MAP's support for the Surgical-CAHPS, which is a more appropriate way to measure patient experience data among surgeons. However, the cost to implement any CAHPS survey is extremely costly and burdensome on a practice, especially a small private practice. Furthermore,

response rates are typically low and based on feedback we have received from providers, patient compliance is very difficult to obtain. The collection of CAHPS data may also lead to survey fatigue by patients due to the fact that CMS requires it in multiple programs affecting various providers and practice settings. If physicians are to be evaluated based on CAHPs performance, they should only be measured based on whether or not they have provided patients with a patient experience survey, not based on completed collection rates. A physician should not be held liable or penalized for lack of patient compliance. Additionally, as with all experience surveys, regardless of survey type, opinions vary based on cultural and regional differences. Finally, it is important to note that many practices already collect patient experience data, but not in the CAHPS survey format (e.g., Press-Gainey), that they find to be more relevant and meaningful to their practice. Indeed, the American Board of Medical Specialties (ABMS) is considering recognizing multiple different patient experience surveys for the purpose of satisfying Maintenance of Certification (MOC) requirements. CMS should therefore recognize and provide credit to practices that use alternative formats to collect patient experience data.

American College of Cardiology

Paul Casale

General: Attribution for Accountability

The ACC continues to be concerned about the MAP's use of measures intended for system-level reporting in the clinician reporting program. One of the continuing challenges for both NQF and MAP is to address the overlapping nature of the health plan/clinician programs and individual measures within the programs. As the incentives for these programs move from pay-for-reporting to pay-for-performance, performance measures for clinicians and groups of clinicians must be evidence-based, patient-centered, and match the appropriate level of provider accountability.

The ACC continues to be concerned by MAP's recommendation for removal of several of the evidence-based measures developed by the ACC with the AMA's Physician Consortium for Performance Improvement. Our measures are evidence-based, patient-centered, and designed to evaluate adherence to clinical practice guidelines. Since the MAP began its work, many of our published measures have been recommended for removal because of the availability of "like" measures designed to measure health plans; these may not be appropriate to attribute to individual or groups of clinicians. Of the 11 ACC/AHA/PCPI measures remaining in 2014 PQRS, MAP only supports five for inclusion in the VBPM and Physician Compare. It is our recommendation that all of our 2014 PQRS measures (#5,6,7,8,118,197,198,226,242,243,326) remain in PQRS and count toward the VBPM in order to promote uptake of evidence-based measures for cardiologists that are considered clinically relevant.

American College of Surgeons

David B. Hoyt, MD, FACS

Clinician Performance Measurement Programs

General Feedback to MAP Clinician Workgroup: Recommendations for the Value-based Payment Modifier and Physician Compare

In the calendar year (CY) 2014 Medicare Physician Fee Schedule final rule CMS provides flexibility in allowing performance on all Physician Quality Reporting System

(PQRS) measures to be included in the value-based payment modifier (VBPM); however, ACS has some concerns with the inclusion of inappropriate measures in the program. We believe CMS should delay the inclusion of new measures in the VBPM for a year so that problems associated with the measure can be identified.

By way of comparison, measures included in the hospital value-based purchasing program must be selected from the pool of measures already approved for the Hospital Inpatient Quality Reporting (IQR) Program, and these measures must have been displayed on Hospital Compare for at least a year. This allows hospitals to be on notice that these measures could impact their payment and allows any potential issues to surface. For example, in the fiscal year 2014 Inpatient Prospective System rule, CMS removed several measures from the Hospital IQR for reasons including lack of National Quality Forum (NQF) endorsement, recommendation by the MAP

for removal, inadequate link to patient outcomes, challenges in validating efficiency, lack of feasibility to implement in light of new practice guidelines, and availability of other more meaningful measures. It is crucial that such inadequate measures are removed prior to being used for payment under the pay-for-performance programs.

While we do not believe it is necessary or helpful to require that all VBPM measures be included on Physician Compare for a year, we do believe that physicians should have the opportunity to report on or otherwise observe how they perform on the measures for a period of time in PQRS before they are used for payment adjustments under the VBPM.

General Surgery Measures

In 2013, ACS and CMS worked together and retooled many general surgery measures that were submitted by ACS for PQRS CY 2014. Both ACS and CMS spent months carefully re-specifying the measures so that they could be reported both individually and as part of the General Surgery Measures Group. The measures were then vetted during the federal rulemaking process and finalized in PQRS.

However, the measures included in the MAP Pre-Rulemaking Report are in their original format and do not reflect the changes made to the measures. ACS is greatly concerned with the lack of coordination between the MAP and CMS in regard the federal rule-making process. This has resulted in a misrepresentation of what is currently finalized in PQRS, and thus very counterproductive for purposes of providing recommendations to the Department of Health and Human Services (HHS). In fact, the MAP's "additional findings" recommend that the general surgery measures "could be included in Physician Compare and VBPM if [they are] made into a composite with other related [surgical procedure] measures." This recommendation is irrelevant because the measures are no longer grouped based on procedures.

This inconsistency is confusing and counter-productive for all stakeholders involved in both the pre-rulemaking and rulemaking process. Time at the MAP could be better spent if CMS is able to align their timelines and coordinate the work done prior to the publishing of the MUC to ensure that the most current versions of the measures are being reviewed. We strongly urge CMS and the MAP to work together to be sure that the MUC list includes a current list of finalized measures.

Below we comment on the retooled General Surgery Measures Group currently finalized in PQRS.

ACS supports the MAP's "conditional support" for inclusion of the measures included in the General Surgery Measures Group for the VBPM and Physician Compare. However, as discussed in our general feedback to the Clinician Workgroup, we believe inclusion of new measures in the VBPM should be delayed for a year so that problems associated with these measures can be identified. ACS welcomes the opportunity to work with CMS to best present these measures on Physician Compare so patients in need of surgery are able to view information relevant to the care they seek.

The General Surgery Measures Group includes the following measures:

- Anastomotic Leak Intervention
- Unplanned Reoperation within the 30 Day Postoperative Period
- Unplanned Hospital Readmission within 30 Days of Principal Procedure
- Surgical Site Infection (SSI)
- Patient-Centered Surgical Risk Assessment and Communication (Patient-Specific Risk Calculator)

General Surgery Measure Group includes the following procedures:

Ventral Hernia, Appendectomy, AV Fistula, Cholecystectomy, Thyroidectomy, Mastectomy +/- Lymphadenectomy or Sentinel Lymph Node Biopsy (SLNB), Partial Mastectomy or Breast Biopsy/ Lumpectomy +/- Lymphadenectomy or SLNB, Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass, Bariatric Sleeve Gastrectomy, and Colectomy.

When recommending these measures for the VBPM and Physician Compare, the MAP provided "conditional support" for certain procedures (Ventral Hernia, Appendectomy, AV Fistula, Cholecystectomy, Thyroidectomy, Mastectomy +/- Lymphadenectomy or SLNB, Partial Mastectomy or Breast Biopsy/

Lumpectomy +/- Lymphadenectomy or SLNB) and "do not support" for other procedures (Bariatric Lap Band Procedure, Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass, Bariatric Sleeve Gastrectomy, Colonoscopy, and Colectomy), without providing a clear rationale. For the measures that they "do not support" the rationale provided was that the "measure does not adequately address any current needs of the program." We seek clarity on why only a subset of these measures was deemed to not meet the current needs of the program. CMS included all of the listed procedures as part of the General Surgery Measures Group, and the American Board of Surgery (ABS) deemed all of these general surgery procedures and outcomes to be the most important to measure for individual surgeons. In fact, this is precisely how these procedures were identified – these procedures were the MOST common procedures performed by the ABS diplomats. So, in fact, these measures represent some of the most common procedures performed in the United States, are clinically relevant, and have been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP). We recommend that the MAP conditionally support all measures in the General Surgery Measures Group for inclusion in the VBMP and Physician Compare.

Additionally, the MAP did not support the inclusion of the Patient-Specific Risk Calculator because the "measure does not adequately address any current needs of the

program." This may be one of the most important measures to include in PQRS that the ACS developed. The ACS believes that objectively assessing patient risk and

supporting such communication between surgeons and patients is critical to ensure informed consent and shared decision-making. The Patient-Centered Surgical Risk

Assessment "risk calculator" provides a personalized, empirically-based estimate of a patient's risk of post-operative complications based on their demographics, comorbidities, and indication for an operation. In addition to the clinically meaningful reasons of more appropriately preparing for the multidisciplinary acuity of patient comorbidities in the perioperative period, evidence suggests that sharing numeric estimates of patient-specific risk will engage patients, improve informed consent, and enhance patient trust in providers. This measure is at the core of patient-centered surgical care. To this end, we recommend that MAP conditionally support this measure because it aligns with both the "patient and family engagement" and "communication and care coordination" priorities of the National Quality Strategy.

General Surgery Measures Not Included in the MUC

In addition to the ACS general surgery measures finalized PQRS, ACS submitted general surgery measures that were not included in the MUC list.

These measures include:

- Esophagogastroduodenoscopy (EGD) 2: Unplanned intubation
- Thyroidectomy 1: Recurrent laryngeal nerve injury
- Thyroidectomy 2: Neck hematoma / bleeding
- Colonoscopy 2: Cecal Intubation Rate
- Colonoscopy 4: Examination time during endoscope withdrawal, when no biopsies or polypectomies are performed
- Bleeding requiring transfusion (Hemorrhoidectomy, Bariatric Sleeve Gastrectomy, Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)
- Vericose Veins: Venous thromboembolism (VTE)
- Percutaneous Central Line Placement: Central line-associated bloodstream infection (CLABSI)
- Percutaneous Central Line Placement: Failure to complete procedure

Similar to the measures included in the General Surgery Measures Group, the American Boards of Surgery and Colon and Rectal Surgery also deemed these procedures and outcomes to be the most important to measure for individual surgeons, and they represent some of the most common procedures performed in the United States. These measures are clinically relevant and have been developed using the same rigor applied to measures used in the ACS NSQIP. Inclusion of these measures

in PQRS follows the Clinician Workgroup's Guiding Principles, which supports alignment with MOC programs and registries. ACS recommends that the MAP support these measures for inclusion in PQRS.

Perioperative Care Measures

The MAP did not support the direction of the following PQRS perioperative care measures for inclusion in the VBPM and Physician Compare.

These measures include:

- Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin (NQF# 0268)
- Perioperative Care: Timing of Prophylactic Parenteral Antibiotics – Ordering Physician (NQF #0270)
- Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures) (NQF #0271)
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (NQF #0239)

The rationale provided by the MAP is that the "measure(s) does not adequately address any current needs of the program." However, maintaining the perioperative care measures is critical for reducing antibiotic resistance, which is closely related to the outcome of surgical site infection (SSI). These measures have been time-tested in the PQRS program and have proven valid, reliable, and feasible. Furthermore, inclusion of these measures will ensure that a wide range of surgeons from multiple specialties are able to participate in Physician Compare and the VBPM, which will drive participation. The perioperative care measures follow the Clinician Workgroup's Guiding Principles which support NQF-endorsed measures, measures that have been reported in a national program for at least one year, and focus on process measures that are proximal to outcomes.

S-CAHPS

ACS supports the MAP's conclusion and rationale to "support" the inclusion of the "Patient Experience with Surgical Care Based on the Consumer of Healthcare Providers and Systems Surgical Care Survey (S-CAHPS)," (NQF # 1741) measure for the inclusion in PQRS, Physician Compare and the VBPM. We would like to note that the MAP "supported" the S-CAHPS for inclusion in PQRS in last year's Pre-Rulemaking Report but CMS did not include this measure in PQRS, despite the MAP's support, as well as broad support from the surgical specialty societies. The rationale that CMS provided was that "the S–CAHPS survey measures must be submitted to the MAP for review." ACS would like to highlight this oversight to be sure that CMS clearly understands the MAP's continuous support of the S-CAHPS measure.

S-CAHPS more closely assesses the patient experience during an episode of surgical care compared to CG-CAHPS by expanding on the CG-CAHPS to focus on aspects of surgical quality. S-CAHPS is the only NQF-endorsed measure designed to assess surgical quality from the patient's perspective. Therefore inclusion of S-CAHPS in PQRS, and the VBPM will allow surgeons to report on a measure that more accurately reflects the care they deliver, and patients in need of surgery should be able to view information relevant to the care they seek on Physician Compare.

Medicare Spending Per Beneficiary

ACS does not support the MAP's recommendation for conditional support of the Medicare Spending Per Beneficiary (MSBP) for inclusion in the VBPM. This measure is currently finalized in the IQR and VBP hospital programs. The MSPB measure is triggered by an inpatient hospitalization and includes all Medicare Part A and Part B payments during an MSPB episode which is three days prior to the index admission and 30 days post-discharge. The rationale that CMS provides for inclusion of this measure is in the VBPM is that Medicare spending post-hospital discharge is a significant source of variation in MSPB measure rates, and the measure will enable CMS to assess groups of physician's performance related to post-acute care spending.

ACS has concerns regarding the validity of the MSPB measure. The measure is currently only NQF-endorsed for hospital analysis and should not be calculated as part of the VBPM cost composite prior to NQF-endorsement at the clinician level of analysis. In addition, we believe CMS should delay the inclusion of the MSPB in the VBPM in order to first see how it performs in PQRS for a year to

identify problems associated with the measure. The MAP has similar concerns, noting that the measure is not ready for implementation because it requires modification or further development, it should receive NQF-endorsement, and it does not align with the program's data sources.

American Medical Association

James L. Madara, MD

Clinician Performance Measurement Programs

Beginning in 2015, physicians who do not successfully participate in the Physician Quality Reporting System (PQRS) will be penalized with a reduction in reimbursement. CMS established 2013 as the performance year for 2015 penalties, and 2014 for 2016 penalties. As a result, PQRS participation is likely to increase exponentially. The program may experience an influx of hundreds of thousands of physicians and other eligible professionals (EPs). The MAP must take into consideration the need to quickly engage EPs in the PQRS in 2014, as it works to achieve quality measurement and improvement activities that foster standardization and better outcomes. There needs to be a balance between the goals of helping physicians and other health care professionals to successfully engage in the PQRS, while also helping the program and its participants achieve quality improvement that results in better outcomes. Physicians and other EPs who have not previously participated in PQRS will benefit from the availability of PQRS measures that allow a good entry point to the program. The AMA urges the MAP to carefully consider these goals in use of the "removal" category. Measures slated for removal should continue to be available for another two to three years, while more outcome-focused measures are being developed and evaluated.

Raising the bar on measurement is a laudable goal. But the MAP should consider both system constraints and deficiencies in the existing measure portfolio, in recommending discontinuation of process measures (as indicated in the attachment). Such recommendations can impact and inappropriately burden physicians and specialties making a good faith effort to report measures for quality improvement. The AMA also finds some inconsistency with the application of MAP measure selection criteria. Though the MAP states there is a need for measures that identify health disparities, the MAP does not support—and actually recommends removal of—a number of ophthalmic measures which assess diabetes-related eye care. Diabetes affects minority populations disproportionately. The MAP has also identified the need for care coordination measures, yet recommends eliminating NQF0089, which addresses communication with the physician managing diabetic care. These recommendations may leave physicians who primarily treat diabetic eye disease, and ophthalmologists in general, without an opportunity to participate in the PQRS.

A flexible approach is critical to ensuring that relevant measures are available to as many physicians as possible. Many new physicians will begin participating in the PQRS, and existing physicians must be supported in continuing to participate in the program. The MAP must also keep in mind that PQRS participation serves as the gateway for VBM participation. MAP recommendations may contribute to creation of a reporting environment that makes it difficult or impossible for many EPs to report satisfactorily under the PQRS, which also subjects them to penalties under the VBM. We estimate that, as a result, over 50 percent of EPs could be penalized simultaneously by the two separate programs. The MAP should take seriously these considerations into account in making its recommendations.

Physician Compare: CMS is required to report publicly quality data and CMS has determined that it will report information compiled under the PQRS on Physician Compare, as well as VBM information. In early 2014, CMS will begin to publicly report performance information. The AMA agrees with the MAP's recommendation to exclude from Physician Compare and VBM calculations the 52 measures that are not NQF-endorsed. Experience needs to be gained with measures prior to implementation in public reporting. They also need to be tested to ensure no association with adverse consequences.

Core Measures: To further support clinician participation, the MAP discussed developing a core measure set for individual clinician reporting and considered two options: 1) identifying a subset of measures for all clinicians; or 2) identifying multiple core sets, for each specialty or groups of related

specialties. The AMA supports advancing clinician participation in PQRS and CMS quality programs, but measuring physicians against a single core set of measures is problematic given their varying practice patterns. What is meaningful and necessary for an internist is different for a surgeon. Core measures by specialty also pose a problem due to sub-specialization. With vast differences in clinical areas and patient populations and a lack of cross cutting outcome measures, it is not yet possible to create a core set of actionable, outcomes oriented measures to sufficiently meet quality improvement goals for a broad range of specialties. Lessons can be learned from the issues surrounding the Stage 1 Meaningful Use (MU) core quality measures; some specialties had no clinically relevant measures and were unable to meaningfully participate in the EHR Incentive Program. This has led to reporting measures that are not relevant in order to meet reporting requirements, and a focus on the wrong improvement activities, diverting precious resources from process improvement activities. The AMA prefers option two but defers to affected specialties on questions of feasibility. We also recommend that the MAP and CMS consult with the appropriate stakeholders for additional input and guidance on design.

Application of Hospital-Based Measures to Clinician Reporting: During the rulemaking for 2014, HHS identified two options for applying existing hospital measures to the clinician performance measurement programs, which the MAP also considered. Generally, the MAP supported both options for using hospital-level measures to assess clinician performance. The AMA supports the proposal to allow hospital-based specialties to receive performance reporting credit for quality measures collected in the hospital inpatient setting. We defer to the individual specialties as to which additional Inpatient Quality Reporting (IQR) measures should be retooled for use in the PQRS. It is important to note that retooling a measure for capture in a different setting and at a different level of measurement (i.e., facility/hospital as compared to individual physician level) is not an insignificant task. We encourage CMS to work very closely with the affected measure developers to ensure careful selection of measures and a smooth process for their retooling. We also encourage CMS to support efforts to retool measures by providing funding for this necessary but expensive undertaking.

The MAP also discussed CMS' question of whether to attribute the reporting periods and performance results from the hospital IQR program to individual EPs or group practices that elect to have their hospital's performance scores attributed to them. The AMA defers to the individual specialties affected by this proposal on whether this is appropriate. In evaluating this approach, the MAP should advise CMS to consider how to attribute hospital performance on a measure to a physician who practices in multiple hospitals treating the same condition.

Categorization of Specific Measures

The MAP pre-rulemaking report categorizes specific measures and provides the MAP's conclusions and rationale for how each measure should or should not be used in a federal program. The AMA applauds the MAP for refining categorization of measures from previous years and publishing the measure list at the start of MAP deliberations. With regard to specific measures, the AMA has the following comments:

Cost-Based Measures: While implementation of the VBM program is statutorily mandated by the Affordable Care Act, there are many issues that need to be resolved before implementation of cost-based measures.

S2158, Medicare Spending Per Beneficiary: The NQF's endorsement criteria require measures to be shown as reliable and valid. This proposed measure does not appear to meet reliability and validity standards for use at the clinician level. MAP Steering Committee members voiced numerous concerns about its reliability and validity, and the AMA shares those concerns. Additionally, the 90-day look-back period seems insufficient to capture a patient's comorbidities to calculate the hierarchical condition categories (HCC) score. The HCC risk adjustment model for the current mortality and readmission measures utilizes a look-back period of an entire year. The measure's complex methodology may enhance measurement accuracy. Unfortunately, the high level of complexity also makes it more difficult for physicians and other clinicians to monitor their performance. The measure also fails to demonstrate a linkage of expenditures as a result of quality achieved. Overall, the measure simply does not

provide actionable information that would assist clinicians in improving their performance.

Total Per Capita Cost: Attribution is critical to total per-capita cost calculations. Due to the attribution methodology, this measure did not receive NQF endorsement. In fact, during Steering Committee deliberations, members voiced numerous concerns about its reliability and validity. The measure does not correlate to an appropriate quality measure that could frame the cost expended with the quality achieved. It also fails to provide actionable information, so a physician could determine how to make improvements. For the foregoing reasons, the AMA does not support the use of this measure.

Episode Measures for CMS Episode Groupers: As a concept, episode groupers are preferable to the cost measures CMS is currently using to calculate the VBM. However, Medicare rejected the existing commercial groupers because they do not work for the Medicare populations. The AMA also believes there are problems with their use in younger populations. There are, however, multiple HHS funded projects addressing the issue of episode groupers. We believe that until the individual episode groupers are further evaluated, it is premature for recommendations to be made on the measures or for inclusion into the VBM.

American Nurses Association

Maureen Dailey

ANA agrees with the need for robust participation by eligible clinicians in the program measure sets reviewed by the MAP. It is important that there be consistent application of the MAP Measures Selection Criteria and voting categories across MAP workgroups. The MAP strong preference that measures first be reported on Physician Compare before consideration and implementation of the public reporting and payment programs is supported by ANA.

American Optometric Association

Kara Webb

The AOA is concerned with the MAP's recommendations for several of the measures related to eye care. For Measure 0055 (Comprehensive Diabetes Care: Eye Exam) and Measure 0089 (Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care), the MAP has recommended against including these measures in Physician Compare or the Value Based Payment Modifier Program. It was noted that this recommendation was made because the MAP has a preference for composite measures that assess diabetes care and for measures that may reveal health disparities. While the AOA understands the value of composite measures, the composite measure related to diabetes care that the NQF supports for the VBPM and Physician Compare does not include an eye care related component. This is a serious deficiency in measure 0729 "Optimal Diabetes Care." According to the American Diabetes Association, nearly 26 million people in the United States, or 8.3 percent of the population, have diabetes. An estimated 7 million Americans are undiagnosed, with Hispanics and blacks at higher risk for developing the disease. In 2008, 4.2 million (28.5%) people with diabetes aged 40 years or older had diabetic retinopathy, and of these, 655,000(4.4% of those with diabetes) had advanced diabetic retinopathy that could lead to severe vision loss.

Yearly, dilated eye exams are extremely important for those living with diabetes. When the eyes are dilated, an eye doctor is able to examine the retina for early warning signs of diabetic eye disease and prescribe a course of treatment to preserve an individual's sight. Ensuring that this needed care is provided, especially to those most vulnerable to diabetes is critical. Diabetes and its vision complications pose a disproportionate burden on certain segments of the U.S. population. Compared to non-Hispanic white adults, the risk of diagnosed diabetes was 18% higher among Asian Americans, 66% higher among Hispanics, and 77% higher among non-Hispanic blacks. The AOA strongly disagrees with the MAP's recommendation not to include Measure 0055 and 0089 in Physician Compare and the VBPM in favor of a composite diabetes measure that does not account for eye care,a necessary component of care as reported by both the Center for Disease Control and Prevention (CDC) and the American Diabetes Association and the American Association of Clinical Endocrinologists.

American Optometric Association

Kara Webb

The MAP has recommended against the continued inclusion of certain eye care related measures in PQRS. Specifically, the MAP recommends that Measure 0088 (Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy); Measure 0563 (Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care) and Measure 0566 (Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement) be removed from PQRS. During the MAP clinician workgroup meeting, concerns were raised regarding these measures and certain workgroup members felt that these measures set the bar too low. The AOA continues to see the value in the use of these quality measures, but also understands the need for the new outcomes focused measures to be developed related to eye care for continued quality improvement.

American Society for Gastrointestinal Endoscopy

Kenneth K. Wang, MD, FASGE

Gastroenterology Finalized Program Measures and Measures under Consideration for Clinical Performance Measurement Programs

As CMS' quality programs move from an incentive to penalty phase, ASGE believes it is critical for CMS to increase the number of meaningful, endoscopy-related measures for reporting by gastroenterologists throughout its clinical performance measurement programs, which will allow for meaningful performance assessment of gastroenterologists.

NQF has appropriately identified colorectal cancer as a high-impact condition. Colonoscopy, a high-volume service performed predominately by gastroenterologists, is considered to be the most effective screening option for colorectal cancer and is the only method that screens and treats concurrently, making development of meaningful colonoscopy measures paramount to ASGE's physician members.

In 2014, gastroenterologists are still struggling with identifying performance metrics that are relevant to their scope of practice. According to the 2011 PQRS and ERx Experience Report published by CMS in May 2013, 12,134 gastroenterologists were eligible to participate in the PQRS program in 2011; however, only 3,164 (26%) participated. ASGE speculates that the lack of endoscopic measures during that program year contributed to the low PQRS participation rate by gastroenterologists.

Gastroenterology Finalized Program Measures for Clinical Performance Measurement Programs

ASGE appreciates the MAP's support of the Colorectal Cancer Screening measure (NQF 034/PQRS 113) and Endoscopy and Polyp Surveillance measures (NQF 658/PQRS 320: Appropriate follow-up interval for normal colonoscopy in average risk patients; NQF 659/PQRS 185: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use) for inclusion the Physician Compare and Value-Based Payment Modifier programs.

ASGE is disappointed with the MAP's recommendation of "Do Not Support" for the Screening Colonoscopy Adenoma Detection Rate (ADR) measure (PQRS 343) relative to its inclusion in the Physician Compare and Value-Based Modifier programs. We believe this measure allows for meaningful comparison of physician performance and are pleased with CMS' decision to include the measure in PQRS beginning with the 2014 reporting period. There is a strong connection between the quality with which the colon is cleared of neoplasia and the effectiveness of the recommended intervals for surveillance. We believe that CMS quality programs must not only address the potential overuse of colonoscopy, but also the quality of the technical aspects of the procedure. This ADR measure is a true outcome measure directly linked to reduced mortality from colorectal cancer. One of the goals of the NQF is to support measures that are truly associated with better outcomes for patients. The ADR measure is consistent with that goal and would provide valuable outcome information to inform consumer decisions and drive quality improvement. The measure pertains to a high-impact condition, promotes alignment across quality programs, helps to prevent a leading cause of mortality and morbidity, upholds equitable access and treatment for health disparities, and does not increase clinical reporting burden.

Given that the ADR measure, developed and supported by ASGE, the American College of Gastroenterology (ACG), and the American Gastroenterological Association (AGA), has strong published evidence proving that it saves lives and decreases frequent surveillance resulting in reduced costs we request that the MAP reconsider its proposed decision of "Do Not Support" for the ADR measure for inclusion in the Physician Compare and Value-Based Modifier programs or provide rationale for its current decision.

ASGE, in concert with its allied GI societies, will be submitting the ADR measure to the NQF for consideration of endorsement this year.

Gastroenterology Measures under Consideration for Clinical Performance Measurement Programs

ASGE appreciates the MAP's support of the Repeat Colonoscopy due to Poor Bowel Preparation and Appropriate Age for Colorectal Cancer Screening Colonoscopy measure concepts for inclusion in PQRS 2015. These outcome measures are currently being specified by ASGE in collaboration with the ACG and AGA.

ASGE thanks the MAP for its comments relative to the Appropriate Age measure: The age limits of this measure should align with the age limits of colorectal cancer screening measures in the program. This measure should [not] cover ages above the screening. The GI societies will consider this input.

The colorectal cancer screening measure (NQF 034/ PQRS 113) is consistent with the U.S. Preventive Services Task Force (USPSTF) recommendation for screening for colorectal cancer in adults using fecal occult blood test (FOBT), sigmoidoscopy, or colonoscopy, beginning at 50 years of age and continuing until 75 years of age. However, it differs with the USPSTF recommendation against screening for colorectal cancer in adults older than 85 years as there is moderate certainty that the benefits of screening do not outweigh the harms.

As overall life expectancy increases, gastroenterologists are faced with the very common clinical situation where a 76-year-old presents for a first-time screening colonoscopy. Recent studies are reexamining the decision model that led to the USPSTF recommendation relative to age range for colorectal cancer screening and challenging the upper age limit for screening colonoscopy.

In developing this measure concept, the GI societies agree colonoscopy should be performed in patients age 85 or older only for assessment of signs/ symptoms of GI tract illness, in high-risk patients, or to follow up previously diagnosed advanced lesions.

American Society of Anesthesiologists

Jane C. K. Fitch, MD

We appreciate the MAP's encouragement of shared accountability measures under the core measure sets. However, MAP's engagement on the matter is limited. We request MAP begin to contemplate additional measures for shared accountability for patient outcomes where multiple specialties working in concert have a significant impact on patient outcomes, especially between surgeons and anesthesiologists. The ASA encourages MAP to identify core measures that would apply across specialties involved in perioperative care.

ASA recommends that MAP contemplate a process to review and include provisions for supporting shared accountability measures. A significant number of measures under review limit attribution to one medical professional. We ask in the future that the MAP take into further consideration the role of each medical professional that contributes to patient outcomes. In this way, we have noted a few measures that received support or conditional support from the MAP where an anesthesiologist contributes to patient outcomes: High-Acuity Care Visits after Outpatient Colonoscopy; NQF #0533 – Postoperative Respiratory Failure; NQF #0349 – PSI 16 Transfusion Reaction; Readmission after CABG, Readmission after Vascular Procedure, 30-Day Mortality after CABG, and Cataract Intra-Operative Complications.

ASA appreciates MAP support for the Qualified Clinical Data Registries (QCDR) as a reporting option that clinicians will soon be able to use for participation in federal programs. ASA is optimistic that physicians will have this opportunity. ASA has long been a supporter of registries and of measuring anesthesia care to promote better patient outcomes. Registries are an effective way of harnessing unique and innovative medical knowledge and practice.

Registries can also be essential in communicating that knowledge to a wider audience. Data gathered by registries also offer an opportunity for inter-specialty collaboration and development of shared accountability quality measures.

ASA endorses MAP's support of incorporating Maintenance of Certification (MOC) program measures into federal programs. The ASA has developed tools to fulfill the Practice Performance Assessment and Improvement (PPAI) component of MOC in Anesthesiology. These modules are case evaluation–based performance improvement activities designed around identified practice gaps. Each PPAI module is designed to close the specified gap by linking education with performance improvement via implementation of an outcome improvement process. Quality of care is enhanced, not just measured. Likewise, the ASA believes federal quality reporting programs should promote and reward such activities that go beyond measurement to foster active quality improvement.

America's Health Insurance Plans

Carmella Bocchino

While we recognize that NQF #0576 Follow-up After Hospitalization for Mental Illness addresses a measurement area not adequately represented in the program measure set, this measure needs to be tested for provider-level measurement as it is currently specified for only health plan and integrated delivery system levels.

Also, while NQF #0022 Use of High Risk Medications in the Elderly addresses an existing measure gap, it may result in the under-treatment of pain and depression in the elderly and therefore should be monitored.

AmeriHealth Caritas

Andrea Gelzer

AmeriHealth Caritas Family of Companies supports Measure #0022 Use of High Risk Medications in the Elderly as it addresses an existing measure gap, but caution that it must be monitored for under-treatment of pain and depression in the elderly.

Armstrong Institute for Patient Safety and Quality at Johns Hopkins University

Matt Austin

XDBHA: We concur with the MAP's recommendation of conditional support and offer the following comments: More clarity is needed on what types of goals and what outcomes would be included in the measure. Universal goals such as longevity, function, symptom relief may be appropriate for encompassing a plan of care for patients at one stage of life and more specific goals for patients with acute or time limited conditions.

XDAEC: We concur with the MAP's recommendation of conditional support and offer the following comments: Greater clarity is needed on what age associated risks would be included in the measure and what would count as appropriate 'management' of those risks.

XDBGH: We concur with the MAP's recommendation of conditional support and offer the following comments: How would success be defined for the numerator? Is success specific to each risk type?

XDFEH: We concur with the MAP' s recommendation of not supporting the measure, as the numerator statement and denominator statement are exactly the same.

S1884: We concur with the MAP's recommendation of support or conditional support for this measure and offer the following comments: The major issue has to do with how often we properly diagnose depression (or other MI) in non psych settings and how often we give PHQ or other outcome scales. If we adopt these, we need to commit to a better job at detection and diagnosis. It is hard for us to say if these are the best metrics as there are no mentions of obesity, smoking, or other behaviors, or regarding the several addiction outcomes. Also, nothing was included on dementia.

S1885: We concur with the MAP's recommendation of support or conditional support for this measure and offer the following comments: The major issue has to do with how often we properly diagnose depression (or other MI) in non psych settings and how often we give PHQ or other outcome scales. If we adopt these, we need to commit to a better job at detection and diagnosis. It is hard for us to say if these are the best metrics as there are no mentions of obesity, smoking,

or other behaviors, or regarding the several addiction outcomes. Also, nothing was included on dementia.

XDCLD: We concur with the MAP's recommendation of conditional support and offer the following comments: The concept of specifying "one time consult" or "co-management desired" is not typically included in referrals.

XDELE: We concur with the MAP's recommendation of not supporting this measure and offer the following comments: This may be very challenging to measure and to interpret results, as the "therapeutic range" is specific to each patient and would need to be embedded into the EHR. Also, it is hard to see how one would be able to identify low INRs which occur in setting of surgery or other intentional interruption. Finally, TTR is only 55-70% in randomized trials with highly motivated patients and excellent follow-up. In addition, patient factors, such as adherence and co-morbidities, will have major impact on TTR. Centers with more complicated patients (transplants, LVADs) will likely do worse than community settings.

XDELF: While the MAP recommended not supporting this measure, we believe this is a reasonable measure for monitoring performance. While a target of 100% is reasonable, there will be challenges in obtaining INR info for patients who get checked in outside labs, snowbirds who get NR checked in Florida in the winter, and those who do home monitoring.

XDDAC: We concur with the MAP's recommendation of conditional support for this measure and offer the follwing comments: The measure needs to better specify the timeframe for receipt after completion of referral and what notification is relevant in systems with a shared ER.

XDELB: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: The measure needs to be clearer in how one would assess if the goal was reached.

XDAFC: We concur with the MAP's recommendation of conditonal support for this measure and offer the following comments: Functional status and disease activity measures, at present, are standard tools in drug treatment studies in RA, more so than in general medical practice or in general rheumatology practice.

E2080: Given the MAP's recommendation of support for this measure for Meaningful Use, we do have the following comment on the measure: Which visits will count for purposes of this measure? IM, ID? All w HIV diagnosis?

E2079: Given the MAP's recommendation of support for this measure for Meaningful Use, we do have the following comment on the measure: Which visits will count for purposes of this measure? IM, ID? All w HIV diagnosis?

E2082: Given the MAP's recommendation of support for this measure for Meaningful Use, we do have the following comments on the measure: Antiretroviral therapy (ART) is recommended for all HIV-infected individuals to reduce the risk of disease progression. The strength and evidence for this recommendation vary by pretreatment -- CD4 cell count: CD4 count <350 cells/mm3 (AI); CD4 count 350–500 cells/mm3 (AII); CD4 count >500 cells/mm3 (BIII). ART also is recommended for HIV-infected individuals for the prevention of transmission of HIV. The strength and evidence for this recommendation vary by transmission risks: perinatal transmission (AI); heterosexual transmission (AI); other transmission risk groups (AIII). Patients starting ART should be willing and able to commit to treatment and understand the benefits and risks of therapy and the importance of adherence (AIII). Patients may choose to postpone therapy, and providers, on a case-by-case basis, may elect to defer therapy on the basis of clinical and/or psychosocial factors.

XDFEF: We concur with the MAP's recommendation for not supporting this measure and offer the following comment: Does this measure apply to all providers or just to rheumatologists?

E0545: We concur with the MAP's recommendation to not support this measure and offer the following comment: There is no mention of insulin in the denominator of measure C; it only mentions oral hypoglycemia agents. Adherence to prescribed insulin is another important metric as well.

E1879: While the MAP recommended support for this measure, we do offer the following concerns: The major issue has to do with how often we properly diagnose depression (or other MI) in non psych settings and how often we give PHQ or other

outcome scales. If we adopt these, we need to commit to a better job at detection and diagnosis. It is hard for us to say if these are the best metrics as there are no mentions of obesity, smoking, or other behaviors, or regarding the several addiction outcomes. Also, nothing was included on dementia.

E2083: Given the MAP's recommendation of support for this measure for Meaningful Use, we do have the following comments on the measure: Antiretroviral therapy (ART) is recommended for all HIV-infected individuals to reduce the risk of disease progression. The strength and evidence for this recommendation vary by pretreatment -- CD4 cell count: CD4 count <350 cells/mm3 (AI); CD4 count 350–500 cells/mm3 (AII); CD4 count >500 cells/mm3 (BIII). ART also is recommended for HIV-infected individuals for the prevention of transmission of HIV. The strength and evidence for this recommendation vary by transmission risks: perinatal transmission (AI); heterosexual transmission (AI); other transmission risk groups (AIII). Patients starting ART should be willing and able to commit to treatment and understand the benefits and risks of therapy and the importance of adherence (AIII). Patients may choose to postpone therapy, and providers, on a case-by-case basis, may elect to defer therapy on the basis of clinical and/or psychosocial factors.

S1880: While the MAP recommended support or conditional support for this measure, we do offer the following concerns: The major issue has to do with how often we properly diagnose depression (or other MI) in non psych settings and how often we give PHQ or other outcome scales. If we adopt these, we need to commit to a better job at detection and diagnosis. It is hard for us to say if these are the best metrics as there are no mentions of obesity, smoking, or other behaviors, or regarding the several addiction outcomes. Also, nothing was included on dementia.

XDBBL: While the MAP has recommended support or conditional support for this measure, we do offer the following concerns:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA... All it takes is one Warren Buffet to bring up the average substantially....

XDBBG: While the MAP has recommended support or conditional support for this measure, we do offer the following concerns:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming

hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific. 6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA... All it takes is one Warren Buffet to bring up the average substantially....

XDBBM: While the MAP has recommended support or conditional support for this measure, we do offer the following concerns:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagin

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

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7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA... All it takes is one Warren Buffet to bring up the average substantially....

XDFLD: We concur with the MAP's recommendation of conditional support of this measure and offer the following comment: Agree that measuring funcational outcomes after spine sugery is important.

XDFDL: Given the MAP's recommendation to not support this measure, we offer the follwoing coments: There has been a lot discussion about this measure in the field of Emergency Medicine nationally. Most vehemently dislike this measure as the outcome is retrospectively defined as to appropriateness. Others like it as there are too many head CTs for trivial trauma. That said, the criteria for not getting a head CT should be clearly defined, and the outcome should not be defined based on a numerator of positive findings. It's devastating to miss even a single bleed. The ACEP clinical rule uses the words "considered for obtaining a head CT', it does not state when a CT is inappropriate.

XAHDG: We concur with the MAP's recommendation of conditonal support and offer the following comments: seems reasonable to evaluate this for internal use, but may be difficult to compare results between centers without risk adjustment.

XDFAG: We concur with the MAP's recommendation of support and conditonal support of this measure, but offer the following comments; The measure specification needs to 1) exclude children, as they do for other cataract measures, 2)exclude crystalline lens subluxation.

XDFGF: We concur with the MAP's recommendation of not supporing this measure, as the criteria are yet to be determined.

XDFAM: While the MAP recommended support or conditional support for this measure, we do offer the following concerns: 1) The measure specs for inclusion/exclusion seem imprecise and could be gamed, 2) use of emmetropia as an empiric target is wrong, it should be within +/- 1 D of target refraction. We currently have no electronic link between the power of the IOL chosen, the specific calculation used to predict a particular refractive outcome, and the refraction generated postoperatively. We also have a large number of patients who are not

refracted with the required degree of accuracy for this outcome, based on severe retinal comorbidities . Hence, we would need a simple method to exclude numbers of patients from that kind of analysis.

XDFCF: While the MAP recommended support or conditional support for this measure, we do offer the following concerns:

We do recommendation on liver lesions based on the published literature but do not track the number of cases that we see. We have published on the subject as well to help with management. We strictly follow the published literature.

Defining vascular signatures of malignant hepatic masses: role of MDCT with 3D rendering.

Ahmed S, Johnson PT, Fishman EK.

Abdom Imaging. 2013 Aug;38(4):763-73. doi: 10.1007/s00261-012-9934-y. Review.

Dual-phase computed tomographic angiography of focal nodular hyperplasia: defining predictable postcontrast attenuation levels relative to aorta and inferior vena cava.

Johnson PT, Zaheer A, Anders R, Fishman EK.

J Comput Assist Tomogr. 2010 Sep-Oct;34(5):720-4.

XDFCG: We concur with the MAP's recommendation of conditional support for this measure and offer the following concerns:

We have strict protocols for the kidney and how we manage lesions but do not collect numbers of cases. We do follow up most renal masses with correlation with pathology.All are reviewed at our biweekly "difficult case conference" for the faculty. We have also published extensively on the topic

Multiphasic enhancement patterns of small renal masses (≤4 cm) on preoperative computed tomography: utility for distinguishing subtypes of renal cell carcinoma, angiomyolipoma, and oncocytoma.

Pierorazio PM, Hyams ES, Tsai S, Feng Z, Trock BJ, Mullins JK, Johnson PT, Fishman EK, Allaf ME.

Urology. 2013 Jun;81(6):1265-71. doi: 10.1016/j.urology.2012.12.049. Epub 2013 Apr 17.

Optimizing detectability of renal pathology with MDCT: protocols, pearls, and pitfalls.

Johnson PT, Horton KM, Fishman EK.

AJR Am J Roentgenol. 2010 Apr;194(4):1001-12. doi: 10.2214/AJR.09.3049.

How not to miss or mischaracterize a renal cell carcinoma: protocols, pearls, and pitfalls.

Johnson PT, Horton KM, Fishman EK.

AJR Am J Roentgenol. 2010 Apr;194(4):W307-15.

XDFCH: We concur with the MAP's recommendation of conditional support for this measure and offer the following concerns:

We have specific adrenal protocols for lesion detection that we follow. We have published on this topic as well. We do not collect numbers but do follow-up with pathology as well as with the Hopkins Adrenal Multidisciplinary conference.

MDCT of adrenal masses: Can dual-phase enhancement patterns be used to differentiate adenoma and pheochromocytoma?

Northcutt BG, Raman SP, Long C, Oshmyansky AR, Siegelman SS, Fishman EK, Johnson PT.

AJR Am J Roentgenol. 2013 Oct;201(4):834-9. doi: 10.2214/AJR.12.9753.

Adrenal masses: contemporary imaging characterization.

Malayeri AA, Zaheer A, Fishman EK, Macura KJ

J Comput Assist Tomogr. 2013 Jul-Aug;37(4):528-42

Adrenal mass imaging with multidetector CT: pathologic conditions, pearls, and pitfalls

Johnson PT, Horton KM, Fishman EK.

Radiographics. 2009 Sep-Oct;29(5):1333-51.

We also believe that the best quality of care is to provide open transparent sessions for the constant training and retraining of our physician staff as well as working closely with our radiologic technologists. We are aware of the importance of incidental findings and it seems the government copied our article in choosing the questions in this survey

Common incidental findings on MDCT: survey of radiologist recommendations for patient

management.

Johnson PT, Horton KM, Megibow

J Am Coll Radiol. 2011 Nov;8(11):762-7.

We not only publish our own experience but these topics are part of our 3-4 JHH CME courses each year. We also have all the material on line and in the Apple app store.

XCLLL: We concur with the MAP's recommendation of conditonal support for this measure and offer the following comments: HRS has adopted this safety metric, which we belive the EP community will accept as reasonable to measure. There is some vagueness about definition of "tamponade" if pericardiocentesis is not performed.

XDFDB: We concur with the MAP's recommendation to not support this measure and offer the following comments: The use of weight, IF it is to used as a measure of quality, should really be based on the preradiotherapy NOT the presurgery weight. That said, we have several, real, concerns about this as a quality measure and think there are other criteria one could develop.

Weight loss is a multi-factorial issue for the irradiated head and neck pt and while it can be a good surrogate for nutrition, there are better measures of nutrition. It also is not clear that by itself, it is the best RT QA measure, as other factors contribute to weight loss that are not necessarily quality of care related. Factors contributing to weigh loss include:

1) Poor/inadequate pain management (this is probably the best QA measure to use as itself is an important endpoint AND, secondarily, may drive weight loss).

2) Taste changes ranging from hypoguesia to marked dysgeusia to even an aversion response to the thought of food placed orally. We have very little insight into the cause of RT induced taste changes except that it is likely dose and anatomically site related but not quality of radiation therapy delivery.

3) Treatment induced changes to oral and pharyngeal secretions that can range from sialorrhea to ropy secretions in the context of perceived xerostomia; pts with the later can then develop a retching syndrome in an attempt to clear the secretions with poor oral intake and weight loss

4) Very importantly, many patients treated with radiation for head and neck cancer are also treated with concomitant chemotherapy. Many patients receiving chemotherapy have nausea both acute and delayed.

5) Depressive symptoms ranging to clinical depression meeting the DSM criteria

6) Lastly, weight loss may be a result of intrinsic, aggressive, tumor biology and not the treatment… thus, reinforcing that weight loss, per se, may not necessarily be appropriate as a QA measure

Our best recommendation for meaningful QA in this area would be to have relative likert measures reported on pain, starting from baseline, and measures of nutritional status, like albumin, etc. (not an expert here, but nutritionists would be).

XCLMD: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Another reasonable safety metric for EP. This metric is more a measure of institutional quality than individual operator. It is unfortunate that they did not adopt a standard 90-day post-op window.

XDFLL: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: After all these years, the jury is still out as to the benefit/harm ratio for use of thrombolytics. It's by no means clear cut.

E0465: We concur with the MAP's recommendation to support this measure.

XDEME: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: "Optimal medical therapy" needs to be clearly defined.

XDFBM: While the MAP recommended support or conditional support of this measure, we do offer the following comment: Since we get consent on each patient we are aware of any allergies and use a 24/12/2 prep for patients with prior reactions. We do not premeditate patients with severe prior reactions (arrest etc) as breakthrough reactions will occur in up to 15% of cases with subsequent reaction similar to initial reaction. We do the premedication with our

nursing staff. We do not have a master list of patient we premeditate. Our policies are online at www.ctisus.comin the contrast protocol section and on our free app on contrast on the Appple app store.

XDFDG: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: It is reasonable to measure 1 yr amputation rates after revascularization.

XDFDH: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: It is reasonable to measure 1 yr amputation rates after revascularization.

XCMDH: We concur with the MAP's recommendation to not support this measure and offer the following commentes: We have questions about the relevance of this measure. In our system. the rate of cystoscopy at the time of continence surgery would be virtually 100%. It would be a extremely rare situation that cystoscopy would not be performed. A patient would never refuse, and the performance of a continence procedure in the setting of a 'fresh repair' would also be rare. There may be variance of this practive for procedures done by the gyn pactitioners, but almost none for urology. In addition, the complications of bladder/bowel/ureteral/urethral injury are not avoided by the use of cystoscopy. The severity and/or sequelae of these injuries are potentialy avoided by cystoscopy. Cystoscopy identifies injury after the fact, allowing more effective intraoperative management.

An alternative might be to look at complications associated with female pelvic surgery (hysterectomy, oopherectomy) or procedures for pelvic organ prolapse not associated with a continence procedure. Cystoscopy may not be done routinely in these cases by the gyn practitioners (sometimes a credentialing or competency issue) resulting in a missed opportunity to identify correctable problems at the time of surgery rather than in a delayed fashion.

XDFGL: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: It could be useful to compare rates of aborted procedures due to poor bowel preps among different providers to identify root causes and perhaps develop interventions (more pre-procedure education, underlying morbidities that contribute to poor preps , such as chronic opioid use, colonic dysmotility, etc.- recent study was published that obesity is an independent risk factor for poor prep!)

What seems to be missing is a requirement that bowel prep quality is recorded and reported on the procedure report. One could use something like the Boston Bowel Prep Score (BBPS) that assigns a numeric value to the quality of the prep in each segment of the colon, and then a total value..
It seems that justification that a colonoscopy is aborted due to poor bowel prep should include some measurement as opposed to simply leaving it to the discretion of the endoscopist.

XDDMH: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: This mesaure is vague and of unclear relevance. It is obvious that providers working in heart centers that have cardiac surgery and interventional cardiology will have much higher resource use than other centers. Similarly, tertiary centers will have higher resource use than community centers.

XDFCC: While the MAP recommended support or conditional support of this measure, we do offer the following comment: Since we get consent on each patient we are aware of any allergies and use a 24/12/2 prep for patients with prior reactions. We do not premeditate patients with severe prior reactions (arrest etc) as breakthrough reactions will occur in up to 15% of cases with subsequent reaction similar to initial reaction. We do the premedication with our nursing staff. We do not have a master list of patient we premeditate. Our policies are online at www.ctisus.comin the contrast protocol section and on our free app on contrast on the Appple app store.

XDEAM: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would

the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDEDC: We concur with the MAP's recommendation of conditional support for this measure.

XDEDD: We concur with the MAP's recommendation of conditional support for this measure.

XDEEB: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

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7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDEBA: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

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DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDEBM: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDECB: While the MAP recommended conditonal support for this measure, we belive the measure is irrelevant, as the major cost of cardioversion is the anesthesiology charge, which the provider does not control.

XDEBC: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Our concerns about this measure include: 1) that CMS is able to correctly attribute appropriate resource use to the ophthalmologist ordering the tests and 2) how case complexity (or avoidance) will be managed by the agency as some hospitals may have higher acuity. Is there evidence CMS or its vendor can do that with ophthalmological services? Note how poor attribution of resources has been in the QRUR program. The chief challenge is not with the concept of the underlying metric, but how to get reliable data without significant human work resources (ie. manual record review). At a hospital site, one can count vitrectomy at the time of cataract surgery by the use of billing codes (there are facility charges, but no surgeon charge levied when a vitrectomy performed); however, at ASC sites, where more than half of the cataract surgery is currently performed, no bill is submitted since there is no allowable facility charge for vitrectomy (fixed facility reimbursement).

XDEBD: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Our concerns about this measure include: 1) that CMS is able to correctly attribute appropriate resource use to the ophthalmologist ordering the tests and 2) how case complexity (or avoidance) will be managed by the agency as some hospitals may have higher acuity. Is there evidence CMS or its vendor can do that with ophthalmological services? Note how poor attribution of resources has been in the QRUR program. The chief challenge is not with the concept of the underlying metric, but how to get reliable data without significant human work resources (ie. manual record review). At a hospital site, one can count vitrectomy at the time of cataract surgery by the use of billing codes (there are facility charges, but no surgeon charge levied when a vitrectomy performed); however, at ASC sites, where more than half of the cataract surgery is currently performed, no bill is submitted since there is no allowable facility charge for vitrectomy (fixed facility reimbursement).

XDDML: We concur with the MAP's recommendation of conditional support for this measure and offer

the following comments: This measure includes a more clearly defined set of patients and providers, but still not clear how one attributes resource use to a provider rather than to the system in which the provider works. Cardiac surgeons do not control how much their hospitals charge for an X-ray, each minute of OR time, a dose of antibiotics, etc.

XDEBB: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDEEA: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDECL: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDDMM: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Same problems as for CABG, but will be more variation in types of procedures performed by centers, making comparison between individuals operating at different centers difficult to interpret.

XDEBE: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Our concerns about this measure include: 1) that CMS is able to correctly attribute appropriate resource use to the ophthalmologist ordering the tests and 2) how case complexity (or avoidance) will be managed by the agency as some hospitals may have higher acuity. Is there evidence CMS or its vendor can do that with ophthalmological services? Note how poor attribution of resources has been in the QRUR program. The chief challenge is not with the concept of the underlying metric, but how to get reliable data without significant human work resources (ie. manual record review). At a hospital site, one can count vitrectomy at the time of cataract surgery by the use of billing codes (there are facility charges, but no surgeon charge levied when a vitrectomy performed); however, at ASC sites, where more than half of the cataract surgery is currently performed, no bill is submitted since there is no allowable facility charge for vitrectomy (fixed facility reimbursement).

XDEBF: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Our concerns about this measure include: 1) that CMS is able to correctly attribute appropriate resource use to the ophthalmologist ordering the tests and 2) how case complexity (or avoidance) will be managed by the agency as some hospitals may have higher acuity. Is there evidence CMS or its vendor can do that with ophthalmological services? Note how poor attribution of resources has been in the QRUR program. The chief challenge is not with the concept of the underlying metric, but how to get reliable data without significant human work resources (ie. manual record review). At a hospital site, one can count vitrectomy at the time of cataract surgery by the use of billing codes (there are facility charges, but no surgeon charge levied when a vitrectomy performed); however, at ASC sites, where more than half of the cataract surgery is currently performed, no bill is submitted since there is no allowable facility charge for vitrectomy (fixed facility reimbursement).

XDDMG: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Not clear what an "ischemic heart condition episode" is and how one would attribute resources used to specific providers. I would consider this vague and irrelevant.

XDECF: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue

to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA... All it takes is one Warren Buffet to bring up the average substantially....

XDEAA: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Same problems as for CABG, but will be more variation in types of procedures performed by centers, making comparison between individuals operating at different centers difficult to interpret.

XDECC: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: This measure may be irrelevant, as the major cost of these procedures is the device hardware, which is not under the provider's direct control, but rather is negotiated by hospitals.

XDECH: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA... All it takes is one Warren Buffet to bring up the average substantially....

XDECD: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment

model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDEDH: While the MAP conditionally supported this measure, we belive the measure should be supported.

XDEBG: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Our concerns about this measure include: 1) that CMS is able to correctly attribute appropriate resource use to the ophthalmologist ordering the tests and 2) how case complexity (or avoidance) will be managed by the agency as some hospitals may have higher acuity. Is there evidence CMS or its vendor can do that with ophthalmological services? Note how poor attribution of resources has been in the QRUR program. The chief challenge is not with the concept of the underlying metric, but how to get reliable data without significant human work resources (ie. manual record review). At a hospital site, one can count vitrectomy at the time of cataract surgery by the use of billing codes (there are facility charges, but no surgeon charge levied when a vitrectomy performed); however, at ASC sites, where more than half of the cataract surgery is currently performed, no bill is submitted since there is no allowable facility charge for vitrectomy (fixed facility reimbursement).

XDECE: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDEDG: While the MAP conditionally supported this measure, we belive the measure should be supported.

XDEBH: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: Our concerns about this measure include: 1) that CMS is able to correctly attribute appropriate resource use to the ophthalmologist ordering the tests and 2) how case complexity (or avoidance) will be managed by the agency as some hospitals may have higher acuity. Is there evidence CMS or its vendor can do that with ophthalmological services? Note how poor attribution of resources has been in the QRUR program. The chief challenge is not with the concept of the underlying metric, but how to get reliable data without significant human work resources (ie. manual record review). At a hospital site, one can count vitrectomy at the time of cataract surgery by the use of billing codes (there are facility charges, but no surgeon charge levied when a vitrectomy performed); however, at ASC sites, where more than half of the cataract surgery is currently performed, no bill is submitted since there is no allowable facility charge for vitrectomy (fixed facility reimbursement).

XDECM: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

XDECG: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA… All it takes is one Warren Buffet to bring up the average substantially….

S2158: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments:

1) How will they adequately risk adjust? Sicker patients use more resources.

2) By provider, do they mean individual providers or institutions? Easier to do this at an institution level, I imagine.

3) How will they deal with hospital transfers and other transfers of care between institutions? Would the resources be attributed to the initial hospital where the patient presented? You don't want to disincentivize tertiary care patients to take the toughest patients from community hospitals.

4) More expensive patients are likely to continue to be more expensive moving forward (eg, end-of-life situations); how do you avoid cherry-picking scenarios that disadvantage the most vulnerable? How do you keep the sickest patients from becoming hot potatoes?

5) Some of the diagnosis categories are very broad

or suboptimally specific.

6) How will all this fit in with the DRG payment model? If there is already an incentive to keep hospitalizations short and use fewer resources based on a DRG payment model, then a long-stay complex patient can hurt you twice (by overstaying his/her DRG and then incurring an additional penalty for bringing up your average cost for that diagnosis).

7) Will they have a "trim" point on costs? The distribution of costs is probably similar to the distribution of incomes in the USA... All it takes is one Warren Buffet to bring up the average substantially....

E0393: We concur with the MAP's recommendation to not support this measure and offer the following comments: Since most nephrologist would not treat HCV, but rather would refer patients to a gastroenterologist, where HCV RNA testing would be performed and, if positive, monitored. Requiring dialysis facilities to measure HCV RNA in a patient with known HCV may lead to additional tests without impacting patient care.

XDFGD: We concur with the MAP's recommendation of conditonal support or not supporting this measure and offer the following rationale: The major issue has to do with how often we properly diagnose depression (or other MI) in non psych settings and how often we give PHQ or other outcome scales. If we adopt these, we need to commit to a better job at detection and diagnosis. It is hard for us to say if these are the best metrics as there are no mentions of obesity, smoking, or other behaviors, or regarding the several addiction outcomes. Also, nothing was included on dementia.

Association of American Medical Colleges

Mary Wheatley

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Measure Applications Partnership (MAP) Pre-Rulemaking Report released January 17, 2014. The AAMC represents all 141 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 82,000 medical students, and 110,000 resident physicians.

Clinician Resource Measures Need Additional Testing

The AAMC supports the MAP recommendations of "conditional support" for many resource measures, including Medicare Spending per Beneficiary (MSPB) and various episode groupers, for clinician or group measurement. The MSPB is an NQF-endorsed measure that is specified for hospitals, not clinicians or group practices. The measure needs to be tested to ensure the changes in attribution and sample size still produce a reliable measure. The episode groupers are still in the design and testing phase. The conditional support of these resource measures underscores the importance of resource measures, but also confirms that these measures need to be tested before being included in pay-for-performance programs.

Thank you for consideration of these comments.

AstraZeneca

Kathy Gans-Brangs

See page 163 & MUC list line 70 RE measure XAHDH, the % of individuals with antiplatelet treatment who also have a PDC with antiplatelet treatment of at least 0.8 during the 12 mo following implantation of a coronary artery drug-eluting stent. The description refers to antiplatelet therapy as clopidogrel or prasugrel. The measure steward, CMS, should broaden the measure specifications to include other appropriate antiplatelet therapy.

BRILINTA (ticagrelor) is FDA approved and indicated to reduce the rate of thrombotic CV events in patients with acute coronary syndrome (ACS). In patients treated with percutaneous coronary intervention (PCI), it also reduces the rate of stent thrombosis.

BRILINTA received a class I recommendation in the 2011 ACCF/AHA/SCAI guideline for PCI in patients with ACS.2 In addition, BRILINTA was included as a class I recommendation in both guidelines, the 2012 ACCF/AHA for UA/NSTEMI and 2013 ACCF/AHA for STEMI.3,4 The ACCP also gave BRILINTA a grade 1B recommendation in patients with ACS undergoing PCI with stent placement.5

BRILINTA was evaluated in PLATO, a multicenter,

randomized, double-blind study comparing ticagrelor (T) to clopidogrel (C) in 18,624 patients with ACS.1,2 At 12 mo, the rate of CV death/MI/stroke was 9.8% for T vs 11.7% for C resulting in a relative risk reduction (RRR) of 16% (p<0.001). The difference between treatments was driven by CV death & MI with no difference in stroke. The RRR of CV death was 21% and MI was 16% for T vs C (p=0.0013 and p=0.0045, respectively).1,6

In PLATO, 11,289 (60.6%) patients had a previous stent implanted (n=1404) or underwent stent implantation during the study (n=9885).7 There was a lower risk of stent thrombosis with T (1.3% for adjudicated "definite") than with C (1.9%) (HR 0.67; p=0.009).1,6,7 The results were similar for drug-eluting stents and bare metal stents.7

The reduction in definite stent thrombosis with ticagrelor was numerically greater for late [> 30 days: HR 0.48], and subacute [24 h – 30 days: HR 0.60] vs. acute stent thrombosis [< 24 h: HR 0.94].7

Please refer to the BRILINTA label for Boxed Warnings related to increased risk of bleeding and reduced effectiveness with maintenance doses of ASA > than 100 mg per day.

References:

1) BRILINTA Prescribing Information at http://www.astrazeneca-us.com/.

2) Levine GN et al. J Am Coll Cardiol. 2011;58(24):e44-e122.

3) Jneid H et al. Circ. 2012;126(7):875-910.

4) O'Gara PT et al. J Am Coll Cardiol. 2013;61(4):e78-e140.

5) Guyatt GH et al. Chest 2012;141(suppl 2):7S-47S.

6) Wallentin L et al. NEJM 2009;361:1045-1057.

7) Steg PG et al. Circ. 2013;128:1055-1065.

Center to Advance Palliative Care

Emily Warner, JD

CAPC urges MAP to reconsider supporting NQF 0383 and 0384, Oncology: Pain Intensity Quantified and Plan of Care for Pain for inclusion into the Physician Compare program. Though MAP states that these measures do not fit the needs of the program, the measures are particularly appropriate for Physician Compare, as they address patient experience, safety, and affect health outcomes and functional status.

CAPC also strongly urges MAP to support the continued inclusion of XCCHG: Functional status assessment for complex chronic conditions in the PQRS program. MAP notes that it prefers outcome measures, but in the absence of available outcome measures, this measure remains extremely valuable for improving care for this high-risk, high need population. The assessment of functional status in heart failure patients is foundational to improving care quality, as awareness of functional impairments and quality of life issues in this population may trigger many forms of support and improves patient-provider communication surrounding goals of care and treatment planning.

Edwards Lifeciences

Reginald Lavender

Edwards supports MAP's efforts to identify measures that address both cost of care and quality of care for inclusion in CMS programs. Edwards specifically supports MAP's recommendation to conditionally support the "Sepsis/SIRS Condition Episode for CMS Episode Grouper (measure #XDECM)" for the Value-Based Payment Modifier Program. Sepsis has a severe impact on the Medicare system as the third most expensive condition billed to Medicaid and most expensive billed to Medicare. Furthermore, evidence-based practices for sepsis management have been shown to be successful in improving outcomes, and likely therefore have an impact on costs associated with the condition. By promotion of reduced costs and improved quality of care associated with sepsis, outcomes for Medicare patients experiencing sepsis are likely to improve.

GlaxoSmithKline

Deborah Fritz

GSK supports re-specifying appropriate hospital level measures and testing them at the clinician level to assure validity, feasibility and usability for clinician reporting. GSK further recommends NQF endorsement of the re-specified clinician level measures before CMS/HHS adopts them. GSK does

not support adoption of hospital rates for clinician accountability

Heart Rhythm Society

Del Conyers

The Heart Rhythm Society (HRS) appreciates the opportunity to comment on the 3rd annual Measures Application Partnership (MAP) Pre-Rulemaking Draft Report. HRS commends MAP's decision to conditionally support two HRS's performance measures, HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation (XCLLL)and HRS-9: Infection within 180 days of CIED Implantation, Replacement, or Revision (XCLMD) for inclusion in the Physician Quality Reporting System (PQRS). In consideration of these measures, it is important to recognize that although there are an abundance of performance measures for cardiovascular care, few measures apply to heart rhythm care.

The Society's Atrial Fibrillation (AF) measure (HRS-12) addresses critically important clinical patient outcomes and fills a gap area. AF can severely depreciate an individuals' quality of life, causing heart palpitations, chronic fatigue, and debilitating pain. The condition also can increase the risk of stroke fivefold and is estimated to be responsible for 88,000 deaths and $16 billion in additional costs to the U.S. health care system. HRS-12 aims to reduce the burden of this condition. HRS-12 is currently undergoing endorsement review in the National Quality Forum's Cardiovascular Project. It is HRS's position that this measure is "ready for implementation" in a voluntary and/or mandatory reporting Medicare program as it is tested and recognized as reliable and valid.

HRS-9 is an outcome measure that assesses the number of Medicare fee-for-service beneficiaries admitted with an infection requiring device removal or surgical revision within 180 days following CIED implantation, replacement, or revision. A recent study including over 200,000 ICD implant patients found that 2 percent of patients undergoing ICD implantation experienced a device-related infection. The evidence demonstrates the need to measure performance in this area. The measure can be feasibly collected using electronic administrative data.

HRS urges MAP and the Department of Health and Human Services (HHS) to create "upstream" opportunities for measure stewards to provide contextual details (e.g., testing status, current use, harmonization effort) about measures under consideration which can inform MAP's review.

Again, HRS appreciates MAP's decision conditionally support HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation (XCLLL)and HRS-9: Infection within 180 days of CIED Implantation, Replacement, or Revision (XCLMD), and encourages MAP and HHS to modify its decision to fully support these measures. If you have any questions, please contact me at lblum@hrsonline.org.

National Kidney Foundaton

Joseph Vassalotti, MD

We disagree with the MAP recommendations to remove kidney disease specific measures related to blood pressure management (122 Adult Kidney Disease (CKD): Blood Pressure Management) and lipid profiles (121 Adult Kidney Disease: Laboratory Testing (Lipid Profile)) from PQRS. These are crucial pieces of information that physicians specifically need to be aware of in patients with CKD so they can document them in their electronic health records and so they can educate patients on strategies to undertake to avoid or slow progression of CKD.

NKF also disagrees with the MAP's recommendations to remove two measures under the hypertension measure group that would improve detection of CKD (297 Hypertension: Urine Protein Test and 298 Hypertension: Annual Serum Creatinine Test). While NKF made recommendations to modify the measures to align with new KDIGO guidelines (in our comments on the CMS-1600-P: Proposed Rule for Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014), we believe these measures are paramount to detecting CKD in patients that are at high risk. Hypertension is a leading cause of kidney disease, second only to diabetes. NKF does not agree that other measures related to hypertension address the need to screen for CKD in people with hypertension. On the contrary we recommend similar measures be included for those with diabetes

and reaffirm our previous support for the Diabetes Composite Measure (M2434) that was approved in the MAP Pre-Rulemaking Report (Public Comment Draft, January 2013).

For patients with kidney failure we disagree with MAP's recommendations to not support two measures added to PQRS in 2014 related to vascular access placement (329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis and330 Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days) for use in other physician quality programs. While we support modification of these measures to include exceptions as to when catheter placement is more appropriate than a permanent access (such as in the event of where the patient's life span on hemodialysis is expected to be very short, acute kidney injury where the need for dialysis does not exceed three months and when the patient has peripheral vascular disease or high risk of steal syndrome) we do not agree with removing the measure, which is designed to protect hemodialysis patients from infections and increased clot formation related to catheters.

[1] Grams ME, Chow EK, Segev DL, Coresh J. Lifetime Incidence of CKD Stages 3-5 in the United States" Am J Kidney Dis. 2013;62(2):245-252

Additional MAP Recommendations impacting Chronic Kidney Disease

NKF is concerned with MAP recommendations to eliminate a number of CKD measures from physician quality programs. One in three American adults is at high risk of developing kidney disease. CKD results in significant morbidity, mortality and financial burden on the healthcare system. Yet it is widely undetected and underdiagnosed. A recent disease risk analysis for the U.S. estimated that the lifetime risk of developing moderate-severe CKD (Stages 3b, 4 or 5) is 33.6%, with a residual lifetime risk of advancing to End Stage Renal Disease (ESRD) at age 40 of 3.2% and 2.2 % for men and women, respectively. This study also found a significant disparity between races, with African Americans more likely to develop CKD at an earlier age and at higher risk of advancing to ESRD. CKD that goes undetected is more likely to result in progression to kidney failure, acute kidney injury, and a need for dialysis or a kidney transplant. NKF supports quality measures that are likely to lead to increased detection, diagnosis, and early treatment of CKD in order to avoid progression to ESRD. The cost of detecting CKD and treating it early is significantly lower than treatment after the kidneys fail. For those reasons we disagree with the MAP recommendations to remove kidney disease specific measures related to blood pressure management (122 Adult Kidney Disease (CKD): Blood Pressure Management) and lipid profiles (121 Adult Kidney Disease: Laboratory Testing (Lipid Profile)) from PQRS. These are crucial pieces of information that physicians specifically need to be aware of in patients with CKD so they can document them in their electronic health records and so they can educate patients on strategies to undertake to avoid or slow progression of CKD.

NKF also disagrees with the MAP's recommendations to remove two measures under the hypertension measure group that would improve detection of CKD (297 Hypertension: Urine Protein Test and 298 Hypertension: Annual Serum Creatinine Test). While NKF made recommendations to modify the measures to align with new KDIGO guidelines (in our comments on the CMS-1600-P: Proposed Rule for Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014), we believe these measures are paramount to detecting CKD in patients that are at high risk. Hypertension is a leading cause of kidney disease, second only to diabetes. NKF does not agree that other measures related to hypertension address the need to screen for CKD in people with hypertension. On the contrary we recommend similar measures be included for those with diabetes and reaffirm our previous support for the Diabetes Composite Measure (M2434) that was approved in the MAP Pre-Rulemaking Report (Public Comment Draft, January 2013).

For patients with kidney failure we disagree with MAP's recommendations to not support two measures added to PQRS in 2014 related to vascular access placement (329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis and 330 Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days) for use in other physician quality programs. While we support modification of these measures to include exceptions as to when catheter placement is more appropriate than a

permanent access (such as in the event of where the patient's life span on hemodialysis is expected to be very short, acute kidney injury where the need for dialysis does not exceed three months and when the patient has peripheral vascular disease or high risk of steal syndrome) we do not agree with removing the measure, which is designed to protect hemodialysis patients from infections and increased clot formation related to catheters.

We appreciate the opportunity to provide guidance and commentary on the MUCs and MAP recommendations. We hope our comments are helpful to further developing and implementing quality measures that will have a meaningful impact on the lives of those with kidney disease and those at risk of kidney disease.

National Partnership for Women & Families

Alison Shippy

The Consumer-Purchaser Alliance (C-P Alliance) generally commends the Clinician Workgroup's written report, as reflecting the discussion and decisions of the Workgroup. There are two areas, however, where the reporting does not reflect the tenor or substance of the discussion. First, the report fails to reflect the very strong message that participants conveyed during the meeting about measure gaps. The Clinician Workgroup found the measure sets to be severely lacking in the kinds of measures that are most needed and noted that little progress had been made in filling measure gaps during the past year. C-P Alliance recommends that a strong message be communicated to CMS (as a primary funder of measure development) to "fast track" the prioritization of filling these gaps. In characterizing the measures, we would point out a possible misconception conveyed to audiences due to the language used in Figure 1 on page 7 of the report. The term "Effective Clinical Care" reasonably refers to outcomes (which are most desirable) and not processes (which are less desirable as they do not fully account for those outcomes). In that sense, the evaluation of total measures by this category could be misleading and C-P Alliance requests NQF consider revising it.

Second, C-P Alliance believes the statement on page 13 to be inaccurate. The statement reads "the MAP Clinician Workgroup considered if its Guiding Principles should be revised based on the review of measures; however, the workgroup determined that the guiding principles still reflect MAP's recommendations". The concern of the Workgroup was not related to its Guiding Principles, but rather was related to the concern with MAP's overall Measure Selection Criteria, stating NQF endorsement was required. The group did not agree with this principle, as it was concerned about filling measure gaps as quickly as possible. As such, it did not want the NQF process to slow down the implementation of good measures. Notably, the lack of support for many measures in the proposed Physician Compare and Value Based Payment Modifier measure sets was due to their not being deemed as high value, irrespective of NQF endorsement.

The Consumer-Purchaser Alliance (C-P Alliance) agrees that the MSSP has many positive attributes (as noted in the report), but the program should strive to include more outcome measures, including patient reported outcomes. Similar to comments previously made, C-P Alliance would like to reiterate that while NQF endorsement is preferred for measures; our understanding of the discussion was that the Workgroup agreed that lack of endorsement should not hold up support for a measure. As such, the full composite Optimal Asthma Care–Control Component should be supported for inclusion without conditions. And for the two PRO measures, again NQF endorsement is preferred, but would not hold back the Workgroup from fully supporting it once the other condition was met.

Renal Physicians Association

Robert Blaser

Adult Kidney Disease: Catheter Use for greater than or equal to 90 Days

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

RPA supports this inclusion of this measure in PQRS, as it is clearly associated with mortality in the ESRD population. Among vascular access modalities, catheters have the highest rates of infectious complications, thrombosis, risk of permanent central venous stenosis or occlusion. Patients receiving catheters and grafts have greater mortality risk than patients dialyzed with fistulae. Long-term catheter use without appropriate adjustments in treatment duration can compromise dialysis adequacy. Compromise of dialysis adequacy is associated with increased morbidity and mortality. Long-term catheter access is associated with a risk for central venous stenosis development, which can preclude the establishment of a permanent vascular access for HD.The measure meets the National Quality Strategy priorities of clinical quality of care, safety and efficiency and cost reduction.

Furthermore, the measure does include the following exceptions: Documentation of medical reason(s) for patient's mode of vascular access being a catheter (e.g., patient is undergoing palliative dialysis with a catheter, patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant, other medical reasons)

Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

RPA supports this inclusion of this measure in PQRS as it meets the National Quality Strategy priorities of clinical quality of care, safety and efficiency and cost reduction. Among vascular access modalities, catheters have the highest rates of infectious complications, thrombosis, risk of permanent central venous stenosis or occlusion. Patients receiving catheters and grafts have greater mortality risk than patients dialyzed with fistulae.

Catheters remain the most common access at the first outpatient dialysis, reaching 64.8 percent in 2008; in 15.3 percent of patients, a catheter is accompanied by a maturing fistula.

The CMS Fistula First program has worked to increase the use of arteriovenous (AV) fistulas, with their lower complication rates and associated costs. But the original KDOQI target — that 50 percent of new patients start therapy with a fistula — has not been realized. Just 30.8 percent of 2008 incident hemodialysis patients used an AV fistula on their first outpatient dialysis run, while another 16 percent had a catheter with a maturing fistula. Despite ongoing initiatives to reduce their use, the use of catheters has remained at 17–18 percent since 2003.

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease. RPA offers comment on the following measures:

XABLM: Adult Kidney Disease: Laboratory Testing (Lipid Profile)

RPA offers the correction that this is NQF-endorsed measure 1668. RPA supports its continued inclusion in PQRS.

1633: Adult Kidney Disease (CKD): Blood Pressure Management

RPA supports its continued inclusion in PQRS.

XACCH: Adult Kidney Disease: Patients on Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL

RPA offers the correction that this is NQF-endorsed measure 1666. RPA supports its continued inclusion in PQRS.

As always, the RPA appreciates the scope of MAP's efforts in the area of quality improvement, and we look forward to future collaboration whenever possible.

Society of Hospital Medicine

Eric Howell, MD

SHM has the following comments on measures being proposed for the Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, and Medicare Physician Quality Reporting System Programs:

MUC ID XDFDA, Appropriate In Vitro Susceptibility Testing. Exclusion criteria should include patients who leave the ED or hospital against medical advice, prior to results of susceptibility testing.

MUC ID XDFHL, Appropriate Treatment of MSSA. Exclusion criteria should include patients who left the hospital against medical advice, before results of susceptibility testing were available. Similarly, exclusion criteria should include patients discharged with a plan to follow up susceptibility results in the outpatient setting who do not return for the follow up visit.

MUC ID XDFCM, Minimum Antimicrobial Therapy for Staph A. Exclusion criteria should include patients who leave the hospital against medical advice, as well as patients who refuse appropriate therapy.

MUC ID E0465, Perioperative Anti-Platelet Therapy for Patients Undergoing Carotid Endarterectomy. SHM supports this measure. Exclusion criteria should include patient refusal.

MUC ID XDFCC (not yet submitted to NQF for endorsement), Use of Pre-Medication before Contrast-Induced Imaging Studies Inpatient with Documented Contrast Allergy. SHM supports this measure, as it is a patient safety concern and therefore awareness of a patient's allergies is appropriate.

Physician Feedback/QRUR, Physician Value-Based Payment Modifier

The following three measures are draft measures comparing the resource use for similar clinical situations in order to drive towards achieving best outcomes at lowest cost. CMS has not yet solidified the length of time of tracking, although they indicate that "…most acute conditions will likely have an episode length of 30 days, and most chronic conditions will likely have a length of a year…"

MUC ID XDECL: Diabetes Condition Episode for CMS Episode grouper

MUC ID XDEBL: Heart Failure Condition Episode for CMS Episode Grouper

MUC ID XDEDA: Ischemic Cerebral Artery Disease Condition Episode for CMS Episode Grouper

Hospitalists will not have direct control over all the costs and resource use for these patients, since subspecialists will influence resource use (perhaps to a greater degree). At the same time, it is not unreasonable to ask that hospitalists be engaged in evaluating appropriate resource use for this group of patients while achieving good outcomes. We appreciate that CMS is trying to decrease variability in care for specific diagnoses; tracking resource use and comparing groups may be one way to achieve this. However, SHM has concerns that if CMS is tracking total dollars spent, this would not accurately capture whether one group achieved lower costs because of less actual resources used (e.g. less inappropriate imaging used) versus achieved lower costs because ancillary resources are less expensive in a particular part of the country or region (e.g. lower cost MRI's of head, for example). Thus, we are not certain that CMS will achieve the goal of appropriate resource use and better outcomes for patients.

For draft measures, MUC ID XDDMG/ Draft: Ischemic Heart Disease Condition Episode for CMS Episode Grouper, MUC ID XDECD/ Draft: Pneumonia Condition Episode for CMS Episode Grouper, and MUC ID XDECE/ Draft: Respiratory Failure Condition Episode for CMS Episode Grouper, the language remains vague, and SHM would request the opportunity to provide more specific input, including selecting the data inputs that would allow proper provider comparison, as these measures are operationalized. This may be an opportunity to collaborate with other specialty organizations. One obvious question is whether ICD-9 or ICD-10 usage would affect the program design.

In general, SHM concurs that it would need more information on how these draft measures would be structured in order to provide more specific feedback as relates to hospital medicine.

SHM supports the MUC ID 2158, Medicare

Spending Per Beneficiary measure for hospital level performance monitoring, but we feel the measure needs further development before it can reasonably be applied to individual providers or even groups of physicians. As this measure is slated to be included in the 2016 Physician Value-Based Payment Modifier, SHM believes that these concerns need to be addressed now. Hospitalists coordinate care for medically complex patients in the inpatient setting; however it is not clear how costs would be attributed to the various providers on the care team who drive them. Patients consult with varying subspecialists throughout the hospital stay, all of whom impact decisions about resource utilization. While hospitalists are in a unique position to manage appropriate use of such resources, as of yet there is not a legitimate way to distinguish hospitalists from outpatient providers within the same specialty (e.g. internal medicine, family medicine, or pediatrics). This will interfere with accurate performance measurement and confuse the data. We do feel that with further development, this measure may serve as a unique means of measuring the efficiency of inpatient care.

Performance Reporting Alignment between Clinicians and Facilities

In the 2014 Physician Fee Schedule Proposed Rule, CMS examined options for individual clinician and group reporting of hospital-based measures from the IQR program. This proposed flexibility would represent a significant harmonization within the healthcare system, while allowing hospitalists to report measures that better fit their practice patterns and structures. The proposed rule included two different options: retooling measures from the IQR to be reportable by individual physicians and direct performance alignment with that of an associated hospital. SHM would like to reiterate its support for including both of these options as meaningful additions to physician quality reporting programs. Each alternative seems to address, in different ways, the questions of measure attribution and alignment between physicians and facilities, while broadening the number and type of measures that may be reported.

SHM greatly appreciates the opportunity to provide comment and feedback on the HHS List of Measures Under Consideration for future reporting years. We believe that hospitalists have a unique and important perspective on both the physician-level and hospital-level performance agendas. We welcome the opportunity to work with NQF and CMS around the important performance measure issues of attribution and measure specifications.

The Advanced Medical Technology Association

Steven Brotman

Pre-Rulemaking Input on Clinician Performance Measurement Programs:

Measures on Radiation Dose Optimization: The Draft Report indicates that the MAP declined to add the following series of individual Radiation Dose Optimization Measures (XBLLC, XBLLD, XBLLL, XCEEC, and XCEED), to the Physician Value-Based Payment Modifier (VBPM) and the Physician Compare Programs:

XCEEC: Radiation Dose Optimization: Images Available for Patient Follow-up and Comparison Purposes

XBLLC: Radiation Dose Optimization: Cumulative Count of Potential High Dose Radiation Imaging Studies: CT Scans and Cardiac Nuclear Medicine Scans

XBLLD: Radiation Dose Optimization: Utilization of a Standardized Nomenclature for CT Imaging Description

XBLLL: Radiation Dose Optimization: Search for Prior Imaging Studies through a Secure, Authorized, Media-free, Shared Archive

XCEED: Radiation Dose Optimization: Reporting to a Radiation Dose Index Registry

The CMS Final Physician Fee Schedule for Calendar Year 2013 finalized the Radiation Dose Measures Group for the PQRI starting in Calendar Year 2014. AdvaMed appreciates this recent effort by CMS to identify these important measures for possible inclusion into the VBPM and the Physician Compare Programs.

Recent peer reviewed medical literature describes the clinical risk/benefit profile of ionizing radiation, an important part of advanced diagnostic imaging

and patient safety. As a result, providers are implementing relatively new technologies to reduce, optimize, track and report ionizing radiation dose exposure.

Recognizing the importance of these measures, AdvaMed is hopeful that CMS will again identify these measures during the next MAP cycle in 2014-2015, for inclusion in these programs, as well as for the Hospital Value-Based Purchasing Program (HVBP). While CMS has not yet included similar measures in the Hospital VBP Program, the agency in the Fiscal Year 2014 Hospital Inpatient Prospective Payment System final rule noted that it would consider doing so in the future. In addition, during 2014, CMS may collect substantial amounts of data through the PQRS to further evaluate and validate these measures for possible inclusion in these programs. Relatedly, we also support all efforts of the measure developer to seek endorsement of these measures by the NQF in the very near future.

AdvaMed strongly encourages the MAP to support these Radiation Dose Optimization Measures for inclusion in the Physician Value-Based Payment Modifier, Hospital Value-Based Purchasing and the Physician Compare programs during the next MAP cycle. At that time, these measures will have been available for reporting for a year under Medicare's PQRS and data will be available for analysis.

Section 4: Pre-Rulemaking Input on Hospital Performance Measurement Programs

American Academy of Hospice and Palliative Medicine

Amy Abernethy, MD PhD, FACP, FAAHPM

"External Beam Radiotherapy for Bone Metastases": AAHPM appreciates the MAP's support for this measure for use under the PCHQR program. This measure only focuses on a very specific population, and we recommend the development of measures that target broader populations in the future. "Patients with Advanced Cancer Screened for Pain at Outpatient Visits": The MAP only recommended conditional support for this measure for the PCHQR program. While it recognized that pain assessment is a critical component of patient-centered care, it felt the measure requirement of repeated patient screenings could be burdensome and costly to implement. It suggested that a sampling methodology may be more feasible. The MAP also felt that this measure might be redundant with two other measures already used in this program. These measures are NQF #0383 "Oncology: Medical and Radiation - Plan of Care for Pain" and NQF #0384 "Oncology: Medical and Radiation - Pain Intensity Quantified." AAHPM continues to strongly urge the MAP to recommend "Patients with Advanced Cancer Screened for Pain at Outpatient Visits" for use in PCHQR since it addresses a critical gap in measurement and directly targets the MAP priorities of Palliative Care and Patient-Reported Symptoms. While we appreciate the MAP's consideration of the potential reporting burden associated with this measure, the more significant burden actually lies in un-assessed and undertreated pain. Many healthcare providers currently screen for pain as the "fifth vital sign," demonstrating its feasibility and lack of burden in practice. Sampling approaches carry their own burdens by adding complexity to reporting. We question whether the PCHQR can accommodate a sampling approach to reporting. AAHPM would like to point out that there is published literature showing that it takes quite a few visits to reach precision for these measures (Bentley TG, Malin J, Longino S, Asch S, Dy S, Lorenz K. Methods for improving efficiency in quality measurement: the example of pain screening. Int J Qual Health Care. 2011 Dec;23(6):657-63). Most importantly, the two existing measures related to pain (NQF #s 0383 and 0384) only target patients undergoing chemotherapy or radiation and not the larger proportion of patients with advanced cancer who are not receiving or not eligible for radiation or chemotherapy for whom pain is a significant issue. While we would welcome harmonization of pain measures in the future, the measurement set for high quality pain care should not be limited to those patients getting certain types of cancer treatments. The measure under consideration addresses a critical gap in measurement, and we believe it should be used for federal quality reporting purposes as soon as possible. We also encourage the MAP to consider even broader pain measures in the future that go beyond cancer care.

American Association of Neurological Surgeons

Katie Orrico

In regards to the stroke readmission and mortality measures in the IQR Program, the American Association of Neurological Surgeons (AANS)/ Congress of Neurological Surgeons (CNS) would like to remind the MAP that there are validated and widely used stroke severity scores that can be used for weighting of clinical outcomes (e.g., NIH stroke scale). Choosing to not incorporate validated measures/risk adjustments related to stroke severity into other outcomes assessments will impair the validity of the process. Lack of relative risk weighting was the primary reason the original stroke measures were not endorsed by the NQF. This logic has not changed regardless of CMS' support for these measures.

American College of Surgeons

David B. Hoyt, MD, FACS

Hospital Performance Measure Programs

Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

ACS does not support the MAP's conditional support

for the inclusion of the Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (NQF #1789) in the Hospital Readmissions Reduction Program (HRRP). MAP's rationale for conditional support is that the measure is not ready for implementation because it needs further experience or testing before being used in the program. As part of the MAP's additional findings, they noted the need to "balance improvement for all patients with the risk of unintended consequences for safety net hospitals that may be more likely to experience payment reduction."

ACS does not agree with MAP's rationale. We have previously provided comments to NQF and CMS that we do not support the inclusion of this measure because the effect of case mix on this measure is currently unproven. The measure does not adequately account for socioeconomic factors and resource use of heavily burdened hospitals that care for disadvantaged populations—factors that may unfairly impact safety net hospitals. Additionally, in surgical care, readmission is most closely related to postoperative complications. Therefore, if we have a readmission measures in surgery, in addition to a complication measure, surgeons could be "dinged" twice for the same issue which could create greater hardship. ACS seeks clarity on how CMS will manage these scenarios and implement this measure to avoid double jeopardy. Lastly, it is important to note that during the MAP Hospital Workgroup meeting, the Committee vote was split and therefore required a re-vote at which point they decided to send the measure to the Coordinating Committee for vote. This measure was also very narrowly passed for NQF-endorsement. Throughout the NQF process, there has been a clear lack of consensus on the HWR measure, which brings into question its reliability across different types of hospitals. For these reasons, we recommend that the MAP delay their conditional support until the measure is tested further and receives broader support from stakeholders. ACS remains vigilant in following the plans for the implementation of the HWR measures as part of the HRRP.

American Hospital Association

Linda Fishman

AHA Hospital Program comments - part 1

CMS Must Improve Stroke Outcome Measures

The MAP was asked to provide input on whether two stroke outcome measures – readmissions and mortality within 30 days of hospital discharge – should be removed from the Hospital IQR program. The AHA remains strongly opposed to the inclusion of either measure in any federal program until adequate adjustment for stroke severity can be made. In opposing these two measures, we do not diminish the importance of including measures in national programs that accurately reflect stroke outcomes. Rather, we do not believe these particular measures are up to the task of providing accurate information that patients can use to evaluate hospital performance, and that hospitals can use in improvement efforts.

These two measures were submitted to NQF as part of the 2012 Neurology Endorsement project. However, both measures were subsequently withdrawn from the project by the measure developers after significant criticism was offered by members of the steering committee, and therefore failed to receive NQF endorsement. During the endorsement project, the steering committee noted significant concerns about both measures. Most notably, neither measure includes an adjustment for the severity of a stroke, which is the most important determinant of clinical outcomes. Stroke severity can be measured using the National Institutes of Health Stroke Scale (NIHSS). However, the measure does not incorporate an adjustment based on the NIHSS or any other indicator that differentiates stroke severity.

A recently published Journal of the American Medical Association article underscores the necessity of incorporating an adjustment for stroke severity. Indeed, the study re-modeled the stroke mortality measure by incorporating the NIHSS into the measure risk adjustment model.[1] Nearly 58 percent of the hospitals identified as having "better than" or "worse than" expected risk-standardized mortality using the measure with stroke severity adjustment would be reclassified to "as expected mortality" using CMS's non-severity adjusted measure. This troubling result

underscores the inability of the proposed measure to differentiate meaningfully hospital performance, and demonstrates that it is not appropriate for a national quality reporting or payment program.

[1] Fonarow et al. Comparison of 30-Day Mortality Models for Profiling Hospital Performance in Acute Ischemic Stroke With versus Without Adjustment for Stroke Severity. JAMA. 2012;308(3):257-264. Available at: http://jama.jamanetwork.com/article.aspx?articleid=1217240.

AHA Hospital program comments - part 2

In response to these concerns, CMS provided the MAP with supplemental analysis discussed during the MAP Hospital Workgroup and Coordinating Committee meetings. CMS contends that it would be infeasible to use the NIHSS in conjunction with its current measures because obtaining NIHSS data require manual chart abstraction; the current stroke measures are reported using only Medicare claims data. Moreover, the agency argues that a severity adjustment is unnecessary for two reasons. First, CMS indicates that it has found that the results generated from the existing claims-based measures are "highly correlated" with results obtained from manual chart abstraction. Second, the agency presented the MAP with an analysis suggesting that hospitals certified as Stoke Centers by The Joint Commission (TJC) have a distribution of performance that is very similar to other facilities. CMS believes these results suggest that stroke centers – which may be reasonably expected to care for a higher severity of stroke patients – are not unfairly disadvantaged by the measures.

We believe CMS's analysis of the performance of stroke centers on the measures actually supports the need for a severity adjustment. CMS did not provide the MAP with an empirical analysis to support its claim that measure results from its existing claims-based measures are highly correlated to the results from chart abstraction. We also would not expect that TJC stroke centers would have a performance distribution so similar to all other facilities. Indeed, TJC-certified stroke centers are required to implement many policies and care processes demonstrated to improve stroke outcomes. [1] CMS also notes that stroke patient volumes drive particularly high and particularly low (i.e., outlier) performance for both stroke centers and other hospitals. However, we would expect that volume would drive outlier performance on these measures because they use a risk adjustment methodology, known as hierarchical linear modeling, in which facilities with higher volumes have a stronger effect on their own performance. In short, the fact that the distribution of measure performance is no different between stroke centers and non-TJC certified facilities suggests the measure risk adjustment approach is inadequate.

[1]The requirements for Joint Commission certified Primary Stroke Centers can be accessed at http://www.jointcommission.org/certification/primary_stroke_centers.aspx

AHA hospital program comments - part 3

All-Cause, All-Condition Readmission Measure May Unfairly Increase Hospital Penalties

The MAP was asked to provide input on the suitability of CMS's all-cause, all-condition readmissions measure for the HRRP. The existing measures in the HRRP are condition-specific – that is, they measure readmissions rates for patients with heart failure, acute attacks, pneumonia, total hip and total knee arthroplasties, and chronic obstructive pulmonary disease (COPD). By contrast, the hospital-wide all-cause readmission measure generates a summary readmission rate for hospitals across nearly all clinical conditions.

The AHA does not believe it is appropriate to include the hospital-wide readmission measure in the HRRP at this time for several reasons. First, the public reporting of this measure commenced on Dec. 12, 2013, the second day of the Hospital Workgroup meeting. The field has had limited opportunity to understand the drivers behind the distribution of performance, the usability of the measure in improving performance and any potential unintended consequences of public reporting.

Second, we are concerned that the use of an all-cause, all condition readmission measure is inconsistent with the statutory intent of the ACA. The statutory language of the ACA appears to call for the use of condition-specific measures in the HRRP. Indeed, section 1886(q)(5)(B) states that the HRRP may be expanded to include "other conditions

and procedures as determined appropriate by the Secretary"of Health and Human Services.[1] Thus, a hospital-wide readmission measure is likely outside the legislative authority of CMS to implement, and if it were implemented, would almost certainly have to be used in conjunction with the condition-specific measures already in the program in order to comply with the statute.

At a minimum, using the hospital-wide measure and condition-specific measures would create confusion among hospitals and the public as to which measures most meaningfully reflect hospital performance. Moreover, a single readmission could be counted twice towards a hospital's performance, thereby increasing the likelihood of hospitals incurring a penalty. Unfortunately, CMS has not articulated a plan for how the all-cause measure could be used in the HRRP without unfairly penalizing hospitals.

[1]Emphasis added.

AHA Hospital program comments - part 4

Lastly, the AHA remains very concerned that the all-cause, all condition readmissions measure, along with all of CMS's other readmission measures, does not adequately adjust for socioeconomic factors beyond the control of hospitals. In reiterating this concern, we appreciate that both CMS and NQF have engaged stakeholders in discussions about whether, when and how performance measures should be adjusted for socioeconomic factors. The AHA is pleased that NQF, with support from CMS, recently convened a multi-stakeholder expert panel to provide recommendations on this critically important issue. We urge CMS to adopt the recommendations of the NQF expert panel in implementing its readmission measures and any other measures for which socioeconomic adjustment is appropriate.

AHA hospital comments - part 5

All hospitals, regardless of the circumstances they face, aim to provide the highest quality of care to the patients and families that rely on them. However, there are numerous studies demonstrating that higher readmissions rates are linked to various markers of lower socioeconomic status (SES). For example, a 2012 systematic review of more than 70 articles examining various factors associated with readmissions concluded that "low socioeconomic status (Medicaid insurance, low income), living situation (home stability rural address), lack of social support, being unmarried and risk behaviors (smoking, cocaine use and medical/visit non-adherence)" all were associated with higher heart failure readmission rates.[1] Similarly, researchers from the Harvard School of Public Health studied the degree to which variation in readmission rates for congestive heart failure was explained by different community factors, and found that "supply-side variables (physician and bed supply in a community) were most important (explaining 17% of the variation) followed by socioeconomic characteristics of the community (poverty rate and racial makeup) at 9%. Differences in hospital quality explained 5% of the variation in readmission rates and differences in case mix explained 4%."[2] The study concluded that "community-level socioeconomic variables and supply-side variables play a much greater role in explaining variation in readmissions than quality of hospital care or underlying sickness of people."[3]

[1]Calvillo-King L, et al Impact of social factors on risk of readmissions or mortality in pneumonia and heart failure: systematic review. JGIM (2012): 1 - 14

[2]Joynt K, Orav EJ, Jha AK Impact of community factors on readmission rates. Circ Cardiovasc Qual Outcomes.2012;5:A12 (Abstract presented at the Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke 2012 Scientific Sessions)

[3] Joynt K, Orav EJ, Jha AK Impact of community factors on readmission rates. Circ Cardiovasc Qual Outcomes.2012;5:A12 (Abstract presented at the Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke 2012 Scientific Sessions)

AHA hospital program comments - part 6

While we absolutely agree that hospitals should do all within their power to care for and assist the patients in challenging circumstances, we do not believe they should suffer financial penalties due to community factors beyond their control. The experience of many of our members indicates that collaborations with services in communities are critically important to reducing readmissions. Yet, forming these collaborations is much more

challenging for hospitals if their communities lack primary care providers, pharmacies, mental health services, physical therapy and other rehabilitative services with whom they can work. Communities also may lack of public transportation (which can affect access to medical care), or have inconsistent access to appropriate foods for patients requiring restrictive diets.

Early experience from the implementation of the HRRP demonstrates that hospitals caring for the most economically disadvantaged patients were most likely to receive readmissions penalties. A 2012 Commonwealth Fund analysis found that hospitals in the top 25 percent of the disproportionate share hospital (DSH) payments have 30-day hospital readmission rates that are approximately 30 percent above the national average for heart attack, heart failure and pneumonia.[1] As a result of this finding, Kaiser Health News found that 12 percent of hospitals that fall into the top quartile of the DSH patient percentage were scheduled to receive the maximum readmissions penalty from CMS starting in FY 2013. In contrast, only 7 percent of hospitals in the bottom quartile of the DSH patient percentage were projected to receive the maximum penalty. [2] Recent data from the fiscal year (FY) 2014 inpatient prospective payment system (IPPS) final rule (shown below) confirms that this trend has continued. Indeed, hospitals in higher DSH deciles are much more likely to incur a penalty. Adding another measure to the HRRP that fails to adjust for socioeconomic factors will only accelerate these troubling trends.

[1]Berenson, Julia and Anthony Shih. Higher Readmissions at Safety-Net Hospitals and Potential Policy Solutions. The Commonwealth Fund. December 2012.

[2]Rau, Jordan. Hospitals Treating the Poor Hardest Hit by Readmissions Penalties. Kaiser Health News. August 13, 2012 (Updated October 13, 2012).

AHA hospital program comments - part 7

The agency presented the MAP Hospital Workgroup and Coordinating Committee with several analyses that, it contends, confirm that any adjustment for socioeconomic status (SES) is unnecessary. However, the AHA believes that some of these analyses actually confirm the need for such adjustments. CMS provided the MAP with an analysis that compares the readmission rates of hospitals caring for high proportions of Medicaid patients with those caring for lower proportions. CMS surmises that the proportion of Medicaid patients is a useful proxy for low SES because the Medicaid program is intended to provide insurance to poorer patients. In assessing the all-cause, all-condition readmission measure, the analysis concludes that while hospitals with high proportions of Medicaid patients "achieved a similar range" of readmissions rates compared with hospitals with low proportions "the range was shifted toward poorer performance for hospitals with high proportions of Medicaid…patients." (emphasis added).

We have repeatedly recommended that CMS consider using dual-eligible status as an adjustment factor in the short term. Dual-eligible status is a powerful predictor of readmission riskand is a factor that is readily available to CMS. A hospital's proportion of dual-eligible patients reflects that hospital's share of impoverished Medicare patients, and since there admission measures include only Medicare beneficiaries, an adjustment based on hospitals' proportion of dual-eligible beneficiaries is appropriate and will enable fairer comparisons of performance among hospitals.

AHA hospital program comments - part 8

Selecting the Right Electronic Clinical Quality Measures

The AHA is pleased that CMS asked the MAP to assess eCQMs it is considering for several program. However, the MAP's discussion highlighted the implementation challenges hospitals face in extracting data from EHRs to support measurement needs. Several members of the hospital workgroup expressed concern that they had less information about the readiness of eCQMs for public accountability applications than the chart and claims-based measures on the MUC list for other programs.

Such information is critical given the significant promise and peril of eCQMs. A major positive benefit of the movement toward adoption of EHRs should be greater ease in calculating and reporting quality of care measures for hospitals to use in their

performance improvement efforts, to report to federal and other payment programs, and share to the insight with consumers. Unfortunately, for Stage 1 of meaningful use, a rushed policy process and immature technology has led to time-consuming efforts by hospitals to generate quality data.[1] Capturing the measure data has added significantly to clinicians' workload with no perceived benefit to patient care. The specifications for Stage 2 were revised months after their initial publication due to errors.

AHA hospital program comments - part 9

To ensure a safe and credible transition from chart-abstracted measures to eCQMs, we urge CMS to provide the MAP with additional data that allow the MAP to assess the scientific validity of eCQMs, their comparability to chart-abstracted measures and their readiness for inclusion in quality reporting and payment. We continue to believe that NQF endorsement is as necessary for eCQMs as it is for any other type of measure. As with other types of measures, CMS should ask the MAP to re-review any eCQMs that have received "conditional support" once they have undergone NQF endorsement review. Indeed, the move to electronic data collection and electronic reporting of measures does not require a diminution of the criteria used to verify the validity, feasibility and reliability of the measures.

The AHA also strongly urges CMS to utilize fully the MAP's input for anticipated Stage 3 meaningful use rulemaking. CMS indicated that the six hospital meaningful use measures reviewed by the MAP this cycle are under consideration for potential inclusion in Stage 3 of the program with a start date in 2017. Given the regulatory rulemaking cycle of the EHR Incentive Program, any eCQMs that may be considered for inclusion in a future Stage 3 also could be considered during the 2015 MAP review of measures and remain timely for inclusion in Stage 3 prior to the publication of a final rule in mid-2015. The additional time will enable the measure developers to complete the specifications and undertake some testing which would inform a consideration of the specification and technology readiness to support the efficient generation of accurate eCQMs.

American Nurses Association

Maureen Dailey

There are persistent important safety measure gaps in public reporting for state of the science measures for injuries from falls and pressure ulcers by the MAP Hospital Workgroup. Additionally, recent evidence has highlighted the lack of alignment of claims-based safety measures (PSI-3) with true hospital acquired condition incidence in the area of pressure ulcers (Meddings et.al, 2013; Coomer and McCall, 2012). ANA appreciates MAP support of innovative safety measures, in particular the opportunity for ANA to present one of the first de Novo eMeasure to the MAP's Hospital Workgroup on 12/11/14. The MAP Hospital Workgroup noted the importance of filling the pressure ulcer measure gap. The ANA's eMeasure isa state of the science measure of pressure ulcer incidence that has been tested and implemented. Data collection has commenced January, 2014. ANA stands ready to fill the persistent safety measure gaps in falls and pressure ulcers, and expedite uptake of innovative eMeasures.

In addition, transparent reporting on Hospital Compare using a robust falls measure is needed that goes beyond capturing hip fractures (PSI-8) as MAP's Hospital Workgroup and Coordinating committee members, including consumers, have expressed concerns regarding the falls safety measure gap. ANA is reporting on an NQF-endorsed falls injury and pressure ulcer measures to the CMS's Partnership for Patients, providing national comparison data. The ANA is the measure steward of a set of falls measures endorsed by NQF which are state of the science. They were re-endorsed by the NQF Patient Safety Complications Steering Committee in 2012. Support for measure development to eMeasures is needed to fill this important measure gap, as CMS is no longer adding paper clinical measures to Hospital Compare.

ANA recommends MAP consideration of important structural safety measure gaps be filled on Hospital Compare including measures of safe staffing, a transparent reporting area of great interest to consumers and purchasers. Decades of research has linked nurse staffing to important safety outcomes, including multiple hospital acquired conditions and mortality. Determining a safe staffing levels and interprofessional mix on teams for vulnerable

populations was identified by MAP Dual Eligible Workgroup as a priority.

American Society for Gastrointestinal Endoscopy

Kenneth K. Wang, MD, FASGE

Gastroenterology Finalized Program Measures and Measures under Consideration for Hospital Outpatient Quality Reporting and for Ambulatory Surgical Center Quality Reporting

ASGE agrees with the MAP that the High-Acuity Care Visits after Outpatient Colonoscopy Procedure measure is a promising measure concept for measuring and reporting at the facilitylevel for outpatient settings, however, we believe it is too soon for the MAP to issue a recommendation of "Conditional Support." Monitoring adverse events relative to colonoscopy procedures is an important activity to ensure high-quality endoscopy, even though there is a low incidence of adverse events relative to endoscopy. Given the complexity of the measure and questions relative to the untested measure's feasibility, reliability, and validity, ASGE supports submission of the measure to the NQF endorsement process before it is implemented in federal quality reporting programs.

ASGE is disappointed with the MAP's proposed decision to support inclusion of the Endoscopy and Polyp Surveillance measures in the Ambulatory Surgical Center Quality Reporting Program. As noted in the MAP's February 2013 and January 2014 pre-rulemaking reports, there are questions about the feasibility of implementing these measures at the facility level. Beyond the potential for significant administrative burden on ambulatory surgical centers (ASCs) for reporting these measures, ASGE questions the appropriateness of using measures outside the direct control of the facility to assess their performance. The ASC Quality Reporting Program should focus on conditions and performance aspects within the direct control of the facility and which lead to greater patient safety, such as a potential future measure relative to proper scope reprocessing.

The Endoscopy and Polyp Surveillance measures are utilization measures developed and endorsed for analysis at the clinician level. Physicians, not facilities, are responsible for their documentation and compliance with recommended surveillance intervals and, therefore, should be held accountable, as inclusion of these measures in PQRS indicates.

These measures have not been analyzed for potential implementation at the facility level. Analysis may demonstrate, for example, an overuse of exclusions. Among the exclusions for NQF 659 is "documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., unable to locate previous colonoscopy report)." There is a strong potential for overuse of this exclusion. Typically, decisions about colonoscopy intervals are based on information obtained during an office visit and upon review of a patient's medical record, which would not be maintained by the ASC unless the ASC was the site of service for the patient's last colonoscopy. If the ASC has difficulty in obtaining this information from a physician, the exclusion likely would be utilized. Overuse of this exclusion would yield skewed performance results or results that are inconsistent with those derived from PQRS. Until analysis of the Endoscopy and Polyps Surveillance measures at the facility level is completed, we request the MAP reconsider its decision to support implementation of these measures in the ASC Quality Reporting program.

Outpatient settings are important sites of service for the practice of gastroenterology. ASGE recognizes the current gaps in outpatient facility-level quality measures available for gastroenterology, which is why the society supports initiatives with the goal of collecting performance data more directly controlled by and related to the facilities where endoscopy is performed. ASGE has initiated the development of endoscopy unit quality indicators that will serve as the foundation for quality measures for outpatient endoscopy facilities, and, as a sponsoring society of the GI Quality Improvement Consortium and the GIQuIC registry, ASGE supports collection of performance data for potential unit quality indicators that will serve to inform the more formal measures development process for ASC reporting.

American Society of Anesthesiologists

Jane C. K. Fitch, MD

The Pre-Rulemaking Report reviewed two options HHS identified for applying existing hospital

measures to the clinician performance measurement programs. The first option re-specified "existing hospital-level measures for application to clinicians" while the second option would "apply a hospital's performance rates to clinicians practicing in that hospital." ASA appreciates the careful deliberations of the MAP on these two issues as they relate to the Hospital Inpatient Quality Reporting Program (IQR) and Hospital Outpatient Quality Reporting Program.

ASA expresses similar concerns with the MAP that CMS ensures fair and accurate reporting of measures attributable to physicians by allowing opportunities for physicians to review their data prior to any public posting. ASA continues to support the CMS proposal that IQR measures be retooled for use in the PQRS. ASA, however, requests that adequate testing, validation and risk-adjustment be appropriately applied to any measure intended for IQR or OQR under consideration for PQRS retooling.

America's Health Insurance Plans

Carmella Bocchino

We agree with the MAP that stroke is a high-impact condition and we strongly support stroke measures that lead to quality improvement. We recommend that CMS monitor for unintended consequences such as changes to coding practices. Such monitoring can help ensure that patients are appropriately captured in the denominator for these measures.

Similarly, NQF #1789 Hospital Wide-All Cause Unplanned Readmissions, may also result in unintended consequences such as greater use of observation stays when patients have relapse or complications after hospitalization. We encourage CMS to expand its efforts to assess unintended consequences, particularly as they relate to vulnerable populations.

Lastly, regarding NQF #0349 Transfusion Reaction (PSI 16), blood transfusion reactions are not always due to the infusion of incompatible blood, errors in the labeling of blood typing samples, or patient identification. For example, during emergency situations, there is urgent need for blood before completion of compatibility testing (ABO-Rh, antibody screen, and crossmatch). This measure could more accurately reflect hospital quality of care if it is stratified for reactions occurring during a medical emergency and non-emergent care.

AmeriHealth Caritas

Andrea Gelzer

AmeriHealth Caritas Family of Companies agrees with MAP recommendations to conditionally support NQF #1789 Hospital Wide All-Cause Unplanned Readmission, and we strongly encourage CMS to expand its efforts to assess unintended consequences (e.g., greater use of observation stays when patients have relapse or complications after hospitalization). Unintended consequences continue to be of concern as it relates to vulnerable populations.

Amgen, Inc

Jason Spangler

Amgen agrees with MAP's recommendation of "conditional support" of MUC XDCFE for inclusion in the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. We recommend a few changes to improve implementation and the likelihood of NQF endorsement.

Amgen supports quality measures that improve the treatment of cancer patients with bone metastases. Osteoclast Inhibitors (OIs) have been shown to be effective in the prevention of skeletal related events in patients with bone metastases in solid tumors with pamidronate disodium pentahydrate and zoledronate effective in patients with multiple myeloma as well. Amgen agrees with the need for a measure as the evidence suggests that approximately half of appropriate patients in the US are untreated. MUC XDCFE addresses an important gap because it includes patients with bone metastases associated with solid tumors, which is not included in the NQF-endorsed measure for treatment of bone metastases in multiple myeloma (NQF #380). We agree with MAP that the measure is not ready for implementation and inclusion in the PCHQR Program, and propose three additional changes to the measure denominator to improve its usefulness and its chances for NQF endorsement. First, we recommend that the exclusion criterion for renal insufficiency be modified to allow for

the inclusion of XGEVA® (denosumab) in patients with this condition. Although bisphosphonates are not recommended in patients with severe renal insufficiency, XGEVA® (denosumab) does not have such a warning, and there are no dose adjustments required in these patients. Therefore, excluding all solid tumor patients with renal insufficiency would not be an accurate assessment of quality since treatment with XGEVA® (denosumab) may be appropriate for some of these patients. Second, we recommend the dental disease exclusion be more specific-exclude patients with recent or planned tooth extraction. Finally, we recommend that the palliative care exclusion be deleted or modified to "hospice care." Many patients provided with palliative care receive OI therapy as part of that care. Hospice care is the more appropriate term to remove patients close to death from the denominator. Also, we support the development of additional measures that would assess adherence to therapy over time for appropriate patients, as this measure will only capture initial treatment, and treatment adherence is essential to preventing skeletal related events in this population.

Amgen does not agree with MAP's recommendation of "conditional support" of MUC XDDAF for inclusion in the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. Instead, we recommend that this measure not be included in the program.

While Amgen supports quality measures aimed at reducing avoidable hospital admissions and ER visits for patients receiving outpatient chemotherapy, we cannot support MAP's recommendation of "conditional support" of MUC XDDAF for inclusion in the PCHQR Program due to clinically relevant issues. Because the causes for admissions and ED visits in cancer patients are not exclusive sequelae of outpatient chemotherapy, the measure may not be a sensitive nor specific indicator of physician practice in prevention of these potential complications. ED visits/admits may be due to symptoms such as nausea/pain, and others may be related to laboratory values (anemia, neutropenic fever (FN)). How to prevent and accurately identify the causes of these conditions will be challenging. For example, patients do not visit an ED for FN, but rather for a non-specific infection and related symptoms. We reiterate our prior comments that supported the NQF's identification of FN as a priority measure gap area and continue to support development of measures that would address this gap. Unfortunately, this measure does not do that. Both internal and external data sources, as well as published studies, have noted the underreporting of both FN and infectious hospitalizations associated with FN, related to incomplete coding, failure to measure absolute neutrophil count (ANC) and/or temperature, and other logistical issues. These are good reasons to develop an FN risk assessment measure, which would require incorporation of both regimen and patient risk, and alignment with existing guidelines.

Armstrong Institute for Patient Safety and Quality at Johns Hopkins University

Matt Austin

E0431: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: This is a reasonable measure and is consistent with that required of other health care institutions.

XDEMA

We concur with the MAP's recommendation of conditonal support and offer the following rationale: We understand the desire to measure the combined rate of unplanned admissions, etc., but do not understand how tabulating the rate of unplanned admissions etc. is meaningful without knowing: the total number of endoscopies performed at an ambulatory care centers in totality or individually by ASCs; the rate of unplanned admissions for outpatients who have endoscopic procedures in hospital settings; and the total number of equivalent type of outpatient procedures (eg eliminating ERCPs and advanced therapeutic procedures) done in a hospitalized setting. There is no indication that there would be tabulation of ASA class of the Medicare beneficiary or the complexity of the procedure, factors that could potentially affect the complication rate. Finally, it would be important to record the reason why patients presented within 7 days of an endoscopic procedure, because it may have not been because of the procedure itself but due to a comorbid illness. We think the interest would be greater for those symptoms or processes that are clearly related to endoscopy. We have

the same concern for endoscopic procedures. In addition, one of the challenges endoscopists face is that pre-procedure office evaluations for Medicare beneficiaries undergoing screening procedures are not covered separately from the cost associated with the procedure itself. Yet the older the patient is, the more likely the patient has chronic illness and comorbidities, some of which may impact the decision about the site at which the procedure is performed and the outcome. We understand that the cost of the pre-procedure visit is covered in the procedure reimbursement itself, but the amount of time required for the pre-procedure evaluation may be lengthy. This has been a disincentive for some physicians from seeing some Medicare patients who need screening procedures in the office before the procedure.

XBELG: We concur with the MAP's recommendation of conditional support for this measure and offer the following rationale: The value of rehospitalization as an outcome measure is questionable and we will also need risk-adjustment to compare between centers.

XDBCB: We concur with the MAP's recommendation of conditional support for this measure and offer the following rationale: The measure does not include a clear definition of hyperglycemia in its definition. It is critical to have an agreed upon definition otherwise individual organizations will have their own and there will be a lack of standardization.

XBGDL: We concur with the MAP's recommendation of conditonal support of this measure and offer the following rationale: the measure seems less valuable because of the vagueness of "vascular procedures" which can range from major to relatively trivial surgery. The scope of "vascular procedures" will vary widely between hospitals, and so comparison likely to be meaningless.

XDBGA: We concur with the MAP's recommendation of conditonal suppor this measure and offer the following rationale: It was unclear to us how the 20 hour interval between two BG readings <40 mg/dl was determined to indicate separate hypoglycemic events. This implies if you have multiple hypoglycemia readings in a 24 hour period that these would all count as one event and not separate events. In clinical practice, given the duration of action of a rapid-acting insulin analogues, it is conceivable that two low BG readings in a 20 hour time period could result from more than one rapid-acting insulin administration and thus be two separate events.

XDEEL: While the MAP recommended conditonal support for this measure, we share concerns on how this measure is specified. "AMI episode" is not defined, and it will prove challenging to do so. Many patients admitted for a variety of reasons receive a discharge diagnosis of "AMI" for small troponin leaks. Other challenges will arise from transfers from lower acuity to more specialized centers, as well as the complex problem of risk adjustment.

XDEEH: While the MAP recommended conditional support of this measure, we belive this measure should be supported. It is an appropriate and widely used measure. Almost all hospitals report this to STS database already.

E0471: While the MAP recommended supporting this measure, we have the following concerns with this measure: The rate of cesarean in term nulliparas with vertex presentation as a performance measure is problematic, particularly for referral centers. We have wrestled with this issue at ACOG and ABOG as well. There are numerous factors that influence success for vaginal delivery, that are not absolute contraindications to try for vaginal delivery. A better performance measure to get at the issue would be adherence to strict criteria for definitions of protraction or arrest disorders in labor prior to performing cesareans for "failure to progress." Much better but albeit harder to track systematically.

XDFMG: We concur with the MAP's recommendation of not supporting this measure and offer the following rationale: The major issue has to do with how often we properly diagnose depression (or other MI) in non psych settings and how often we give PHQ or other outcome scales. If we adopt these, we need to commit to a better job at detection and diagnosis. It is hard for us to say if these are the best metrics as there are no mentions of obesity, smoking, or other behaviors, or regarding the several addiction outcomes. Also, nothing was included on dementia.

XDFGE: We concur with the MAP's recommendation of not supporting this measure and offer the following rationale: The major issue has to do with how often we properly diagnose depression (or other

MI) in non psych settings and how often we give PHQ or other outcome scales. If we adopt these, we need to commit to a better job at detection and diagnosis. It is hard for us to say if these are the best metrics as there are no mentions of obesity, smoking, or other behaviors, or regarding the several addiction outcomes. Also, nothing was included on dementia.

XDFMF: We concur with the MAP's recommendation of not supporting this measure and offer the following rationale: The major issue has to do with how often we properly diagnose depression (or other MI) in non psych settings and how often we give PHQ or other outcome scales. If we adopt these, we need to commit to a better job at detection and diagnosis. It is hard for us to say if these are the best metrics as there are no mentions of obesity, smoking, or other behaviors, or regarding the several addiction outcomes. Also, nothing was included on dementia.

ASC Quality Collaboration

Donna Slosburg

Please accept these comments regarding XDEMA: High-Acuity Care Visits after Outpatient Colonoscopy Procedure on behalf of the ASC Quality Collaboration, a cooperative effort of organizations and companies interested in ensuring ASC quality data is appropriately developed and reported.

Although the measure topic is of interest, the measure specifications are incomplete and the information currently available is insufficient to allow a meaningful evaluation of the measure. For example, it is unclear how a valid measure based on administrative data would be aligned across the proposed settings given the differences in Medicare billing policies for the various providers, even in light of the recent proposal to use the "PD" modifier to identify selected claims. It is also unclear how usable the measure score would be: on the one hand, the broad scope of the measure poses challenges for actionability and usability; on the other hand, the limitation to Medicare FFS patients is not representative of the patient population served in the ASC or other proposed settings, limiting the utility of the results for public reporting and consumer decision-making.

The MAP's decisions carry great weight. With so much at stake, it is not reasonable to issue recommendations based on measure concepts or measure drafts. When these situations arise, MAP should instead determine whether the measure concept/draft would fill a measure gap, reserving further judgment for the completed measure.

Given that it is still in the development stage, it is too early to make decisions regarding the inclusion of the measure in the ASC Quality Reporting Program. Until the information needed for a thoughtful review of the measure - including completed specifications - is available, a "Do Not Support" decision is needed. We believe the MAP's current conclusion of "Conditional Support" is premature. The measure should be evaluated at a later date when measure development has been completed and testing has been performed so that questions regarding validity, feasibility, and usability can be fully addressed.

ASC Quality Collaboration

Kim Wood

XDEMA: High-Acuity Care Visits after Outpatient Colonoscopy Procedure is under consideration for the Hospital Outpatient Quality Reporting Program. In this draft report, the MAP has indicated a "Conditional Support" conclusion despite technical problems with the measure.

The measure is incomplete, but would use administrative claims as a data source. In earlier comments, it was pointed out that the developers had not taken into account the impact of the Medicare three-day payment window policy, which bundles payments for certain outpatient services when the patient is admitted as an inpatient within a three-day window.

As a result of this policy, separate claims for many HOPD services that result in near-term complications requiring inpatient hospitalization are not generated. It has been unclear how this measure would identify inpatient admissions that may have resulted from colonoscopies performed in the HOPD setting when those unplanned admissions occur on the date of the colonoscopy, or during the three days subsequent to the procedure. This missing data would skew the analysis by undercounting the number of hospital admissions attributed to any wholly owned or wholly

operated entity.

CMS has responded that, for claims before 2012, it plans to identify HOPD colonoscopies "with Medicare Part B file physician claims for colonoscopy in the HOPD setting AND inpatient admissions ≤3 days AND no corresponding HOPD facility claim." However, as OIG audits have shown, place of service coding on physician claims can be highly unreliable (see for example A-02-04-01010, A-05-04-00025, and A-06-04-00046). Any case detection algorithm that relies on this approach is unlikely to yield scientifically acceptable results.

CMS indicates that, for claims from 2012 forward, it plans to use the "PD" modifier to directly identify colonoscopies affected by the 3-day payment window. CMS states that "[o]ur testing shows that almost all [emphasis added] HOPD colonoscopies can be identified and attributed to the corresponding HOPD facility using approach", and "[t]his would further reduce [emphasis added] the number of colonoscopy outcomes that cannot be assigned to an HOPD." Because the outcomes being evaluated are uncommon, the identification of "almost all" HOPD colonoscopies is not sufficient. This issue is particularly critical because CMS plans to use this measure to publicly report performance across multiple settings, though none of the other settings are impacted by the three-day payment window policy. Before the measure is accepted, it should be conclusively shown that measure results allow fair and accurate comparisons to be made between facilities that are wholly owned or operated, and those that are not. Until this can be demonstrated, MAP should issue a "Do Not Support" recommendation.

Association of American Medical Colleges

Mary Wheatley

AAMC Comments on January 2014 MAP Pre-Rulemaking Draft Report (Page 1)

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Measure Applications Partnership (MAP) Pre-Rulemaking Report released January 17, 2014. The AAMC represents all 141 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 82,000 medical students, and 110,000 resident physicians.

The AAMC commends the MAP for reviewing and recommending hundreds of measures for federal quality programs in a short time period. As more federal pay-for-performance programs are being implemented and the amount of payment at risk increases, MAP has an important role to ensure that measures are used properly and do not result in unintended consequences. This year, the MAP relied heavily on the term "conditionally support" to identify measures that have potential, but may not be ready for implementation in a pay-for-performance program. In most cases, the conditions are tied to ensuring the measure meets NQF endorsement standards, but in a few circumstances, the conditions are tied to how the measure is used within the federal program. The pre-rulemaking report will offer a guide to CMS as it considers changes to the federal quality and performance programs.

The AAMC offers the following high-level comments concerning measures under consideration:

All outcome and efficiency measures used in pay-for-performance programs must be properly risk-adjusted, which should include an adjustment for socio-economic status (SES) factors.The SES adjustment is not to hide disparities, but to ensure that providers who care for complex patients, many of whom do not have access to the same community resources, are not negatively affected by the pay-for-performance programs. At a recent meeting of an NQF expert panel on SES and risk adjustment, members discussed the importance of adjusting for SES and most likely will be making the recommendation that all measures should be risk-adjusted for SES (unless there is a solid explanation why the adjustment is not necessary). Unfortunately, the current measures in the Hospital Readmissions Reduction Program (HRRP) and the efficiency measure in the Hospital Value-Based Purchasing (VBP) Program do not include this important consideration, although the MAP did recommend an adjustment for a new HRRP measure.

With rare exception, measures that are submitted

to the MAP for the pre-rulemaking process should be NQF-endorsed. NQF endorsement demonstrates that a measure has been tested, is reliable, and can be used in a specific setting. With the volume of measures the MAP has to review, the Workgroups and Coordinating Committee rely heavily on NQF endorsement to ensure the measure is sound. The one exception to this rule is measures for the Physician Quality Reporting System (PQRS), where some clinicians have the option to choose their measures and there is a gap in available endorsed measures. However, whenever a provider is required to be accountable for a measure (which is the case for all hospital measures and for the physician resource measures), NQF endorsement must be required.

All measures must be tested and endorsed for the proper unit of measurement.For example, the Medicare Spending per Beneficiary (MSPB) measure was listed for consideration in the Physician Value-based Payment Modifier, a physician pay-for-performance program, yet the measure was not specified for clinician or group reporting. MAP appropriately made its support conditional on testing the measure for clinician and group practices and ensuring that the revised measures meet the NQF endorsement criteria.

Finally,the MAP should focus on a more holistic approach to measure selection and measure implementation. Appropriate measurement means not only having a valid measure, but also having it implemented in an appropriate fashion. This year, in the hospital-wide readmission, the MAP considered not only the measure, but how the measure is incorporating into HRRP. This is an example how MAP can review other measures moving forward.

Hospital-Wide All-Cause Unplanned Readmission Measure Premature for Hospital Readmissions Reduction Program FY2015 Rulemaking Cycle

The AAMC strongly believes that it is premature for the Hospital-Wide All-Cause Readmission measure to be considered for inclusion in the Hospital Readmissions Reduction Program (HRRP). Providers are still digesting their data and trying to understand the usability of this measure in improving performance or to identify any unintended consequences that may have occurred. The amount of publicly available data has been limited as well. Due to the federal government shutdown in October of 2013, this measure was only first reported on Hospital Compare in December 2013, at the same time the Hospital Workgroup was reviewing this measure. Stakeholders did not have an opportunity to review the data during the pre-rulemaking process. Hospital Compare also reported only the single hospital rate, not the individual rates for the subcomponents, making it more difficult for stakeholders and policy makers to determine the drivers behind the readmission rates. The AAMC requests that MAP add language to the pre-rulemaking report noting the lack of available data during the review process.

Nevertheless, the AAMC appreciates that the MAP had a robust discussion concerning this measure and that support for this measure in HRRP was contingent on two conditions:

HHS should resolve the double jeopardy concern that hospitals may be penalized twice for the same readmission. Hospitals are already assessed on three condition-specific measures (AMI, HF, and PN). The inclusion of an All-Cause Readmissions measure would double-count some readmissions.

The MAP Coordinating Committee echoed MedPAC's recommendation that HHS should assess hospitals based on "peer groups" of similar facilities in order to avoid unfair penalties for hospitals that disproportionately care for economically disadvantaged populations

These conditions are necessary, but not sufficient to prevent unintended consequences in the HRRP. The AAMC has long advocated for including SES into the HRRP, and using peer groups is one possible way of implementing that concept. However, this recommendation should be expanded to ALL the measures in the HRRP, not just the hospital-wide measure. Another reason to delay implementing this measure in the HRRP, is that the NQF is hosting a panel of experts to evaluate how and when to incorporate SES into provider measurement programs, such as readmissions. Next year, the MAP can incorporate the outcome of those discussions into its recommendations.

For these reasons, the AAMC does not think the

hospital-wide readmission measure is suitable for the HRRP in the 2015 rulemaking cycle. The AAMC urges CMS to delay the inclusion of this measure in the HRRP in this year's rulemaking, and resubmit this measure to be reviewed by the MAP in December 2014. By this time, the MAP will have two cycles of data and stakeholders can have an informed discussion about whether or not this measure could have any unintended consequences.

Measures for Hospital Acquired Conditions Reduction Program Should be Validated and Publicly Reported Before They are Implemented in Pay-for-Performance

The AAMC is concerned that the MAP recommended two additional claims-based patient safety indicators (PSIs) for inclusion in the Hospital Acquired Conditions (HAC) Reductions program:

PSI 11: Postoperative Respiratory Failure Rate (NQF 0533)

PSI 16: Transfusion Reaction (NQF 0349)

The HAC Reductions Program automatically affects one-quarter of all hospitals in the country. Given the penalty, all measures in the program should be of high importance, reliable and valid enough to be publicly reported, yet these measures are not recommended for public reporting. Therefore these measures should not be included in the HAC program. Providers should also have the opportunity to see feedback on their data and have the opportunity to improve performance before any measure is included in a pay-for-performance program. The AAMC also believes that the ultimate goal of the HAC program should be a transition away from the use of claims-based measures towards those that are clinically-validated, such as the CDC-NHSN measures currently being reported. In the future, we ask that the MAP take a more long term strategic approach to determining which measures should be incorporated into the program.

Stroke Measures Recommended for Value Based Purchasing (VBP) Need Additional Study

The MAP Coordinating Committee recommended four stroke measures for inclusion into the Medicare Value Based Purchasing Program (VBP) program:

STK 01: VTE Prophylaxis

STK 02: Discharged on Antithrombotic Therapy

STK 04: Thrombolytic Therapy

STK 05: Antithrombotic Therapy By end of Hospital Day two

The report discusses the importance of the stroke measures, but does not mention how these measures can be reported by two mechanisms: through chart abstraction or by the electronic reporting pilot. As finalized in the FY 2014 IPPS Final Rule, hospitals will have the option to electronically report 14 stroke measures (which include the 4 measures recommended by the MAP) in order to get credit for both the Inpatient Quality Reporting (IQR) program and for the Meaningful Use program. The AAMC believes that it would be inappropriate to compare hospitals that gather measures through chart abstraction to those that report these measures electronically in a pay-for-performance program without prior validation. We ask that MAP document this potential data issue in its pre-rulemaking report.

Thank you for consideration of these comments.

California Hospital Association

Alyssa Keefe

a. CHA remains concerned that due to the lack of time afforded this process to deliberate on measures and the programs that for which they are being considered, that the MAP has defaulted to selecting measures in multiple programs as a definition for measure alignment. Where this is most concerning is the MAPs recommendation to support the all-cause all-condition readmission measure for inclusion in the readmissions payment penalty program. This program is only a penalty program. There are not points or payment incentives for improving your readmissions rates. By including measures that are duplicative of the current measure while leaving in the condition specific readmissions measures, the MAP has supported a recommendation that penalizes a hospital twice for the same readmission, rather than promoting a recommendation that would further drive improvement. This type of recommendation is takes double the resources away from hospitals, resources that could be used to improve readmissions rates by implementing any one of a number of quality improvement efforts that are costly to implement

and then sustain over time. CHA does not support this MAP recommendation. CHA urges the MAP to reexamine its goals for measure alignment and to allow more time for shared understanding of the consequences of duplication of measurement in performance and penalty programs. CHA urges NQF to undertake additional analysis that more fully illustrates these types of interactions so that the MAP can fully consider any unintended consequences.

b. CHA does not support inclusion of the stroke measures in the IQR and VBP programs until such time as they are adjusted for stroke severity. Our sentiments regarding this measure were best captured by those of the AHA and we ask that they be given additional consideration.

c. CHA urges CMS to provide the MAP and other stakeholders data that allow the MAP to assess the scientific validity of eCQMs, their comparability to chart-abstracted measures and their readiness for inclusion in quality reporting and payment programs. We continue to believe that NQF endorsement is as necessary for eCQMs as it is for any other type of measure. As with other types of measures, CMS should ask the MAP to re-review any eCQMs that have received "conditional support" once they have undergone NQF endorsement review. In addition, CHA urges CMS submit measures under consideration for Meaningful Use Stage 3 to the MAP for consideration.

d. CHA does not support the inclusion of the substance abuse or tobacco use measures in the inpatient quality reporting program. While important measures, in the spirit of parsimony, we believe there are other more pressing and important measures that should drive hospital quality improvement efforts at this time.

Edwards Lifeciences

Reginald Lavender

Edwards supports MAP's decision to conditionally support three new outcomes measures for the Inpatient Quality Reporting Program (IQR): (1) "Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery (measure XBELG);" (2)"Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery (measure # XDEEH);" and (3) "Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures (measure # XBGDL)." Significant costs driven by morbidity/mortality are associated with CABG and vascular surgeries in the U.S. The adoption of these outcomes measures in the IQR Program will promote broader use of evidence-based post-surgical practices. Edwards supports MAP's decision to "prioritize for inclusion" the "Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)" measure in the Hospital Value-Based Purchasing Program. Edwards supports efforts to incentivize the reporting of additional electronic measures to reduce the burden associated with chart abstracted measures. Edwards specifically supports MAP's decision to conditionally support the "Severe Sepsis and Septic Shock Management Bundle (measure #0500)" measure for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Hospitals and Critical Access Hospitals (CAHs). Edwards supports MAP's decision to conditionally support two measures for the Inpatient Quality Reporting Program (IQR) and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Hospitals and Critical Access Hospitals (CAHs) related to glucose control: Adverse Drug Events – Hyperglycemia (measure XBDCB) associated with increased mortality regardless of ICU type, severity of illness and ICU LOS, especially among non-diabetics.Adverse Drug Events- Hypoglycemia (measure #XDBGA). Even one episode of severe hypoglycemia (<40 mg/dL) is independently associated with increased risk of mortality.Close monitoring and intensive treatment of glucose has become an emerging standard of care among critically ill patients in the last several years. As new technologies become available in the Critical Care setting it improves the feasibility of monitoring and managing glucose levels in acute settings, these adverse event measures related to hyperglycemia and hypoglycemia will further the necessity to track this patient population. These measures align with the recommendations put forth in the draft National Action Plan for Adverse Drug Event Prevention

released by the department of Health and Human Services (HHS) in October of 2013, which prioritizes these adverse events as significant areas of focus nationally.

Eisai, Inc.

Charles Hampsey

Eisai agrees with the MAP's conditional support of Measure XDDAF (Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy) for inclusion in the PCHQR program, subject to its submission for NQF endorsement. Eisai urges CMS, the measure steward, and NCQA and Mathematica Policy Research, the measure developers, to submit this measure to NQF's All Cause Re/Admissions Measures Project.1 Further, we recommend that NQF consider Measure XDDAF for endorsement (for 3 years) or time-limited endorsement (for 2 years). Time-limited endorsement may afford CMS additional time to test the measure at PPS exempt cancer hospitals, provided that the measure meets the NQF endorsed evaluation criteria with the exception of not having been adequately field tested.2

Poorly controlled Chemotherapy Induced Nausea and Vomiting (CINV) is an acknowledged driver of ER visits and hospital admissions.3 A significant number of ER visits and subsequent hospitalization occur in the delayed phase of CINV.4 Health care providers may underestimate the incidence of delayed CINV, which can occur after patients leave the site of outpatient administration. Adherence to national treatment guidelines (NCCN, ASCO) for CINV is suboptimal.5 Several independent studies have confirmed that adherence to antiemesis guidelines improves patient outcomes and reduces health care utilization.6,7 Currently, antiemetic therapy for moderately and highly emetogenic chemotherapy are quality performance measures in ASCO's Quality Oncology Practice Initiative (QOPI).8 Eisai believes that Measure XDDAF will encourage performance improvement on these QOPI measures as well as improved adherence to national treatment guidelines for CINV.

1. Available at: http://www.qualityforum.org/projects/all-cause_admissions_readmissions/?section=PublicandMemberComment2013-10-14#t=2&s=&p

2. Criteria for NQF time-limited endorsement - http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=74121.

3. Mayer, D.K., et al. J Clin Oncol. 2011;29:2683-2688. - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3139372/

4. Cohen, L., et al. Support Care Cancer. 2007;15:497-503. - http://www.ncbi.nlm.nih.gov/pubmed/17103197

5. Gomez, D.R., et al. Cancer. 119: 1428-1436, 2013 - http://onlinelibrary.wiley.com/doi/10.1002/cncr.27899/full

6. Gilmore, J.W., et al. J Oncol Pract. 2014 Jan 1;10(1):68-74. - http://jop.ascopubs.org/content/10/1/68.abstract

7. Aapro, M., et al. Ann Oncol. 2012 Aug;23(8):1986-92. - http://www.ncbi.nlm.nih.gov/pubmed/22396444

8. See page 3 at: http://qopi.asco.org/Documents/QOPI-Fall-13-Measures-Summary.pdf

Federation of American Hospitals

Jayne Hart Chambers

Hospital Quality Programs:

The FAH recommends a change in wording to strengthen the Inpatient Quality Reporting paragraph addressing the episode-of-care payment measures for heart failure and pneumonia. The draft report "noted the need for condition-specific cost information; instead, the FAH recommends removing "noted the need for condition-specific information" and instead state that "the MAP recommends the development of condition-specific cost information…

The FAH recommends a clearer definition of the conditional recommendation in the paragraph stating that the two condition-specific readmission measures for coronary artery bypass graft surgery and vascular procedures are "conditionally supported."

The FAH opposes the inclusion of the all-cause, all condition readmission measure in the Hospital Readmission Reduction Program. We do not believe the statute allows for the inclusion of measures that are not condition-specific. In addition, hospitals do not have enough experience with this measure prior to its being moved to a significant penalty program.

Inpatient Psychiatric Measures:

The FAH supports the recommendations on the inpatient psychiatric measures. FAH hospitals have participated in The Joint Commission-collected measures and strongly recommend these measures for inclusion in the IPFQR program.

Hospital Outpatient Quality Reporting:

The FAH strongly supports the MAP recommendation to further explore the development of individualized psychotherapy services measures for vulnerable populations. The concepts presented on the MUC list are worthy of consideration, but true quality measures that have been tested and evaluated through the NQF process are essential before the MAP can undertake further consideration.

Similarly, FAH supports the MAP recommendation to exclude a 30-day readmission measure in the OQR program and the recommendation for further assessment of how an outpatient readmission would fit with the overall work already underway on readmissions.

Thank you for the opportunity to comments.

Florida Hospital

Richard E. Morrison

Hospital Performance Measurement Programs
Comment 1 of 2

In the pre-rulemaking draft, you have provided input on whether two stroke outcome measures – readmissions and mortality within 30 days of hospital discharge – should be removed from the Hospital IQR program. Florida Hospital is opposed to the use of these measures because they do not include sufficient adjustment for stroke severity.

We think that the use of logical and fair outcome measures is vital to the success of national quality programs. However, we do not think that these measures currently reflect health care outcomes or hospital performance in a manner that is accurate and applicable for health care consumers. For this reason we think that these measures should not be retained in the Hospital IQR program and should not be used in any quality programs until they have incorporated adjustments for stroke severity.

It is reasonable to expect that a hospital specialized in treating stroke cases will achieve better outcomes. It is also reasonable that this hospital will see stroke cases of a greater average severity. However, the current stroke outcome measure does not incorporate stroke severity and therefore may compare the stroke specialized hospital as performing equally as well as another hospital that achieves the same outcomes while treating cases of a lesser average severity.

Would it be reasonable to conclude that a minor league baseball player who hits 50 home runs over the course of 100 games is performing at the same level of a major league baseball player who also hits 50 home runs in as many games? No, this is because it is widely known and acknowledged that the skill of the average major league pitcher is much greater than the average minor league pitcher.

The same can be said of hospitals treating stroke cases. Two hospitals may have the same stroke outcome performance under the current measure. Yet, this information is useless, if not misleading, to the public because the public is not privy to the average severity of the stroke cases treated by the hospitals.

Studies have found that the National Institutes of Health Stroke Scale (NIHSS) is a very good indicator of mortality risk in Medicare beneficiaries with acute ischemic stroke [1-2]. A study published in the Journal of the American Medical Association explains the necessity of incorporating an adjustment for stroke severity into outcome measures [3]. In the study, about 58% of hospitals with "worse than expected" mortality according to a claims-based 30-day risk model equivalent to the stroke outcome measure used by CMS were reclassified to "as expected" when using a model that adjusted for stroke severity via NIHSS scores. This finding clearly substantiates the need for a severity adjustment if this measure is to be used in a meaningful national quality reporting or payment program.

In the pre-rulemaking report you note that "MAP has concluded that the need for data on stroke outcomes outweighs [member] concerns." Additionally, it is stated that "MAP recognized the limitations of claims based measures" such as the stroke outcome measures in question. Yet, the argument for using

these measures is a belief that "consumers need data on stroke outcomes to see possible variation among hospitals" and that this "will drive quality improvement efforts." We very much disagree with this conclusion and the reasoning supporting it. Clear, fundamentally sound and accurate data on stroke outcomes is certainly needed. However, we think it is very unwise to make unreliable and potentially inaccurate data available in a national quality reporting program. It is also imprudent to use such data in a payment program. The risks associated with using inaccurate are too great. Inaccurate data could fiscally reward facilities with substandard practices and inequitably penalize those treating the most severe stroke cases. Most importantly, as referenced in the report, "publicly reporting inaccurate data about performance could have the unintended consequence of misdirecting patients" especially as they make crucial health care decisions.

[1] Fonarow et al. Relationship of National Institutes of Health Stroke Scale to 30-Day Mortality in Medicare Beneficiaries With Acute Ischemic Stroke. J Am Heart Assoc. 2012; 1:42-50. Available at: http://circ.ahajournals.org/content/122/15/1496.

[2] Smith et al. Risk Score for In-Hospital Ischemic Stroke Mortality Derived and Validated Within the Get With The Guidelines–Stroke Program. J Am Heart Assoc. 2010; 122: 1496-1504. Available at: http://circ.ahajournals.org/content/122/15/1496

[3] Fonarow et al. Comparison of 30-Day Mortality Models for Profiling Hospital Performance in Acute Ischemic Stroke With versus Without Adjustment for Stroke Severity. JAMA. 2012; 308(3):257-264. Available at: http://jama.jamanetwork.com/article.aspx?articleid=1217240.

Hospital Performance Measurement Programs Comment 2 of 2

In the pre-rulemaking report MAP has provided input on the potential implementation of a Hospital-Wide All-Cause Unplanned Readmission (HWR) measure in the Hospital Readmissions Reduction Program (HRRP). We are very concerned about the use of this measure and believe that its use would not be consistent with the Affordable Care Act (ACA). Section 1886(q)(5)(B) of the ACA references only measures for specific conditions to be used in the HRRP and also states that the program may be expanded to include "other conditions and procedures as determined appropriate by the Secretary [of Health and Human Services]." We oppose the HWR measure because we think it is outside of the statutory intent of this legislation and the authority of CMS to include in the HRRP.

Additionally, it is noted in the pre-rulemaking draft that "concerns were raised about the need to risk adjust for socioeconomic status (SES)." We echo these concerns and encourage further consideration of the inclusion of risk adjustment for SES in readmission as well as other outcome measures.

Genentech

Darren Tayama

We commend the Measure Application Partnership (MAP) for their preliminary endorsement of select STK measures within Hospital Value Based Purchasing (HVBP) Program. We agree that the four STK measures endorsed by MAP have the ability to provide the greatest impact on patient care and outcomes.

We have one specific comment with regard to the additional findings for STK-4 (thrombolytic therapy - measure #0437). MAP states: "MAP questioned whether there is sufficient opportunity for performance on this measure to continue to improve and recommended that CMS reconsider the measure's exclusion criteria."

During the Hospital Workgroup meeting on December 11-12, we believe that the success rate on the STK-4 measure may have been misquoted. At the meeting, an individual stated that hospitals achieved a 99.7% success rate on STK-4. According to Hospital Compare data released in December 2013, STK-4 achieved only a 60% national average, which suggests significant improvement, especially when compared to other HVBP program measures and STK measures.

Therefore, we believe that hospitals have a significant ability to improve their success rate on STK-4 and urge that MAP appropriately call this out in the final recommendation.

Greater New York Hospital Association

Lorraine Ryan

Hospital Readmissions Reduction Program (HRRP)

NQF #1789 -Hospital-Wide all-cause Unplanned Readmission Measure (HWR): The Greater New York Hospital Association (GNYHA) opposes including NQF #1789 in HRRP. Like the other readmission measures, it unfairly penalizes hospitals primarily serving disadvantaged patients (GNYHA analysis, 1/15/14, Hospital Compare dataset). When we juxtaposed the newly published HWR rates with the price-standardized Medicare spending per beneficiary (MSPB) ratios, we observed an R-squared of <2% because, for almost half of all hospitals, there is an inverse relationship between observed-to-expected HWRs and MSPB ratios. The vast majority of hospitals with high readmission rates and below-average spending are high-DSH hospitals. Thus, high readmission rates are not always an indicator of wasteful spending, but often an indicator of below-average spending on disadvantaged patients. Until the HRRP's inherent inequality is removed, we do not support adding new measures. Also, if both a HWR and condition-specific readmission measures are included in HRRP, a single readmission may be counted more than once, potentially double penalizing hospitals.

Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization: GNYHA agrees with MAP that this measure is not ready for HRRP inclusion, as it has not passed NQF endorsement. Many commenters, including the American Stroke Association, expressed concern that the measure fails to include stroke severity–the most important factor for determining a patient's outcome from a stroke, and directly related to likelihood for readmission–within its risk-adjustment model. Including this measure in HRRP may unfairly subject certain hospitals–safety net hospitals for example–caring for severe stroke patients to unwarranted penalties.

Hospital 30-day, all-cause, RSRR following Coronary Artery Bypass Graft (CABG) Surgery: GNYHA does not support this non-NQF endorsed measure for HRRP inclusion.

PPS-Exempt Cancer Hospital Quality Reporting Program

NQF #1822 – External Beam Radiotherapy for Bone Metastases: Extracting information on pain levels from patient records is burdensome and exceeds the measure's value. Further, because there are cases of "painful" bone metastases that cannot necessarily be identified by using ICD-9 codes, many cases would fail to be included in the denominator.

NQF #450 – PSI 12 Perioperative PE or DVT rate: GNYHA urges CMS to include risk-adjustment for this measure to account for high-risk cancer patients.

GNYHA agrees these measures are not ready for implementation: Initiation of Osteoclast Inhibitors; Overuse of Imaging for Staging Breast Cancer; NQF #1638 Patients with Advanced Cancer Screened for Pain at Outpatient Visits; andPotentially Avoidable Admissions and ED Visits among Patients Receiving Outpatient Chemotherapy.

Highmark, Inc.

Deborah Donovan

Highmark appreciates the MAP's focus on the objective of identifying strategic areas with pronounced gaps in measurement development. Futhermore, we understand the impetus to include mesures that may have not received NQF endorsement due to developer timing or inability to organze information into the format required to put forward for NQF review. We do feel however that there is a significant distinction between those measures that have not yet been put forward for NQF endorsement and those that were voted on and denied endorsement after careful review/discussion/debate by the applicable Project Steering Committee and member Councils'.

Hospital IQR:

Measure ID # 2027: Hospital 30-day, All -cause Risk-standardized Readmission Rate (RSRR) following acute ischemic stroke hospitalization.

MAP conclusion: Retain

The above measure did not receive NQF endorsement when presented as a measure within the Neurology Phase 1 Project based on expressed concerns over the measure's validity. If this measure

could not receive consensus based on validity (Scientific Acceptablitlity of Measure Properties: Validity: H-0; M-12;L-4; I-6), it should not be put forward for continued inclusion in any of the CMS program measure sets. This course of action puts into jeopardy the very foundation of accurate, meaningful measurement.

NOTE: Highmark did participate in this project's discussion and did ultimately support this measure in both comments and voting; however we acknowledge our appreciation for our colleagues' insights, collective knowledge and objective viewpoints and wish to respect the NQF process.

HAC Reduction program measures Under Consideration:

NQF 0349: Transfusion Reaction

MAP conclusion: Supported

Comments under Additional Finding: transfusion reactions are straightforward, preventable events.

Highmark does not agree with the " additional finding" statement put forward. Blood transfusion reactions are not always due to the infusion of incompatible blood and errors in the labeling of blood typing samples or patient identification. While it is appreciated that the omission of check and balances do indeed result in preventable medical errors and harm; this measure does not have a stratification or numerator code that allows this measure to isolate reactions resulting from the uncrossmatched emergency infusion of blood due to medical necessity .

Memorial Sloan-Kettering Cancer Center

Sara Berger

Memorial Sloan Kettering Cancer Center (MSK) is the world's oldest and largest private cancer center. At MSK, there is a close collaboration between physicians and scientists, thereby enabling us to provide patients with the best care available as we work to discover more effective strategies to prevent, control, and ultimately cure cancer. Because of our focus on cancer, we are able to provide a unique perspective regarding the Prospective Payment System (PPS) Cancer Hospital Quality Reporting (PCHQR) program measures. We appreciate the opportunity to comment on the following measures:

- External Beam Radiotherapy for Bone Meta

• This would present a reporting burden requiring manual chart review since at present, we do not have discrete data elements for the following:

- "Painful" bone metastases, which cannot be identified from ICD-9 codes
- RT administered outside of repo

XDC- Initiation of Osteoclast Inhibitors for Patients with Multiple Myeloma or Bone Metastases Associated with Breast Cancer, Prostate Cancer, or Lung Cancer

Issues identified field-testing:

- Relevance/Usefulness-Conceptual Issues:

• Osteoclast inhibitors (OI) are used routinely only in castrate-resistant prostate cancer patients with bone metastases (not in castrate-sensitive cancer patients). OIs in lung cancer patients with bone metastases and multiple myeloma patients are still the focus of clinical trials.

- Feasibility-Technical Issues:

• We suggest that the date of clinical or pathologic confirmation of diagnosis be substituted for date of diagnosis. It may take time for newly diagnosed patients to decide to make an appointment at the reporting facility; therefore, it may be difficult to achieve the time frame of OI administration specified by the measure.

• There are a number of exclusions (without clear data definitions) which add to the data collection burden. It is difficult to identify some of the exclusions based on diagnosis codes.

Memorial Sloan Kettering Cancer Center (MSK) is the world's oldest and largest private cancer center. At MSK, there is a close collaboration between physicians and scientists, thereby enabling us to provide patients with the best care available as we work to discover more effective strategies to prevent, control, and ultimately cure cancer. Because of our focus on cancer, we are able to provide a unique perspective regarding the Prospective Payment System (PPS) Cancer Hospital Quality Reporting (PCHQR) program measures. We appreciate the

opportunity to comment on the following measures:

- Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis

Issues identified during field-testing:

- Relevance/Usefulness-Conceptual Issues:

• Patients on clinical trials and/or patients receiving neo-adjuvant chemotherapy (in advance of definitive treatment such as surgery) who require imaging should be excluded. Also, imaging required for multiple primary cancers (previous or current) should be excluded. Without these exclusions, it would be hard to attribute the purpose of the imaging.

• Certain patients and imaging studies were excluded from the code sets.

- Feasibility-Technical Issues:

• This would present a reporting burden requiring manual chart review since at present, we do not have discrete data elements (from ICD-9 codes) identifying bone pain.

E- 1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits

• This would present a reporting burden requiring manual chart review since at present, we do not have discrete data elements to identify patients with advanced cancer (Stage IV) after diagnosis.

- Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate

• These data should be risk adjusted to account for high risk patients, including those with cancer.

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Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy

Issues identified during field-testing:

- Relevance/Usefulness-Conceptual Issues

• This requires clarification regarding the population of patients to whom the measure applies. Patients receive chemotherapy for varying reasons (curative, adjuvant or palliative intent) and the number of admissions / ED visits may vary depending on the population of patients in each category. Stratification of such patients would clarify the reasons for admission and accelerate prevention and improvement strategies. Also, the measure does not allow for stratification for more or less toxic chemotherapy regimens; this may result in varying rates of hospital admission.

• Patients on clinical trials should be excluded or stratified.

• Some ED visits and hospital admissions may be the result of disease progression rather than complications of the treatment. An algorithm should be developed to help in distinguishing such patients as a way of reducing the measurement burden and increasing the accuracy of the measure

• Many ED / Urgent Care visits are intended to reduce hospital admissions.

• Many of our patients may start outpatient chemotherapy at the reporting facility, but complete their treatment locally in their communities. The measure should address how to handle attribution for patients treated at multiple sites.

MSK was the first cancer hospital to create a pain and palliative care service more than twenty-five years ago. Today, the service continues to work to relieve, or palliate, the pain and distress that may be experienced by cancer patients, including those in active, curative treatment and those with advanced, late-stage cancers. In most cases, a patient's oncologist coordinates with the Palliative Medicine Service to assist with complicated cases and to address issues related to pain and palliative care. Patients at MSK are referred to external facilities for their hospice care. Furthermore, MSK does not have an inpatient palliative care unit. Because of this

unique way of treating hospice and palliative care patients, many of the end of life care measures would not be applicable for our Center. We appreciate the opportunity to comment on the following measures:

Hospital and Palliative Care - Pain Screening

- Non-applicable to facilities (such as MSK) that don't have in-house hospice.
- Further clarification of the definition of "hospital-based palliative care" would be required; we do not have an inpatient palliative care unit.
  - Hospital and Palliative Care - Pain Assessment
- Non-applicable to facilities (such as MSK) that don't have in-house hospice.
- Further clarification of the definition of "hospital-based palliative care" would be required; we do not have an inpatient palliative care unit.
  - Advanced Care Plan
- This would present a reporting burden requiring manual chart review since at present, we do not have discrete data elements to capture a discussion regarding advance care plans.
  - Hospice and Palliative Care - Treatment Preferences
- Non-applicable to facilities (such as MSK) that don't have in-house hospice.
- Further clarification of the definition of "hospital-based palliative care" would be required; we do not have an inpatient palliative care unit.
- This would present a reporting burden requiring manual chart review since at present, we do not have discrete data elements to capture discussion / communication regarding life sustaining treatment preferences.

National Partnership for Women & Families

Alison Shippy

The Consumer-Purchaser Alliance (C-P Alliance) was pleased that the stroke readmission and mortality measures will be retained in the Inpatient Quality Reporting (IQR) program, as publically reporting stroke outcomes are important for achieving improvement. We applaud the level of CMS engagement in the MAP's discussion of these measures. As evidenced by the report, CMS provided valuable updates on their efforts to further assess the measures' scientific acceptability, potential impact, and noted their commitment to continuous refinement of the measures, which ultimately allowed MAP to make an informed recommendation. Additionally, C-P Alliance reinforces MAP's support of PSI-5/NQF #0363 Foreign Body Left During Procedure for inclusion in the IQR program, as well as PSI 16/NQF # 0349 Transfusion Reaction for inclusion in the HAC Reduction Program. These measures are important for ensuring these avoidable complications do not occur and that patients receive safe and effective care. C-P Alliance commends MAP's recommendations focused on filling previously identified measure gaps, including measures focused on maternity care and cost and resource use in the IQR program, as well as a number of important outcome measures around elective delivery, surgical complications, mortality and cost/resource use, for the value-based purchasing program.

With the many successes of this Workgroup come additional opportunities for improvement. The Consumer-Purchaser Alliance (C-P Alliance) would like to draw attention to the measure gaps cited in the report around hospital-acquired conditions and that they do not recognize existing gaps in publically reported information on falls and trauma. Improvement in these measures can result in avoidable pain and suffering for patients, families and caregivers, as well as decreased expense to the healthcare system. Moreover, NQF has an existing patient fall rate measure that has previously been recommended by MAP in the patient safety family of measures (NQF #0141), and C-P Alliance was disappointed that the report does not reflect the recommendation that it be added to the IQR program this year. This recommendation was noted during the in-person MAP proceedings. Notably, measure #0141 would address a broader set of outcomes that are more understandable to patients than the postoperative hip fracture rate measure currently included in IQR, VBP and HAC Reduction Programs as part of PSI-90.

We are concerned with the MAP's discussion of risk-adjustment for case-mix and/or socioeconomic status for the readmission measures. C-P Alliance

recognizes the potential impact socioeconomic status can have on health outcomes, but we continue to support the notion that limiting risk-adjustment to patient clinical factors helps identify disparities in care and channel necessary resources for intervention and improvement. Concerns about the financial impact of the readmissions program are important to consider, but are challenged by a recent study that shows American hospitals have overall increased their operating margins by billions of dollars, even after taking bad debt and charity care into account.[1] Additionally, the average hospital was fined less in the second year of the program than in the first, and the total national penalty will be $53 million less despite the 2 percent maximum penalty.[2] This means hospitals are making real progress in improving care and are able to do so even considering the financial obligations applied by this particular federal program. MAP should continue to impress upon all stakeholders that publically reporting readmissions information is a critical step towards improvement and reporting must be done in a timely manner.

[1] Kutscher, Hospitals on the rebound, show stronger operating margins.Modern Healthcare. January 2014. Available here: http://www.modernhealthcare.com/article/20140103/NEWS/301039973?AllowView=VDI3UXk1TzRDdmVCbkJiYkY0M3hlMEtwakVVZERlVT0=&utm_source=link-20140103-NEWS-301039973&utm_medium=email&utm_campaign=mh-alert

[2] Ness and Kramer, Reducing hospital readmissions: its about improving patient care. Health Affairs Blog. August 2013. Available here: http://healthaffairs.org/blog/2013/08/16/reducing-hospital-readmissions-its-about-improving-patient-care/

Finally, C-P Alliance does not agree with the assessment from the report that "including both [all-cause and condition specific] readmissions measures would essentially penalize hospitals twice for the same event." We believe that the all-cause measure is of the utmost importance and has the potential to uncover and address system-wide issues, while simultaneously providing important information to patients. The condition-specific measures also hold value, offering providers actionable and specific information to help guide improvement. Despite our disagreement with the assessment of "double jeopardy," we feel that the report and MAP's final recommendations regarding the readmissions program reflect a comprehensive discussion that ultimately led to a strong, consensus-based recommendation.

Society of Hospital Medicine

Eric Howell, MD

SHM has specific comments regarding the following measures in the Hospital Acquired Condition Payment Reduction Program:

MUC ID XDDLA, PSI 10: Postoperative Physiologic and Metabolic Derangement Rate and MUC ID E0533, PSI 11: Post-Operative Respiratory Failure refer to elective surgeries. As such, 'elective' should be included in the measure title.

MUC ID E0349: PSI 16: Transfusion Reaction effectiveness rationale should be changed to, "This measure is intended to reduce the number of transfusion reactions on medical and surgical discharges," instead of "...transfusion reactions after surgery."

Hospital Inpatient Quality Reporting, Medicare Shared Savings, Medicare and Medicaid EHR Incentive

Program for Hospitals and CAHs, Physician Compare, Physician Feedback/QRUR, Physician Value-

Based Payment Modifier, Medicare Physician Quality Reporting System:

MUC ID XDBGA, Adverse Drug Events- Hypoglycemia should include an exclusion for patients with insulinoma in the denominator.

MUC ID XDEEL, Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure should include an exclusion criterion in the denominator for patients on hospice or palliative care, unless the risk adjustment methodology already accounts for patients with noncardiac terminal illnesses such as advanced cancer.

Hospital Readmissions Reduction Program, Physician Feedback/QRUR, Physician Value-Based Payment Modifier: SHM appreciates the exclusion of planned readmissions from the MUC ID E1789, Hospital-Wide

All-Cause Unplanned Readmission Measure (HWR). Exclusion criteria should be added to the denominator such that a planned hospital transfer is not included as a 'readmission,' or alternatively the definition of a planned admission should include intrafacility transfers.

Hospital Value-Based Purchasing Program

SHM supports the following stroke measures as they would be considered best practices in the care of stroke patients including, MUC ID E0434 ,STK-1 Venous Thromboembolism (VTE) Prophylaxis, MUC ID E0441, and MUC ID E0435, STK-2 Antithrombotic Therapy for Ischemic Stroke. Further, SHM supports the following HVBP measures with specific comments including:

MUC ID E0439, STK-6 Discharged on Statin Medication. As written, it is unclear as to whether patients with sickle cell disease or other conditions that would predispose younger patients to stroke, who develop ischemic stroke, would equally benefit from a statin, and perhaps should be excluded.

MUC ID D0440, STK-8 Stroke Education. SHM supports this important care transitions measure. However, if the numerator includes all patients discharged home, then the exclusion criteria should also include patients transferred to another facility or discharged to a SNF, as they might not receive all of these details in their discharge summary.

MUC ID D0376 VTE-6: Incidence of Potentially Preventable VTE. SHM supports this patient safety measure so that institutions continue to emphasize the critical importance of identifying and initiating VTE prophylaxis in appropriate medical and surgical patients.

SHM does not support the following measures for inclusion in the Hospital Value-Based Purchasing Program:

MUC ID E0371, VTE-1: Venous Thromboembolism Prophylaxis. Historically, SHM has supported this as an important process measure; however, the momentum behind this movement has slowed down quite a bit. New data suggests that perhaps not everyone benefits from VTE prophylaxis, and in fact, many "low-risk" patients may be harmed. SHM does not endorse this measure in its current form, until more definitive data about appropriate patient selection is available, or it can be denoted that "high risk" patients are in the denominator (rather than "all"). There should also be clarification about whether VTE prophylaxis refers specifically to pharmacologic VTE prophylaxis or is also inclusive of mechanical compression devices (although the evidence for this on medical patients is not as well-established as it is on surgical patients). This measure is currently under category "E"—endorsed by NQF, but it might be considered for the "D" category, if this is strictly about pharmacologic VTE prophylaxis.

MUC ID E0373 VTE-3: VTE Patients with Anticoagulation Overlap Therapy. This measure has become somewhat outdated due to the prevalence of newer anticoagulants, many of which have an onset of action in just 24 hours and do not require the 5 days overlap. While Warfarin is still most commonly used, the environment is changing rapidly and separating out which patients are on Warfarin versus a newer agent would be problematic. The specifications of this measure should be changed to reflect that it is applicable to Warfarin only.

MUC ID D0374 VTE-4: Patients Receiving Un-Fractionated Heparin with Doses/Labs Monitored by Protocol. Much like the measure above, this would have been a good measure a decade or so ago. Very few patients with DVT/PE get managed with IV Heparin. In fact, most hospitals have gone to pharmacist protocol monitoring, so it would be collecting data on a very few outliers. Also, tracking the performance would be difficult as IV Heparin is primarily used as bridge therapy now, which may be used only for 6-24 hrs. and in that short time frame the protocol monitoring is less important.

Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs: SHM supports MUC ID E0500: Severe Sepsis/Septic Shock: Management Bundle, and would recommend that this measure would also be appropriate for other incentive programs such as Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing.

The Joint Commission

Sharon Sprenger

The Joint Commission previously commented on the IPPS rule that the two stroke outcome measures need to address severity using the NIHSS score. As currently constructed, we cannot support the stroke outcome measures. Of special concern is the stroke mortality measure that if used could have significant unintended adverse consequences to quality improvement, and for patients. For example, certified primary stroke centers frequently treat the more severely ill stroke patients. To be certified, they must use the latest clinical science and professionally endorsed guidelines. The guidelines contain scientific processes known to make a difference to patients. However, the proposed mortality measure may erroneously conclude that some stroke centers have unacceptable stroke mortality rates, and a false rate could lead to the abandonment of these accepted practices as being ineffective. Similarly, hospitals without stroke certification but with high mortality rates may fail to embrace endorsed science when trying to improve, because they do not see that its use makes a difference in some certified stroke centers. The many concerns raised respecting these measures are too great for their use.

We support PC-02 C Section measure for the Hospital IQR Program & PC-01 Elective Delivery for the VBP Program. Both measures address overuse of procedures and wide variation in practice. We concur that the public will need basic information about the nulliparous term singleton vertex C Section rates evaluated by PC-02. The purpose of this measure is not to eliminate C Sections, but to enable hospitals to establish a performance baseline from which improvement can be measured over time.

We agree that NQF# 0028, XCAEA, XDCBA, XDCFD, XDFGC, & XDFGD should not be included in the IPFQR Program. Instead, the MAP encouraged the inclusion of The Joint Commission's tobacco, substance use and hospital-based inpatient psychiatric services measures. Co-occurring substance use disorders are prevalent and under-detected in many patients with psychiatric diagnoses. HBIPS-1 assesses the proportion of patients admitted to a hospital-based inpatient psychiatric setting who are screened for risk of violence to self or others, substance use, psychological trauma history and patient strengths. By adopting HBIPS-1 for the IPFQR Program, theentire HBIPS measure set will be used as designed. Joint Commission accredited IPFs have been collecting the HBIPS set since 2008, and 533 IPFs currently report the data. SUB-1 was adopted for the IPFQR Program, but we support inclusion of all measures in the substance and tobacco treatment measure sets. The SUB measures complement each other and evaluate 4 key processes related to alcohol and substance use for an overall view of care provided. The SUB and TOB measure sets are in the final stages of NQF endorsement consideration, along with HBIPS-1. The SUB and TOB measures should be part of the Hospital IQR program.

The Leapfrog Group

Melissa Danforth

The Leapfrog Group supports the MAP recommendation to see additional outcome measures in the HVBP measure set. In particular, Leapfrog is very supportive of the following measures from the IQR program being added to the HVBP proggram:

- NQF #0469 Elective delivery prior to 39 completed weeks of gestation
- NQF #0351 PSI–4 Death among surgical inpatients with serious treatable complications

Section 5: Pre-Rulemaking Input on Post-Acute Care and Long-Term Care Performance Measurement Programs

American Medical Rehabilitation Providers Association

Bruce Gans

Overall, AMRPA supports the recommendations made by the MAP regarding the eight measures under consideration for inpatient rehabilitation hospitals and units (IRH/Us) for the inpatient rehabilitation facility quality reporting program (IRF QRP). We reviewed all measures under consideration in terms of their impact on a patient's ability to participate in rehabilitation. As noted in the pre-rulemaking report, Measure 1717 (CDI Outcome measure) is important because such an infection could affect a patient's ability to participate in rehabilitation. Therefore, we agree with the MAP's support of the measure. Measure 1716 (MRSA) also captures an important concept for inpatient rehabilitation providers but we have concerns about the cost of implementation of such a measure given its rare occurrence in this setting. We appreciate the incorporation of our feedback as it relates to Measure 0674 (falls with major injury). As noted in the report, there are many issues that need to be resolved before this measure is adopted including what constitutes a "major" injury and how to account for assisted falls. With regard to the four functional measures under consideration, we believe that assessing a patient's function is critical in this setting but the existing measures are not ready. It is important to limit provider burden, develop a risk-assessment model, and select a tool or method for assessing functional status. Finally, while inpatient rehabilitation providers recognize the importance of understanding the patient experience of pain, the existing measure (0676) does not specify when the pain assessment should take place and does not account for cognitive impairment and pain reporting. For example, if the patient experiences pain prior to admission to the IRH/U it is important that the failure to deal with the pain is not inappropriately attributed to this setting. Additionally, it may be more appropriate to assess the reduction or control of pain. We agree with the MAP's decision to offer conditional support for these measures given the issues that have been identified until resolution to these concerns are found.

American Nurses Association

Maureen Dailey

ANA supports harmonization of measures across programs and settings as appropriate, monitoring for unintended consequences, including burden, where existing minimum data sets (MDS) are in place. It is important that state of the science metrics in key NQS priority areas be implemented across settings and programs, however, individualization that's appropriate for settings should be considered. ANA agrees with the PAC/LTC Workgroup support for the alignment of measures to promote patient-centered care across the healthcare continuum. In addition, ANA agrees the recognition of the heterogeneity of populations served in each setting is important, and that measures should be specified and applicable to specific populations.

American Society of Nephrology

Thomas H. Hostetter, MD

On behalf of the American Society of Nephrology (ASN), thank you for the opportunity to provide comments on the National Quality Forum (NQF) Measures Application Partnership (MAP) Pre-Rulemaking. ASN is the world's leading organization of kidney heath professionals representing nearly 15,000 physicians, scientists, nurses, and health professionals who improve the lives of patients with kidney disease every day. ASN and the professionals it represents are committed to maintaining the integrity of the physician-patient relationship as well as simplifying patient access to optimal quality care, regardless of socioeconomic status, geographic location,or demographic characteristics.

ASN Appreciates the efforts of NQF, and well as MAP, to identify the best available healthcare performances for use in specific applications. The society recognizes the importance of evidence-based clinical practice measurements in advancing the quality of patient care, and is committed to actively participating in the consideration and selection of evidence-based quality measures related to kidney disease care and has submitted comments on the

proposed end-stage renal disease-related measures for your consideration to Allison Ludwig, Senior Project Manager.

ASN appreciates the efforts of NQF, as well as MAP, to identify the best available healthcare performance measures for use in specific applications. The society recognizes the importance of evidence-based clinical practice measurements in advancing the quality of patient care, and is committed to actively participating in the consideration and selection of evidence-based quality measures related to kidney disease care and kindly submits the following comments on the proposed end-stage renal disease-related measures for your consideration.

Measure XDGAM: Pediatric Peritoneal Dialysis Adequacy: Frequency of Measurement of Kt/V.

Measure XCBMM Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V.

ASN conditionally supports measures XCBMM and XDGAM overall at this time, noting that these measures correspond directly to existing KDOQI guidelines. However, ASN observes that these measures should be updated in the future to reflect any subsequent KDOQI updates.

Measure XDGBA: ESRD Vaccination – Lifetime Pneumococcal Vaccination.

Measure XDEFL: ESRD Vaccination - Pneumococcal Vaccination (PPSV23).

Measure XDEFH: Pneumococcal Vaccination Measure (PCV13).

Measures XDGBA, XDEFL, and XDEFH all pertain to dialysis patient pneumococcal vaccination status. Measure XDGBA refers to the percentage of patients age 2 years old and older who have ever received either the PPSV23 or the PCV13, were offered and declined the vaccination or were determined to have a medical contraindication. XDEFL specifically covers the PPSV23 vaccine while XDEFH specifically covers the PCV13 vaccine. Traditionally, the PCV13 is used in children, although, for 'chronic renal failure', the Advisory Committee on Immunization Practices (ACIP) recommends both the PPSV23 and the PCV13. This recommendation is based on the definition of chronic renal failure as an immunocompromised state. However, limited outcome data exists assessing the effectiveness of this strategy. Of note, per the ACIP, individuals who have an indication to receive both PCV13 and PPSV23, such as dialysis patients, should be vaccinated according to the following schedule:

- For patients who have not previously received either PCV13 or PPSV23, a single dose of PCV13 should be given, followed by a dose of PPSV23 at least eight weeks later.
- For patients who have previously received one or more doses of PPSV23, a single dose of PCV13 should be given one or more years after the last PPSV23 dose was received.
- For patients who require additional doses of PPSV23, the first such dose should be given no sooner than eight weeks after PCV13 and at least five years after the most recent dose of PPSV23.
- Patients <65 years of age who have functional or anatomic asplenia or who are immunocompromised should be revaccinated one time five years after the initial dose, and again at or after age 65 (and at least five years after the previous dose).

ASN agrees that encouraging immunization where indicated is a worthy goal. However, as the society observes that none of the three overlapping measures have been refined and none of them have been tested. ASN would support eventual adoption of XGDBA (the simplest of the three proposals) once reporting has been streamlined and the measure appropriately refined.

As currently written, XDEFL fails to account for potential medical complexities associated with pneumonia vaccination, including issues with recent transplantation as well as the interval duration between PCV13 and PPSV23 administration. The society's trepidation to support measure XDEFL and XDEFH reflects the fact that they are highly specific in a field that is subject to rapid change. For example, when newer vaccines are developed, how will they be integrated into these measures and when will this occur? These logistic issues are similar to those discussed below in regards to influenza vaccination.

In sum, ASN supports the XDGBA measure in concept although notes that testing is required for measure validity, and ASN does not support XDEFL

and XDEFH.

Measure XDGAF: Hepatitis B vaccine coverage in hemodialysis patients.

ASN does not support measure XDGAF in its current form, and feels this measure needs to be fully specified. As currently written, the measure leaves many important questions unanswered. For example, what if one cannot prove that a patient has received three vaccine doses but has adequate Hepatitis B Ab titers? How should a facility respond to a patient with both Hepatitis B core Ab + and Hepatitis B S Ab + due to known prior infection? What is the denominator? ASN also notes that, in the United States, Hepatitis B vaccination is now routinely administered during childhood. As such, the society expects that there will be a substantial number of dialysis patients moving forward who do not have well documented records of vaccination available to the dialysis facilities. If this measure were to be implemented, how would a facility respond to such ambiguity, as there is no statement regarding serology results in this measure? Finally and most importantly, Hepatitis B testing and vaccination is described in detail in the Conditions for Coverage (Tag V126). ASN does not support implementation of measure XDGAF at this time because of a lack of details, redundancy with existing regulations, and, in the absence of details, potential conflicts with these existing regulations.

Measure XDEGC: Measurement of Plasma PTH Concentration.

ASN does not support Measure XDEGC. PTH is typically measured quarterly in most dialysis facilities, and at present there is no evidence supporting a performance gap in this aspect of care. Moreover, no clinical practice guidelines rated above level 2D currently exist delineating: 1) how to measure PTH; 2) how to respond to PTH results; or 3) the optimal frequency of PTH measurement. Moreover, the proposed measure has not been tested, and the additional data reporting requirement—including data entry with the specific assay described— may be substantial.

Measure XDEFF: Standardized Kt/V.

ASN does not support Measure XDEFF. Given the increasing complexity of hemodialysis regimens, there may be a role for future use of stdKt/V when examining small molecule clearance across hemodialysis strategies. However, at present, ASN observes that optimal small molecule clearance remains uncertain, even for thrice weekly hemodialysis, and even less certain for more frequent hemodialysis modalities. The society believes that more data may be helpful to be able to better study these treatment strategies. ASN notes that most LDOs do already collect these data, but at the same time recognizes that there could be potential data collection feasibility and cost of data entry concerns. ASN also maintains concerns that there are no data to support specific targets. Accordingly, ASN believes extensive piloting and refining of this measure would be necessary before it can be considered for adoption.

In sum, ASN would support a future measure on this topic but does not support the current measure due to insufficient validity testing as well as potential feasibility of data collection and cost of data entry.

Measure XDEFE: Surface Area Normalized Kt/V.

ASN does not support Measure XDEFE. While ASN realizes that there is ongoing debate about how to best account for volume and acknowledges that opinion leaders in this field posit that surface area normalization may explain the discrepant results in the HEMO study by sex, this concept remains a research question. Additionally, there is a tremendous data gathering effort required for this measure as well as a lack of specificity about how to, and how often to, determine height (which is in actuality a complicated issue in clinical practice and research studies). There is no guideline supporting this measure and there is no information as to what to do with these data.

Accordingly, ASN does not support measure XDEFE.

Measure XDEGB: Percentage of Dialysis Patients with Dietary Counseling.

ASN does not support measure XDEGB. While ASN concurs with the measure sponsor that dietary counseling is important, the society maintains numerous issues with this measure as proposed. 1) Dietary counseling is already extensively discussed within the Conditions for Coverage, with notes from dieticians required more frequently than stated in this

proposed metric for each dialysis patient; 2) Not all patients require counseling on dietary phosphorus, and the emphasis on phosphorus over fluid in this proposed measure is vexing; 3) The reliability and validity of this measure remains very uncertain; and 4) Aside from the proposed measure's specificity regarding dietary phosphorus, much else remains vague, such as what is dietary counseling, and who might be acceptable to provide this counseling.

Accordingly, ASN does not support measure XDEGB.

Measure XDEGA: ESRD Vaccination - Timely Influenza Vaccination.

Measure XDEFM: Full-Season Influenza Vaccination (ESRD Patients).

ASN is concerned that measures XDEGA and XDEFM would create an unnecessary burden for ESRD facilities, and notes that the measures as currently written remain vague and insufficiently detailed. It is unclear as to the documentation required to demonstrate immunization that occurs outside the dialysis facility to satisfy this metric. The issue of immunization in children remains complex and may present an additional burden for dialysis facilities. Lastly is the topic of record keeping. The data elements necessary for testing are "not currently required and/or available" in the CROWNWeb data repository, and CMS currently reports that this measure has not been tested for reliability or validity.

In sum, ASN does not support the measure as currently proposed but does supports a measure on influenza vaccination in concept, focusing on a single measure rather than two competing measures, preferably similar to XDEFM (seasonal) once this is better refined. Specifically, the dates for vaccination should align between the numerator and the denominator, patients initiating dialysis late in an influenza season should not be required to be vaccinated, and there needs to be a comment regarding influenza vaccine availability, as there have been shortages in recent years.

Measure E0260 /NQF 0260: Assessment of Health- Related Quality of Life (Physical & Mental Functioning).

While ASN acknowledges the importance of patient-specific quality of life assessments, ASN does not support the measure as currently proposed, reflecting the following concerns: 1) redundancy with the Conditions for Coverage; 2) survey burden when viewed in concurrent context with dialysis facility specific surveys as well as current twice yearly ICH-CAHPS requirements; and 3) unclear wording of the measure description, which presumably refers to the use of the KDQOL instrument; and, 4) facility burden for both assisted administration as well as documentation of results and the documentation of the multiple exclusions from administration.

Measure XAHMH: Percent of patients with a UFR greater than 10 ml/kg/hr.

ASN does not support Measure XAHMH. The proposed measure is discrepant between the title and the numerator, with one specifying a UF rate of 10 and the other of 13 ml/kg/hour. There are many issues with this measure that make it very inappropriate to be advanced at the current time. First, there is no consensus or data regarding an optimal ultrafiltration rate. In fact, both levels mentioned in the measure (10 ml/kg/hour and 13 ml/kg/hour) reflect semi-arbitrary thresholds analyzed in a recent administrative database of dialysis patients. Second, while many providers do feel that slowing down the ultrafiltration rate is important, there is no consensus to this effect. Third, there are only two ways to reduce ultrafiltration rate – increase dialysis time or decrease total ultrafiltration. While ASN and most providers are generally supportive of increasing dialysis time, there are no clinical trials of improved mortality outcomes and there are patient symptoms that occur with prolonged dialysis, even with smaller dialysis membranes and reduced blood flow rates. In fact, this is the goal of the first major ongoing US pragmatic dialysis trial, the TIME Trial. Fourth, the ultrafiltration rate may differ among sessions and notably, typically differs by day of the week. Accounting for this factor would be important. ASN applauds MAP for recognizing that volume control is extremely important, but we feel that the specificity of the proposed measure, whether using a threshold of 10 or 13 ml/kg/hour, is unsupported by data at the current time. The society notes that a recently convened TEP failed to support a measure on this topic and that a KDOQI guideline panel on hemodialysis adequacy, which has already convened, is expected to address this specific question.

In sum, ASN opposes this measure given the paucity of evidence to support this measure and potential issues with measure validity.

Measure E0029 / NQF 0029: Counseling on Physical Activity in Older Adults: 1. Discussing Physical Activity 2. Advising Physical Activity.

While exercise and physical activity are important for dialysis patients, this measure is poorly defined. As worded, it seems to require an additional patient survey, and is beyond the scope of dialysis facilities.

Measure E0393/ NQF 0393: Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia.

ASN does not support Measure E0393. Hepatitis C testing is currently widely performed by facilities, however, the role for referral for treatment and whether safe interventions to treat hepatitis C in dialysis patients exist remain uncertain. While Hepatitis B testing is extremely important, there is little role for Hep C RNA testing in the dialysis facility, and, for issues related to Hepatitis C, dialysis facilities are already governed by the CfCs. Given these factors, most notably the uncertain role for referral of these patients to a specialist given competing comorbid conditions and the lack of well-accepted, easily tolerated and efficacious therapies at the current time for dialysis patients with Hepatitis C, this proposed measure is premature and likely unnecessary.

Measure E0004 / NQF 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

While an important measure for the health of individuals and a topic that the nephrology team should be aware of and potentially be engaged in, ASN does not believe that the quality of care delivered either by dialysis facilities or nephrologists or nephrology practices should be judged using this measure as this is beyond the purview of the dialysis facility. While there are social work interventions available within a dialysis facility, these issues are beyond the scope of dialysis care.

ASN therefore recommends against approving this proposed measure.

Measure E0431/ NQF 0431: Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

ASN applauds the overall purpose of this quality measure but suggests that it needs to be validated to assess the feasibility of reliable immunization data collection. This measure could potentially represent a significant additional reporting burden on dialysis facilities without generating reliable data. Members of the healthcare team, including to medical students, residents, and other personnel who received immunizations, may not possess the documentation at the time of their visit to the dialysis facility. The logistics of reliably obtaining this information need to be assessed prior to implementation. Finally, a measure on this topic would needs to be synchronized with a similar measure proposed by University of Michigan Kidney and Epidemiology Cost Center (UM-KECC).

ASN opposes this measure at the current time, primarily because the logistics of implementation of this measure could be very complicated and the reporting burden quite high.

Measure E0420 NQF 0420: Pain Assessment and Follow-Up.

ASN agrees that chronic pain is an important issue for dialysis patients. The society notes that the burden of this measure, as worded, is very high for an outpatient dialysis facility. Recognizing the dialysis patients typically dialyze at a center three times per week, the requirement for documentation of a pain management plan at each encounter is excessive, particularly for chronic pain. Moreover, the CfCs already elaborate on care plan items such as pain in considerable detail. This proposed measure has not been adequately studied or validated in dialysis, and the tools to assess pain in this population remain insufficient.

Measure E0418/ NQF 0418: Screening for Clinical Depression.

Rates of depression among dialysis patients are presumably very high, although instruments remain poorly validated for assessing depression versus instruments identifying competing somatic symptoms that are associated with dialysis itself. The efficacy of therapies for treatment of depression in dialysis patients is also poorly studied, with only a

few small trials addressing this important issue.

Accordingly, ASN supports screening for depression with a standardized tool that could be chosen by the individual facility. However, at the current time ASN cannot support this metric as it does not apply to dialysis facilities. The society would be pleased to consider supporting a future measure designed to address depression screening in dialysis facilities.

Amgen, Inc

Jason Spangler

Amgen supports the immediate inclusion of MUC XDEGC into the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP).

Amgen appreciates and supports the efforts to identify quality measures for consideration of inclusion in the ESRD QIP specific to measuring plasma levels of parathyroid hormone (PTH). Measurement of PTH is the essential biochemical measure for determining the presence or absence of secondary hyperparathyroidism (SHPT), and the only practical method for assessing the progression and severity of the disorder. SHPT is a common co-morbid condition that affects the majority of ESRD patients. The long-term consequences of inadequately controlled SHPT can be serious and may include: fractures, increased risk for cardiovascular calcification, cardiovascular disease, hospitalization, surgical parathyroidectomy, and increased mortality. The disease has important implications for kidney transplantation candidates because the presence of extensive vascular calcification can preclude successful graft surgery and adversely affect graft function.

Regular determination of PTH levels will enable identification of trends to help guide appropriate treatment and prevent excursion of PTH levels into ranges that are felt to be associated with increased risk of adverse outcomes as delineated in current treatment guidelines. Despite the potential long-term clinical outcomes of uncontrolled SHPT, there are currently no quality measures under the ESRD QIP that support monitoring clinical or biochemical outcomes related to SHPT. Yet, since implementation of the ESRD PPS, external data sources show that PTH levels have increased and the proportion of patients with very high PTH levels increased substantively, particularly among African Americans. For these reasons, we strongly believe CMS should move for the immediate inclusion of measure XDEGC in the ESRD QIP.

Armstrong Institute for Patient Safety and Quality at Johns Hopkins University

Matt Austin

E0260: While the MAP recommended not supporting this measure, it has been implemented pretty standardly in most dialysis facilities. as it is included in CMS' Conditions for Coverage.

XDEFL: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: This is an important measure, but given the recent changes in the CDC guidelines for pneumococcal vaccination, it will be difficult to implement. It could also lead to inadequate vaccination, since it only requires that the patient received a single immunization--either PCV13 or PPSV23, when in fact any patient > 5 years should receive both.

XDEGA: We concur with the MAP's recommendation of not supporting for this measure and offer the following comments: Although the benefit of early vaccination has been demonstrated, this measure may inadvertantly reduce the rate of "late" immunization, since it would not be included in the measure.

XDGBA: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: This is an important measure, but given the recent changes in the CDC guidelines for pneumococcal vaccination, it will be difficult to implement. It could also lead to inadequate vaccination, since it only requires that the patient received a single immunization--either PCV13 or PPSV23, when in fact any patient > 5 years should receive both.

XDEFM: We concur with the MAP's recommendation of conditional support for this measure and offer the following comments: This is a very reasonable measure and should be able to be relatively easily tracked in dialysis facilities.

XDGAF: While the MAP recommended support for this measure, we do have the following concerns: This is a measure will be difficult for facilities to track and does not necessarily improve care. Patients with ESRD may lose immunity to Hepatitis B, despite previous immunization. In fact, CDC guidelines recommend monitoring Hepatitis B s Ab annually and providing additional doses of vaccine if it is negative. So measuring whether or not a patient received 3 or more doses does not accuratly reflect practice to minimize risk for Hepatitis B infection.

E0004: While the MAP recommended support for this measure, we do have the following concerns: This measure places the burden of AOD treatment on the dialysis facility, rather than the primary care physician or medical home. A process measure for screening of AOD might be appropriate, but requiring the facility to document referral is beyond the scope of their care and minimizes efforts to coordinate care through the medical home.

XDEGC: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: This is a reasonable measure and a pediatric nephrologist served on this TEP.

E0420: While the MAP recommended support for this measure, we do have the following concerns: In theory, this is a reasonable measure, but the questions is at what point in a visit is the assessment performed? For example, patients may begin a hemodialysis session with no pain, but experience cramping or nausea as the procedure continues. Would facilities be required to perform the assessments on multiple occassions during a treatment? Some patients receive treatment 4 to 5 times a week, so the assessment must be done at each visit? This seems like a significant burden that would not necessarily improve patient care.

XCBMM: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: This is a reasonable measure and a pediatric nephrologist served on this TEP.

E0418: We concur with the MAP's recommendation to support this measure.

XDEFH: While the MAP recommended to not support this measure, we do offer the following comments: This is an important measure but very difficult to implement and could potentially lead to inappropriate or repeat immunization, since it relies on documentation of previous PCV13 (not PCV7) or pneumovax. In addition, the exclusion of pts who received PPSV23 in the last 12 months is not appropriate for children. Only in adults is it recommended that PCV13 not be given within one year of PPSV23. The CDC guidelines recommend a delay of 8 weeks. . Given the relatively recent changes to the immunization guidelines, it would be reasonable to delay implementation of this measure.

XDEGB: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: This is a reasonable measure, but might be difficult to monitor. That is, for a unit treating 120 patients, all of whom must be seen by a dietician each month, must the unit review the 6 months worth of dietician's notes to determine if the measure was met. Also, there are some patients who have normal phosphorus, especially infants, for whom this counseling may not apply.

XDGAM: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: This is a reasonable measure and a pediatric nephrologist served on this TEP.

XAHMH: We concur with the MAP's recommendation of conditional support for this measure and offer the following comment: This would be very difficult to implement and assumes the UFR for a single session reflects the care provided thrice weekly.

XDFFA: We concur with the MAP's support of this measure. We belive the measure is appropriate and should remain as it is.

XDAEH: We concur with the MAP's support of this measure. We belive the measure is appropriate and should remain as it is.

XDAEH: We concur with the MAP's support of this measure. We belive the measure is appropriate and should remain as it is.

XCHGG: We concur with the MAP's support of this measure. We belive the measure is appropriate and should remain as it is.

XDFGB: We concur with the MAP's support of this measure. We belive the measure is appropriate and should remain as it is.

Association of Rehabilitation Nurses

Kristen Mauk

Re: Pre-Rule Making Report for Post-Acute and Long-term Care Performance Measurement Programs

ARN concurs with the Measure Application Partnership's (MAP) intention and desire to align measures across the post-acute care continuum when possible.

ARN does not support the indicators MUC ID #E1717 – Clostridium difficile infection (CDI) and MUC ID # E1716 – Methicillin Resistant Staphylococcus aureus (MRSA) bacteremia. The purpose of rehabilitation is to promote functional recovery and achievement of goals by patients so that they may function to their maximal potential in the least restrictive environment. These indicators do not represent the quality or outcomes of rehabilitation programs. Furthermore, the incidence of these conditions occurring in rehabilitation is extremely rare. If a patient in rehabilitation has either condition, generally it is something that is present on admission from transfer from acute care. The inclusion of these indicators as so called "quality measures" may cause rehabilitation facilities to inappropriately screen for these conditions.

ARN requests that NQF use correct terminology with respect to patients – specifically MUC ID E #E0674 uses the term "resident". Inpatient rehabilitation patients are referred to as patients – not residents.

The Inpatient Rehabilitation Facility Quality Reporting System could be greatly enhanced by further developing and expanding core measures such as mobility and self-care. ARN supports these indicators with the caveat that they are risk-adjusted and diagnosis/impairment group specific with definitive inclusion/exclusion criteria.

While ARN agrees with the MAP's intention to align measures whenever possible, we do not support measures that are not clinically relevant or representative for a given setting or patient population - measures must be meaningful in order to be useful. ARN would further advocate that whatever measures are selected, that the collection (and reporting) of such measures does not present an undue burden on the organizations or facilities implementing them. With the latest proposed measures, once again, a burden is added to the facility to collect and submit measures that do not all provide information on the quality or outcomes of rehabilitation.

Finally, ARN suggests that NQF adopt a process or system that obtains actual patient input – similar to what Patient Centered Outcomes Research Institute has in place. Specifically, can NQF be confident that actual patients are asking for this information and measures?

California Hospital Association

Alyssa Keefe

As previously noted, CHA is concerned with the MAP recommendations of conditional support for what clearly are measurement concepts. We do support the MAP calling for more functional outcome measures in the area of inpatient rehabilitation but remain concerned that the measures under consideration lack sufficient information to make informed decisions regarding their readiness for inclusion in the program. Rather the information provided was more of a measure concept than an actual measure suitable for reporting. Therefore we ask that all measures that were conditionally supported by the MAP be reconsidered at a future date to ensure that when fully vetted through the NQF process that they indeed meet the measure gaps and are appropriate for inclusion in the programs.

Kidney Care Partners

Lisa McGonigal

Thank you for the opportunity to comment on the Measure Applications Partnership (MAP)'s draft Pre-Rulemaking Report. Kidney Care Partners (KCP)is a coalition of members of the kidney care community that includes the full spectrum of stakeholders related to dialysis care—patient advocates, health care professionals, dialysis providers, researchers, and manufacturers and suppliers—organized to advance policies that improve the quality of care for individuals with chronic kidney disease and end stage renal disease (ESRD). We greatly appreciate the MAP undertaking this important work.

Twenty-one[1] of the Measures Under Consideration

(MUCs) submitted to the MAP by the Centers for Medicare and Medicaid (CMS) on November 27, 2013, are proposed for use in the ESRD Quality Incentive Program (QIP), and consequently are of particular interest to KCP. In reviewing these measures, we offer the following comments.

I. KCP supports both proposed pediatric peritoneal dialysis measures, Achievement of Target Kt/V (MUC-XCBMM)and Frequency of Measurement of Kt/V (MUC-XDGAM); however, we appreciate and fundamentally concur with the MAP's general principle of reserving its full support for NQF-endorsed measures and urge NQF to consider these important measures expeditiously.

(CONTINUED)

[1]We note that MAP posted only 20 measures on the web site for early comment and that only because KCP has a representative on the LTC-PAC Workgroup did we become aware that CMS had forwarded an additional item. We strongly recommend that when addendums to the list are made, they become immediately available through a public posting.

I. KCP notes that 10 of the 21 proposed ESRD QIP measures cannot be adequately evaluated because of a lack of essential information. Specifically, the measures are either a) not yet fully specified (i.e., "in development") or b) reliability and validity testing information for the measures is either not available or is asserted as not necessary.

a) MUC-XDGAF: Hepatitis B Vaccine Coverage in Hemodialysis Patientsis noted by the measure developer (CMS) as being "in development" at this time and as such, full measure specifications are not available for review. Consequently, KCP cannot adequately evaluate the technical aspects and merits of this measure and thus opposes its advancement for any purpose.

b) Seven MUCs have not been tested for reliability or validity by CMS because the data elements necessary for testing are "not currently required and/or available" in the CROWNWeb data repository:

MUC-XDEFM: ESRD Vaccination–Full-Season Influenza Vaccination

MUC-XDEGA: ESRD Vaccination–Timely Influenza Vaccination

MUC-XDEFH: ESRD Vaccination–Pneumococcal Vaccination (PCV13)

MUC-XDGBA: ESRD Vaccination–Lifetime Pneumococcal Vaccination

MUC-XDEFL: ESRD Vaccination–Pneumococcal Vaccination (PPSV23)

MUC-XDEGB: Percentage of Dialysis Patients with Dietary Counseling

MUC-XDEGC: Measurement of Plasma PTH Concentration

(CONTINUED)

[1] Kidney Care Partners. August 19, 2013 Letter to CMS on Proposed TEP Measures. http://kidneycarepartners.com/files/2013-08-tep-comments.pdf. Last accessed December 20, 2013.

II.b. (continued)

Two additional MUCs (XDEFF: Surface Area Normalized Standard Kt/V Reporting Measure and XDEFE: Standard Kt/V Reporting Measure) have not been tested on the premise that reliability and/or validity testing is not applicable or necessary because the measures are "reporting measures" ("N/A—Reporting measure"). As noted in our August 19, 2013, letter[1] to CMS on the proposed measures developed for the Agency by Arbor Research, KCP is particularly troubled by this assertion.

As the MAP is aware, NQF requires testing data before it will consider measures for endorsement because it considers the criterion "Scientific Acceptability"—i.e., validity and reliability—to be an essential component of a measure's properties. NQF describes reliability and validity testing at either the data element level or the level of the computed measure score, as follows:

Reliability of data elements refers to repeatability and reproducibility of the data elements for the same population in the same time period. Validity of data elements refers to the correctness of the data elements as compared to an authoritative source. Reliability of the measure score refers to the proportion of variation in the performance scores due to systematic differences across the measured entities (or signal) in relation to random error (or noise). Validity of the measure score refers to the

correctness of conclusions about the quality of measured entities that can be made based on the measure scores (i.e., a higher score on a quality measure reflects higher quality).

KCP upholds that the mere fact that data elements must be reported does not mean they can be reliably reported; it is incumbent upon CMS, the measure developer, to demonstrate this. As important, NQF measure testing guidance notes that even if data elements can be reliably reported, it does not necessarily follow that they are indicative of, or have an impact on, health care quality—i.e., that they are valid. Pursuant to NQF's measure testing guidance, KCP asserts that if CMS wishes to proceed with these measures, it should demonstrate through testing that the specified data can be reliably reported and that reporting of the data per se as a measure is valid indicator of quality. The notion that testing of the reporting measures is not applicable fails to recognize the purpose of validity and reliability testing.

Because we can assess neither reliability nor validity, KCP opposes advancement of these measures for any purpose.

[1] Kidney Care Partners. August 19, 2013 Letter to CMS on Proposed TEP Measures. http://kidneycarepartners.com/files/2013-08-tep-comments.pdf. Last accessed December 20, 2013.

III. KCP opposes MUC-XDEFM: Full-Season Influenza Vaccination of ESRD Patients because it is not aligned with the NQF-endorsed standardized specifications for influenza immunization measures. Further, as noted by the MAP, KCP reiterates that a dialysis facility-level measure already exists in the NQF portfolio that fully aligns with the NQF-endorsed standardized specifications: #0226 Influenza Immunization in the ESRD Population.

First, we note that the dates contained in the measure description differ from those specified in the numerator—October 1-March 31 versus August 1-March 31, respectively, making it difficult to evaluate the developer's (CMS) intent.

Second, KCP opposes advancing the proposed Full Season Influenza Vaccination in ESRD Patients measure because we believe that CMS should work within the NQF rubric to seek modifications it wishes to pursue. We object to the assertion that the measure is "harmonized" with the standardized specifications from the 2008 NQF report: It is not. Specifically, this measure does not follow the NQF standardized specifications for the measurement timeframe of "October 1 through March 31 or whenever the vaccination is first available." KCP supports the current NQF-endorsed measure (#0226 Influenza Immunization in the ESRD Population, developed by the Kidney Care Quality Alliance [KCQA]), which fully aligns with NQF's standardized specifications for influenza and pneumococcal vaccinations. These specifications were developed at the behest of and funded by CMS to address the plethora of care site-specific, varying specifications. [1] As part of the Population Health/Prevention Maintenance project, NQF #0226 was most recently reviewed in early 2013 against the standardized specifications and found to comport with them, and its NQF endorsement was maintained.

We recognize that measurement specifications, like evidence, evolve. However, we believe CMS and the kidney care community are best and most efficiently served if CMS conforms to existing NQF processes to address full-season influenza vaccination performance measurement. Specifically, if CMS believes the evidence supports the changes its specifications encompass, it should work with KCQA, and use the NQF endorsement maintenance process to request that NQF #0226 deviate from the standardized specifications or that the standard specifications themselves be updated.

[1]NQF. National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations: A Consensus Report. Washington, DC, 2008. www.qualityforum.org. Last accessed December 13, 2013.

IV. KCP opposes MUC-XAHMH: Ultrafiltration Rate >10 ml/kg/hr.

First, we note a discrepancy between the target ultrafiltration rate (UFR) stated in the measure description and that specified in the numerator (>10ml/kg/hr and >13ml/kg/hr, respectively), making it difficult to evaluate the developer's (CMS) intent.

Second, as noted in our August 19, 2013, letter to CMS on the proposed measures developedfor the Agency byArbor Research,[1] KCP opposes this

measure for multiple reasons—the most salient of which is that the current body of knowledge on UFR does not rise to a level of evidence to support a performance measure. For example, recent research that examined UFR linearly in relation to body size found that at the high end there was a preponderance of patients with small body size and at the low end, patients had a preponderance of large body size.[2] A logical conclusion of these findings is an uncertainty that rate of removal is the appropriate measurement of quality.

[1] Kidney Care Partners. August 19, 2013 Letter to CMS on Proposed TEP Measures. http://kidneycarepartners.com/files/2013-08-tep-comments.pdf. Last accessed December 20, 2013.

[2]Abstract accepted for poster presentation, American Society of Nephrology, November 2013. Currently under ASN embargo.

V. KCP strongly opposes advancement of the Comorbidities Reporting Measure (MUC ID not assigned) for use in the ESRD QIP.

First, KCP objects to the fact that the Comorbidities Reporting Measure was not on CMS's list of MUCs submitted to the MAP on November 27, 2013. Because of this oversight, stakeholders were unable to submit early comments on the measure, thereby depriving the MAP of potentially valuable input and varied perspectives prior to its deliberations.

Second, KCP notes that the proposed comorbidity "measure" is not truly a quality measure per se, which NQF defines as "a standard: a basis for comparison; a reference point against which other things can be evaluated; they set the measure for all subsequent work… v. To bring into comparison against a standard."[1] NQF further states that "[p]erformance measures give us a way to assess healthcare against recognized standards."[2] In addition, NQF has established a clear set of criteria that it applies when evaluating measures. Four of the fundamental components are:

Having a high impact on an aspect of care, addressing a demonstrated performance gap and presenting an opportunity for improvement in care, and being grounded in evidence supporting the relationship of the outcome to a process or structure of care (Impact, Opportunity and Evidence);

Containing data elements that produce the same results a high proportion of the time when assessed in the same population in the same time period; having specifications that are consistent with the evidence to support the focus of the measure; having been the subject of testing validating that the data elements and measure scoring are correct; containing necessary exclusions supported by clinical evidence or sufficient observation; for outcomes-based measures, including a specified evidence-based risk-adjustment strategy; demonstrating that methods for scoring and analysis are statistically significant; and allowing for identification of disparities if identified through stratification of results (Reliability and Validity);

Demonstrating that the intended audience (beneficiaries, purchasers, providers, and policymakers) can understand the results and find them useful for decision-making (Usability); and

Having data that are readily available or could be captured without undue burden (Feasibility).[3]

[1]NQF. ABCs of Measurement. http://www.qualityforum.org/Measuring_Performance/ABCs_of_Measurement.aspx. Last accessed December 20, 2013.

[2]Id.

[3]NQF. Measure Evaluation Criteria. http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx. Last accessed December 20, 2013.

The proposed comorbidity measure does not meet the definition of a measure because it is not establishing a true standard. Rather, the measure will be used to gather comorbidities data that will be used to risk adjust CMS's standardized mortality ratio (SMR) and standardized hospitalization ratio (SHR) measures. While KCP applauds CMS for recognizing the need for risk adjustment with these outcome measures, we oppose using the QIP as a data collection mechanism. Such use is inconsistent with the statutory mandate and would establish an inappropriate precedent that anytime the Agency sought data it could impose an unfunded mandate on facilities to provide data under the guise of value-based purchasing programs. The Social Security Act authorizes CMS to establish measures against which to judge facility performance; it does not authorize data collection.[1]

Third, because dialysis facilities rarely have complete information on patient comorbidities, KCP asserts that the provider burden of the proposed Comorbidities Reporting Measure would be substantial. Additionally, we note that the measure would be a wholly unnecessary burden for facilities, given that CMS already has the most up-to-date co-morbidity patient-level data available in its own Common Working File.

Fourth, KCP notes that the Comorbidities Reporting Measure has not been subject to testing or evaluation to ensure reliability or validity. Pursuant to NQF's measure testing guidance, KCP asserts that if CMS wishes to proceed with this measure, it should demonstrate through testing that the specified data can be reliably reported and that reporting of the data per se as a measure is valid indicator of quality.

Finally, as was discussed by the MAP PAC/LTC Workgroup during its December 10, 2013 in-person meeting, KCP notes that the Comorbidities Reporting Measure was not supported by the Technical Expert Panel (TEP) convened by Arbor Research at the behest of the developer (CMS). As did the PAC/LTC Workgroup, KCP objects to the advancement of this measure for consideration as a QIP measure when the developer's own TEP questioned the technical merits of the measure and ultimately opposed it. We believe that discrepancies such as this necessarily bring into question the soundness and validity of the QIP measure selection process.

Because of these myriad issues, KCP opposes advancement of the proposed Comorbidities Reporting Measure for any purpose.

[1]42 U.S.C. § 1395rr(h).

VII. KCP offers the following comments on the five measures endorsed by NQF for other purposes and levels of analyses, as well as measure endorsed at the facility level.

MUC-E029: Counseling on Physical Activity in Older Adults: 1) Discussing Physical Activity, and 2) Advising Physical Activity. KCP opposes this measure for the QIP. While recognizing the importance of physical activity, generally, we note that, although NQF-endorsed (NQF #0029), this is a check-box measure and question its impact, especially in light of other quality domains. We also note that the KDQOL, which is required under the Conditions for Coverage, has a physical activity component. Thus while we have concerns about the KDQOL and oppose its inclusion in the QIP, which is the MAP's focus, we note the measure's focus is already incorporated in the overall ESRD program by inclusion in the Conditions for Coverage. Finally, we note that the measure is NQF-endorsed at the health plan and population levels, and question its validity, reliability, and impact in dialysis facilities.

MUC-E0393: Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia. Hepatitis C is an important disease and identifying patients with hepatitis C is clearly of concern. However, KCP opposes this measure, which is endorsed at the physician level and has not been tested in dialysis facilities, for use in the QIP. Specifically, KCP does not believe that the focus of this measure, RNA polymerase testing, is appropriate for or applicable to dialysis facilities. While we note that HCV antibody testing is within the purview of facilities, RNA testing is typically performed by applicable specialists (e.g., gastroenterologists, hepatologists) upon referral of a patient for positive antibodies—as borne out by the AMA PCPI's development of this measure for physician-level implementation and NQF's endorsement (NQF #0393) for such.

VI. KCP opposesMUC-E0260: Assessment of Health-Related Quality of Life (Physical and Mental Functioning—KDQOL-36) measure for inclusion in the QIP.

KCP recognizes the importance of—and strongly supports—capturing information on patients' quality of life, but opposes use of RAND's Kidney Disease Quality of Life (KDQOL) instrument in the ESRD QIP. KCP notes that the KDQOL is already required by the Conditions for Coverage; we thus question how enactment of a measure for a process that is already required and surveyed will further improve patient care.

Additionally, absent validation at the patient-level or risk/case-mix adjustment, KCP believes the KDQOL it is not an appropriate measure for the penalty-based QIP. Further, KCP is unaware of peer-reviewed evidence that interventions undertaken as part of dialysis care result in clinically important or statistically significant changes in the domains

reflected in the survey score. Finally, we note that the KDQOL was originally validated on 165 patients in 1997.[1] As dialysis patients are known to have greater disease burden today than 17 years ago, we believe it would be prudent to revalidate the instrument in a large, more contemporary dialysis population.

[1]Mayne T, Dunn D, Marlowe G, Schatell D. Revalidation of the Kidney Disease Quality of Life Questionnaire (KDQOL). Davita, Inc. Denver, CO; MEI, Madison, WI. Abstract presented at ASN's 2010 Renal Week. https://www.asn-online.org/. Last accessed January 16, 2014.

VII. (continued)

MUC-E0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. KCP opposes this measure for inclusion in the QIP. KCP does not mean to imply through its opposition that the measurement area overall is unimportant. However, we again note that NQF endorsed this measure (NQF #004) for use at the health plan and population levels. KCP asserts this measure is not feasible; facilities do not collect this data, a fact that would have been elucidated by testing.

MUC-E0420: Pain Assessment and Follow-Up. KCP recognizes that pain is common and believes that a pain assessment should be part of the evaluation of every patient. However, the proposed measure was endorsed (NQF #0420) as a clinician-level measure and is not appropriate for use in dialysis facilities. Pain is a particularly complex issue in the dialysis setting, in which chronic and acute pain oftentimes coexist. While the dialysis facility must respond immediately to pain related to the dialysis procedure itself, the measure does not address this issue. Rather, the measure focuses on the strict monitoring by the dialysis facility of broader pain management regimens that can only be appropriately addressed by the physician. KCP's beliefs that chronic pain must be addressed by the physician and that use of this measure at the facility level is inappropriate are reflected by NQF's endorsement of this measure at the clinician level. KCP further notes that a dialysis-specific measure may be appropriate through an internal quality improvement approach, but not for the QIP.

VII. (continued)

MUC-E0418: Screening for Clinical Depression. KCP is acutely sensitive to the importance of clinical depression in ESRD patients, and notes that mental health is always an issue with chronic illness. However, we again note that despite our previously identified concerns and our opposition to its inclusion in the QIP, the KDQOL, required by the Conditions for Coverage, in fact includes a mental health assessment component that addresses depression in the dialysis setting. We further believe that dialysis facility social workers are already quite attuned to the need to assess patients for depression. Combined with the required use of KDQOL, an informal, small sampling of KCP members suggests that depression assessment—with a documented plan of care—already occurs to a significant, nearly universal, degree within dialysis facilities.

Nevertheless, KCP opposes the inclusion of this measure (NQF# 0418) in the QIP for the following reasons.

- First, the measure was endorsed as a clinician-level measure and is not appropriate for use in dialysis facilities. The follow-up component of the measure necessarily requires action (e.g., referral) by the nephrologist—not the facility. This is again borne out by NQF endorsement at the clinician level. We believe additional testing at the dialysis facility level should be pursued before performance measurement is incorporated into the QIP so as to avoid unintended consequences.[1]
- Second, we note that this is merely a screening and documentation measure—a "check box" measure—that does not address the critical issues of implementing treatment and assessing consequent outcomes. As such, KCP believes that the measure would do very little to actually improve care.
- Finally, there are limited data on the pharmacotherapeutic treatment of depression in patients with ESRD, and even less data to support the role of cognitive behavioral therapy and social support group interventions.[2] Prior to implementing such a measure in the dialysis facility setting, therefore, KCP believes that larger randomized, controlled clinical trials aimed at the treatment of depression in patients with ESRD are needed.

[1]Kravitz RL, Franks P, Feldman MD, et al. Patient

engagement programs for recognition and initial treatment of depression in primary care: a randomized trial. JAMA. 310(17):1818-1828, 2013.

[2] Kimmel P, Cohen S, Peterson R. Depression in patients with chronic renal disease: where are we going? J Ren Nutr. 2008;18(1):99-103.

VII. (continued)

MUC-E0431: Influenza Vaccination Coverage Among Healthcare Personnel. KCP believes that influenza vaccination of health care personnel, the focus of this measure, is an important public health concept. We also note that NQF #0431, developed by the Centers for Disease Control and Prevention (CDC), has been tested in dialysis facilities. However, the measure specifications proposed to MAP by CMS differ from those of CDC's. We strongly object to CMS's pattern of denoting that measures are NQF-endorsed when, in fact, transmitted specifications differ from those of the measure steward's. Specification details are important—validity and reliability testing were performed on the endorsed specifications. We further note that some of CMS's alterations deviate from the NQF-endorsed standardized specifications for influenza vaccination measures, and we oppose such deviations. While we do support the deviation eliminating the requirement for written documentation, we note that this is a significant change resulting in a new measure—the performance gap information alone is likely to be quite different. CMS should either work with the developer (CDC) to change and seek an updated NQF endorsement or address and justify why it is proposing to use a new measure—and cease referring to it as NQF endorsed. Finally, KCP also has concerns about implementation and feasibility of what CMS has proposed, even with the new specifications—in particular, the requirements related to the third part of the denominator, adult students/trainees and volunteers.

National Kidney Foundaton

Joseph Vassalotti, MD

E0029

We do not feel that this rises to the level of a dialysis facility quality measure. Counseling alone will not improve outcomes for patients.

XDGAF

We suggest CMS identify whether a current gap in care among dialysis patients exists that would warrant the need to include this as a performance measure. If CMS moves forward with development of this measure we suggest alignment with the CDC recommendations for hemodialysis and peritoneal dialysis patients, which include recommendations on when re-vaccination is necessary.

E0393

NKF supports moving forward with testing this measure for use in the dialysis facility. However, the measure should specify testing only when HCV antibodies are detected.

E0004

NKF opposes moving forward with this measure for use in the QIP. While dialysis facilities may see patients more than any other care provider they are not equipped to identify or treat alcohol and drug dependence.

XDEGC

NKF supports the direction of this measure, however as currently proposed it requires unnecessary testing when PTH values are in the normal range. The KDOQI U.S. commentary on the KDIGO guidelines recommends PTH testing intervals every 3-6 months, based on the frequency of abnormalities. Testing at least every three months is only recommended when PTH levels are abnormal or when treatment for CKD-MBD has been initiated – when PTH levels are normal less frequent testing, every 6 months, is acceptable. We suggest CMS modify this measure accordingly.

E0431

NKF supports this measure for use of an influenza vaccination among healthcare personnel.

E0420

NKF supports this measure as it is important for a properly trained health care worker, we recommend a technician, nurse, or physician or advanced practitioner, to ask at every treatment whether the patient is experiencing pain, to have the patient rate their pain, and for the nurse, physician, or advanced practitioner to try and assess the root

cause. We further agree that the pain, its source, and recommended treatment be documented in the patients care plan and that a referral to a specialist be made when appropriate.

E0418

We agree with MAP findings that the Beck Depression index has been validated to evaluate depression in dialysis patients and would serve as a good tool for dialysis facilities to use to assess depression. Dialysis facility social workers ware equipped and trained to employ strategies to improve depression by providing education and counseling. However, severe depression needs to be referred to a mental health practitioner for further diagnosis and treatment.

E0260

This is currently a requirement of the Medicare Conditions for Coverage and we recommend the agency look at other measures that are actionable by dialysis facility staff that will improve patients' quality of life.

Measures Under Consideration for the ESRD QIP

NKF believes all performance and reporting measures need to be tested for validity and reliability before they are used in a quality program that ties measure performance to payment, this is true even when those measures are based on clinical guidelines. However, we recognize that many of the MUCs are in the process of further development and or testing and therefore offer the following comments on the potential of the measures to improve kidney care.

We previously submitted comments to MAP during the preliminary comment period and to Arbor Research during the TEP process for measures to be used in the ESRD QIP. Our comments on those measures can be found in Appendix A.

E0029 Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity

While the KDOQI guidelines support counseling all dialysis patients on the need for physical activity, including those under age 65, we do not feel that this rises to the level of a dialysis facility quality measure. Counseling alone will not improve outcomes for patients and "unique challenges to exercise in dialysis patients need to be identified in order to refer patients appropriately (e.g., to physical therapy or cardiac rehabilitation) and to enable the patients to follow regimens successfully. Such challenges include orthopedic/musculoskeletal limitations, cardiovascular concerns, and motivational issues." Physical activity counseling, assessment and need for referral should be a component of the patients care plan, but at this time we cannot justify moving forward with a measure that is age limited and for which the dialysis facility staff can do little to improve patient outcomes.

XDGAF Hepatitis B vaccine coverage in hemodialysis patients

NKF questions whether there is a current gap in care to warrant inclusion of this measure in the QIP. While Hepatitis B was a concern in past years, today screening and infection control requirements included in the Medicare Conditions for Coverage for dialysis facilities and the availability of the vaccination have significantly reduced incidences of Hepatitis B outbreaks in dialysis facilities. We suggest CMS identify whether a current gap in care among dialysis patients exists that would warrant the need to include this as a performance measure. In addition, if CMS moves forward with development of this measure we suggest that CMS align its measure with the recommendations by the Centers for Disease Control for hemodialysis and peritoneal dialysis patients, which include recommendations on when revaccination is necessary for dialysis patients.

E0393 Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia

NKF supports moving forward with testing this measure for use in the dialysis facility. Confirming the presence of Hepatitis C provides information that the dialysis facility needs in order to reduce the risk of transmission. Confirmed infection of hepatitis C also has implications for the patient's kidney transplant evaluation and candidacy. However, the measure should specify testing only when HCV antibodies are detected.

E0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

NKF opposes moving forward with this measure for use in the QIP. While it is an important public health measure it is unclear if the scope of the problem

warrants including this measure in the performance program. In addition, while dialysis facilities may see patients more than any other care provider they are not equipped to identify or treat alcohol and drug dependence.

XDEGC Measurement of Plasma PTH

NKF supports the direction of this measure, however as currently proposed it requires unnecessary testing when PTH values are in the normal range. The KDOQI U.S. commentary on the KDIGO guidelines recommends PTH testing intervals every 3-6 months, based on the frequency of abnormalities. Testing at least every three months is only recommended when PTH levels are abnormal or when treatment for CKD-MBD has been initiated – when PTH levels are normal less frequent testing, every 6 months, is acceptable. We suggest CMS modify this measure accordingly.

Given that PTH levels are not currently recorded by CMS and that there is controversy over variance among assays, we support renewed collection of PTH through modification of this measure. However, we believe that developing a composite measure for phosphorus, calcium and PTH is the best way to improve patient outcomes related to mineral and bone disorder. The biochemical regulation of serum levels of phosphorus, calcium, and PTH is highly interdependent, and maintaining clinically appropriate levels of all three requires careful balancing of diet and medications. Including oral phosphorus binders and calcimimetics into the bundled ESRD PPS in 2016, as CMS proposes, will significantly change the economics in treatment for mineral and bone disorder. As a result, there is an urgent need for a composite quality measure that looks at all three of these interrelated elements that are proven to contribute to hospitalization and mortality in patients. NKF strongly recommends CMS work with experts in the kidney community to develop a composite phosphorus/calcium/PTH measure, as it would be much more likely to improve patient outcomes than any measure that evaluates just one of these parameters.

E0431 Influenza Vaccination Coverage Among Healthcare Personnel

NKF supports this measure for use of an influenza vaccination among healthcare personnel as it is important to help protect patients from the spread of influenza and its serious side effects.

E0420 Pain Assessment and Follow-Up

Pain is highly prevalent in dialysis patients and often is underdiagnosed and undertreated. One prospective cohort study found that 50% of hemodialysis patients report experiencing pain. Effective pain management is paramount to patients' quality of life. NKF supports this measure as it is important for a properly trained health care worker, we recommend a technician, nurse, or physician or advanced practitioner, to ask at every treatment whether the patient is experiencing pain, to have the patient rate their pain, and for the nurse, physician, or advanced practitioner to try and assess the root cause. We further agree that the pain, its source, and recommended treatment be documented in the patients care plan and that a referral to a specialist be made when appropriate.

E0418 Screening for Clinical Depression

NKF recognizes that rates of depression among dialysis patients are significantly higher than that of the general population. Depression is associated with higher mortality and poor outcomes for dialysis patients. In conversations, with members of our council of nephrology social workers we have found that most are assessing and documenting depression, however, the process for which they do so varies. The Kidney Disease Quality of Life survey includes two questions related to depression. Many facilities use this tool as an initial assessment of depression, which is then followed up by a more thorough evaluation. We agree with MAP findings that he Beck Depression index has been validated to evaluate depression in dialysis patients and would serve as a good tool for dialysis facilities to use to assess depression. Dialysis facility social workers who have their master degrees in social work are equipped and trained to employ strategies to improve depression by providing education and counseling. However, severe depression needs to be referred to a mental health practitioner for further diagnosis and treatment. Unfortunately, social workers and patients report lengthy waiting periods and great difficulty in accessing mental health practitioners, which is a tremendous barrier to getting treatment. Regardless, of this barrier and we believe screening and

developing an appropriate care plan is an appropriate expectation of the dialysis facility.

E0260 Assessment of Health-related Quality of Life (Physical & Mental Functioning)

NKF agrees that assessing dialysis patients' quality of life is important to their overall health and well-being. However, this is currently a requirement of the Medicare Conditions for Coverage and we therefore do not feel this is a helpful measure to include in the QIP. Simply surveying patients does not lead to a course of action nor does it improve outcomes. We recommend the agency look at other measures that are actionable by dialysis facility staff that will improve patients' quality of life.

National Partnership for Women & Families

Alison Shippy

The Consumer-Purchaser Alliance (C-P Alliance) applauds MAP's support of two measures for the home health quality reporting program that address important issues around care coordination, including Rehospitalization During the First 30 Days in Home Health and ED Use Without Hospital Readmission During first 30 days of Home Health. Additionally, we appreciate MAP's emphasis on the importance of harmonizing measures across settings. For instance, we support the recommendation to include a falls measure in the IRF Quality Reporting Program, but were disappointed that the group did not further discuss strategies for ensuring the measure is specified and tested in the short-term. It would have been useful to garner feedback whether there are existing fall measures that are already being used for local quality improvement that might be appropriate for NQF review. Ultimately, our recommendation is that MAP strives to provide actionable recommendations around filling measure gaps quickly.

Renal Physicians Association

Robert Blaser

ESRD-QIP Measures

There are many measures which address care that goes beyond the scope of the ESRD facility and are therefore of questionable appropriateness for the ESRD QIP. For greater detail, please refer to the Kidney Care Partners (KCP) comment letter.

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

Uniform Data System for Medical Rehabilitation

Beth Demakos

UDSMR's Commentto the Measures Applications Partnership Pre-Rule Making Repor for Post-Acute Care and Long-Term Care Performance Measurement Programs

With over 830 subscribing inpatient rehabilitation facilities, Uniform Data System for Medical Rehabilitation (UDSmr) welcomes the opportunity to comment on the Measures Applications Partnership Pre-Rule Making Report: Public Comment Draft, which was released in January 2014.

UDSmr applauds the National Quality Forum for its work in measuring and reporting performance for quality improvement. We have been measuring physical and cognitive function and reporting benchmarks based on functional changes for over twenty-five years, and we believe functional health deserves measurement that advances the quality of healthcare.

For several years, we have observed that the MAP Measures under Consideration have pertained primarily to process measures. Although some of these measures may relate to quality in other settings, many of these measures are not relevant in an IRF setting, and we are concerned by the increased administrative burden of collecting data that does not measure quality in patients treated at an IRF setting. We understand the desire to align measures across post-acute venues, but we believe these measures should be relevant and applicable to all post-acute venues. Additionally, process measures are highly limited in scope and are not preferred in measuring quality of care.

It is our position that the current versions of MUC #1716 Endorsed National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure and MUC #1717 NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure do not measure quality in an inpatient rehabilitation facility. Our inpatient rehabilitation data from the first three quarters of 2013 includes 324,352 patients discharged from an IRF, and it includes a very small percentage of reported cases of either infection:

1.4% have a MRSA code as a comorbidity, indicating the patient had the infection upon admission to the IRF.

0.2% have a MRSA code as a complication, indicating the infection was diagnosed during the IRF stay.

1.7% have a C. diff. code as a comorbidity.

0.4% have a C. diff. code as a complication.

The incidence and prevalence of these infections in an inpatient rehabilitation facility are very low. We agree that they are important to document and monitor, but we maintain that the measures do not indicate the quality of care.

We also have observed that the MAP has several functional measures that have been listed as "still in development" or "not ready for implementation: data sources do not align with program's data sources." We urge you to consider the FIM® instrument to measure functional quality and outcomes in post-acute care. The FIM® instrument has been used across all post-acute care settings and is already being used by CMS for theIRF Prospective Payment System. The FIM® instrument has long been recognized as the industry standard for measuring each patient's function and patient burden of care in terms of hours. It has been thoroughly tested for validity, reliability, responsiveness to change, feasibility of use, and meaningfulness in the clinical setting when administered by a trained and tested assessor.

The FIM® instrument, which takes fifteen to twenty minutes to administer, can help rehabilitation clinicians set treatment goals and manage care. It has been incorporated into hundreds of research studies. We understand the FIM® instrument does not measure every aspect of quality of care, but the instrument has a long-track record of success in measuring functional change in the inpatient rehabilitation, skilled nursing, and long-term care hospital settings.

UDSmr has begun several prospective pilot research studies with healthcare systems that have incorporated the FIM® Instrument and its derivatives in their acute hospitals, IRFs, skilled nursing facilities, long-term care hospitals, and home health agencies to measure function in patients across settings. Preliminary results demonstrate the ability of the instruments to measure functional change over time. In addition, one of these derivatives, the AcuteFIM™ instrument, is being used in acute care hospitals to assess patient functional status and as a discharge placement instrument.

A lot of time, money, and effort have been spent on creating new functional measures that are intended to closely resemble the FIM® instrument. These new measures have been incorrectly referred to as "analagous" to the FIM® instrument, but they do not have the longevity of FIM® instrument, which has been used for twenty-five years. They also lack the research that demonstrates their reliability, validity, stability, and utility. By contrast, hundreds of peer-reviewed journal articles have used the FIM® instrument and can reference the psychometric properties of the tool. The FIM® instrument has been shown to have predictive validity (the highest form of validity), whereby it can be used to predict length of stay (resource utilization), discharge placement (the need for additional health care resources), and functional gain (improvement and the quality and outcome of rehabilitation).

Recreating the wheel is a very timely and expensive process. The FIM® instrument has been offered to CMS free of charge, so it can be used with no additional cost.

Section 6: General Comments

Alliance of Dedicated Cancer Centers

R. Donald Leedy

On behalf of the Alliance of Dedicated Cancer Centers (ADCC), we welcome the opportunity to respond with comments on the draft of the 2014 Measure Application Partnership (MAP) Pre-Rulemaking Report.

The ADCC comprises the eleven cancer centers that have a singular focus on cancer. The ADCC institutions are dedicated to advancing the nation's understanding of the causes, prevention, diagnosis, and treatment of cancer; providing innovative cancer therapies and the best possible care to patients; and, disseminating this knowledge to the community at large. The ADCC's members continuously collaborate to improve quality of care and outcomes for cancer patients, and our institutions and clinicians are national leaders on these issues.

We appreciate the thoughtful consideration that the MAP applied in its deliberations on the measures proposed for the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) program, as reflected in the draft Pre-Rulemaking Report—particularly since the existing timeline requires the MAP to review a large number of measures in a brief time period. We also commend the decision to allow for earlier public feedback through informal commenting, which the MAP considered in its deliberations. As the MAP continues to refine its process, we encourage activities like this that allow for greater public input and more rigorous review.

Of note, we believe that a shorter Measures Under Consideration (MUC) list allows the MAP and commenters more time to review the measures, and we encourage the Department of Health & Human Services (HHS) to continue this practice. We also encourage HHS to extend the MAP's review period to allow more time for commenters to deliberate thoughtfully on these measures and to provide more meaningful feedback. In addition, we urge the Centers for Medicare & Medicaid Services (CMS) to limit the MUC list to fully vetted and validated measures, since this timeline is insufficient for the MAP (and public commenters) to vet the measures' complete technical specifications.

As in years past, we have given the MAP's recommendations serious consideration and offer comments that we believe will assist the MAP in finalizing its recommendations for the PCHQR program. We trust that the MAP will give due consideration to our comments for the PCHQR program, as it applies solely to the ADCC member institutions.

Program Measure Set Characterization

- CMS-Proposed Measures The ADCC supports the intent of the six proposed measures under consideration for our program (See Table 1 and Appendix A). We believe that the proposed measures target key areas in care delivery and could ultimately improve outcomes. However, while we find some of the measures to be valuable, they require clearer definitions to be utilized effectively (See Table 1 and Appendix A). In addition, several proposed measures evaluate concepts, such as pain, that are already monitored on a consistent basis. Including these measures in our program offers questionable benefit to our patients while significantly increasing reporting burden. Instead, a stronger emphasis on outcome measures would be more valuable to efforts to improve quality and patient care.
- MAP-Proposed Measures We support the intent of the four measures recommended by the MAP for palliative care (See Table 2 and Appendix B). Such measures promote quality improvement during an important phase of the care continuum where patients tend to experience significant symptom burden, which, in some care settings, is poorly managed. However, as national leaders in cancer care, our palliative care teams already provide systematic management of pain and related symptoms for patients as a matter of course, and we do not consider this to be a gap requiring measurement at our institutions. The relevance of the proposed palliative care measures to our centers is also of concern. While most ADCC centers offer inpatient palliative care consults, some of our centers do not have a beds dedicated

to palliative care or a formal palliative care unit. Furthermore, some ADCC members do not offer inpatient palliative care services and, instead, refer patients to outside organizations to receive this service. Finally, our member hospitals do not provide hospice services. Thus, as written, these measures have little apparent relevance for our program.

Measure Validation Consistent with the MAP's recommendations, we do not support adoption of any measures that have not been vetted through a rigorous measure review process, such as the National Quality Forum's (NQF) measure endorsement process. The NQF measure endorsement process has been developed to ensure that measures selected for public reporting have been thoroughly evaluated for appropriateness, validity, and relevance. A process like this is necessary for any measures proposed for use in a federal reporting program.

- Sampling As noted in previous years, the ADCC supports adoption of an appropriate sampling methodology for measures that will require manual chart abstraction. While the currently proposed measures incorporate some electronic data elements, our review suggests that we would need to work outside of our existing processes to obtain some of the required data elements—a process that frequently requires manual chart review. We look forward to working with CMS to develop an appropriate sampling methodology for our program.
- Measure Redundancy The redundancy of certain measures would add undue burden to data collection, while offering questionable benefit for our patients. We note that a number of pain-related measures with slight, but meaningful, differences have been proposed for our program, in addition to two measures that were previously adopted by CMS (NQF #0383—Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology; and, NQF #0384—Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology). We strongly urge harmonization of these measures.

Below, we provide detailed recommendations related to the measure adoption process that CMS and the MAP have instituted (see Tables 1, Table 2, Appendix A, and Appendix B) as well as concerns with the proposed measures themselves. We would be happy to provide clarification or additional background for each of our concerns and recommendations, should the MAP require any clarification.

Again, we thank you for your thoughtful consideration of the proposed measures and for the opportunity to provide input into the 2014 MAP Pre-Rulemaking Report.

Table 1: ADCC Position on CMS-Proposed Measures

MUC ID	Measure Title	ADCC Position
E1822	External Beam Radiotherapy for Bone Metastases	Adopt with modifications; adopt a formal sampling methodology for this measure; we favor adoption of a patient-reported outcome (PRO) instrument as an alternative
XDCFE	Initiation of Osteoclast Inhibitors for Patients with Multiple Myeloma or Bone Metastases Associated with Breast Cancer, Prostate Cancer, or Lung Cancer	Postpone adoption until the measure has been through further testing and validation and a formal vetting process; formalize a sampling methodology for this measure
XDBLG	Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis	Postpone adoption until the measure has been through further testing and validation and a formal vetting process; formalize a sampling methodology for this measure
E1628	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Adopt a patient-reported outcome (PRO) instrument as an alternative that assesses multiple symptoms that impact quality of life (e.g., fatigue); if adopted, harmonize measure with other adopted pain-related measures and incorporate a formal sampling methodology for this measure
E0450	Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	Adopt with modifications; Incorporate appropriate risk adjustment for cancer-specific risks
XDDAF	Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy	Postpone adoption until the measure has been through further testing and validation and a formal vetting process; formalize a sampling methodology for this measure

Table 2: ADCC Position on MAP-Proposed Measures

MUC ID	Measure Title	ADCC Position
1634	Hospital and Palliative Care – Pain Screening	Adopt a patient-reported outcome (PRO) instrument as an alternative that assesses multiple symptoms that impact quality of life (e.g., fatigue); if adopted, harmonize measure with other adopted pain-related measures; adopt a formal sampling methodology and clarify the definition of "patient visit"
1637	Hospice and Palliative Care – Pain Assessment	Adopt a PRO instrument as an alternative that assesses multiple symptoms that impact quality of life (e.g., fatigue); if adopted, harmonize measure with other adopted pain-related measures; adopt a formal sampling methodology and clarify the definition of "patient visit"
0326	Advance Care Plan	Adopt with modifications; adopt a formal sampling methodology for this measure; modify measure to include all adult patients
1641	Hospice and Palliative Care – Treatment Preferences	Adopt with modifications

Appendix A: Input on CMS Proposed Measures

E1822: External Beam Radiotherapy for Bone Metastases

Position: Adopt with modifications described below.

Relevance: Multiple visits to a radiation facility make it difficult for patients who are in pain and for caretakers who provide their transportation. This measure would work towards eliminating the overuse/underuse of radiotherapy, thereby reducing unnecessary services for patients, while ensuring that they receive appropriate treatment to manage their condition.

Usefulness: This measure would add value to the

program measure set since there is solid evidence behind single-dose therapy, which is not used frequently. We favor adoption of a patient-reported outcome (PRO) instrument that assesses pain over baseline in these patients as a more effective and patient-centric alternative.

Feasibility: "Painful" bone metastases cannot be identified from ICD-9 codes. We could identify patients who express pain through manual chart review as well as patients with bone metastases, but it would be difficult to determine whether the bone metastases were the clear (and sole) cause of pain. Reporting of this measure would be manageable if an appropriate sampling methodology were adopted.

XDCFE: Initiation of Osteoclast Inhibitors for Patients with Multiple Myeloma or Bone Metastases Associated with Breast Cancer, Prostate Cancer, or Lung Cancer

Position: Postpone adoption until the measure has been through further testing and validation and a formal vetting process, such as the NQF measure endorsement process.

Relevance: Research suggests underutilization of bisphosphonates and osteoclast inhibitors for patients with multiple myeloma and bone metastases, respectively. However, this research does not evaluate use of these drugs in a PPS-exempt cancer center.

Usefulness: The drugs included in the measure represent a subset of drugs that may be appropriate in these patients, limiting its ability to add value for patients. Additionally, clinical contraindications must be incorporated in this measure. For example, osteoclast inhibitors are used routinely only in castrate-resistant prostate cancer patients with bone metastases (not in castrate-sensitive cancer patients). Additionally, osteoclast inhibitors in lung cancer patients with bone metastases are still the focus of clinical trials, as are osteoclast inhibitors in multiple myeloma. Greater consideration of exclusion criteria (e.g., greater specificity to identify patients with dental disease, for whom these therapies are contraindicated) is warranted. Finally, by specifying particular drugs this measure does not allow for use of innovative (and potentially superior) treatments in our patients.

The time component included in the measure is also problematic. It may take time for newly diagnosed patients to decide to make an appointment. Additionally, many of our patients seek care at our centers after receiving care from another oncology provider. Therefore, it may be difficult to achieve the time frame of osteoclast inhibitor administration specified by the measure. We suggest that the date of clinical or pathologic confirmation of the diagnosis be substituted for date of diagnosis.

A 2013 field test of this measure by several ADCC centers highlighted the need for further testing and validation to address the content validity of this measure, which has been developed for reporting from the electronic health record (EHR). Electronic reporting should be the direction of measures used in public reporting, where possible, but attention needs to be directed toward the content validity and clinical appropriateness of the measures. Of note, the measure developers have acknowledged these issues, and we trust that it will be addressed through further field testing. We look forward to evaluating this measure after this has occurred. However, we do not consider this measure to be ready for reporting at this time.

Feasibility: The number of exclusions and the vagueness of the data definitions provided for some exclusions (e.g., dental disease) add to data collection burden. It is also difficult to identify exclusions based on diagnosis codes. Thus, while this measure has been developed as an EHR-based measure, it will require manual data collection.

Once the concerns described above have been addressed fully, reporting of this measure would be manageable if an appropriate sampling methodology were adopted.

XDBLG: Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis

Position: Postpone adoption until the measure has been through further testing and validation and a formal vetting process, such as the NQF measure endorsement process.

Relevance: The overuse of staging procedures is an issue as it may affect the cost- effectiveness in diagnosing patients. In addition, researchers suggest that patients are subjected to diagnostic testing

that may be unnecessary. These issues have been highlighted by the American Society of Clinical Oncology (ASCO).

Usefulness: As written, this measure does not exclude imaging unrelated to breast cancer diagnosis. Many of our patients have complex comorbidities, concurrent disease, or other conditions that require advanced imaging that is clinically appropriate. For example, bone

pain may warrant use of advanced imaging for these patients. This measure is not sensitive to these distinctions. Also, patients on clinical trials may require imaging as part of a protocol and should be excluded.

Frequently, patients are diagnosed locally and subsequently scheduled for scans before coming to an ADCC center. Therefore, our ability to reduce unnecessary imaging in these patients is limited. With respect to scans performed outside our institutions, such patients should be included in the denominator, but not included in the numerator as a measure of overuse. We recommend that the measure definition be changed to "administered or performed" as opposed to "ordered" to avoid misattribution to one of our centers, which would not have performed the ordered scan.

A 2013 field test of this measure by several ADCC centers highlighted the need for further testing and validation to address the content validity of this measure. In particular, we note that the code sets created for this measure require further refinement to ensure appropriate inclusion and exclusion criteria. The measure developers have acknowledged these issues, and we trust that these concerns will be addressed through further field testing. We look forward to evaluating this measure after this has occurred. However, we do not consider this measure to be ready for reporting at this time.

Feasibility: In looking at the numerator/denominator definitions, the stage and date of diagnosis are not embedded within any electronic system as a searchable field for data extraction. Moreover, certain exclusion criteria (e.g., bone pain) cannot be identified from ICD-9 codes. Thus, while this measure has been developed as an EHR-based measure, it will require manual data collection.

Furthermore, many patients are diagnosed locally and subsequently scheduled for scans. If the scans are performed outside the ADCC center, they will not be captured in structured data and may not be identifiable through a manual review of scanned documents. Any data generated by our centers will pertain to exams performed within the reporting organization.

Patients who obtain scans externally should be included in the denominator, but not the numerator. Several of our centers find that imaging may be ordered by an affiliate but performed elsewhere. We recommend that the measure definition be changed to "administered or performed" as opposed to "ordered" to avoid misattribution to one of our centers, which would not have performed the ordered scan. Reporting of this measure would be manageable if an appropriate sampling methodology were adopted.

E1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits

Position: We do not support adoption of a third process measure related to pain assessment. This measure should be harmonized with previously adopted measures that address pain management (NQF #0383—Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology; and, NQF #0384—Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology).

Relevance: Assessment of pain alone may be too simplistic for a specialty whose focus is to improve quality of life and reduce suffering. By focusing on pain only, there is a missed opportunity to assess multiple symptoms in this vulnerable population. Prior studies have shown that other physical and psychological symptoms can be as devastating and debilitating as pain. In addition, symptoms, such as nausea, sedation, and fatigue, may be caused by pain treatment and should be evaluated in conjunction with pain to optimize quality of life for patients with advanced cancer. Thus, adoption of broader symptom inventories is preferred.

Usefulness: It would be more useful to focus on the outcome important to patients—pain relief—by utilizing a PRO instrument. Additionally, this measure has some overlap with previously adopted pain

management measures and should be harmonized.

Feasibility: A manual chart review would be required for this indicator in order to obtain the numerator since there are no billing codes used in practice for identifying administration of a quantitative standardized pain assessment tool. Likewise, this is not captured currently in a discrete format within the EHRs in place across the ADCC.

It is unclear how a patient visit would be determined in our care setting, as our patients frequently see multiple providers when they come to our cancer centers. Reporting of this measure would be manageable if an appropriate sampling methodology were adopted. However, we reiterate our concerns about the lack of parsimony in adopting this measure.

E0450: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate

Position: We support the direction of this measure, with inclusion of appropriate risk adjustment for cancer-specific risks.

Relevance: These complications can be prevented through continuous in-hospital risk assessment and appropriate prophylactic treatments. However, our centers did not strongly support this measure as a value driver for our program, given the potential risk for PE/DVT among our patients as well as prevalence of pre-existing DVT among our patients.

Usefulness: Data from some of our centers suggest low post-operative DVT rates at our centers—well below national averages. Moreover, some of our centers have very low surgical volumes, suggesting a limited impact on patient outcomes at these centers.

For our patient population, this measure would need to be risk stratified for cancer patients who, because of their disease and treatment, are at very high risk for VTE.

Feasibility: We do not anticipate a significant data collection burden. One concern is that this measure has not been revised to include ICD-10 codes, which likely will be in use prior to adoption of this measure.

XDDAF: Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy

Position: Postpone adoption until the measure has been through further testing and validation and a formal vetting process, such as the NQF measure endorsement process.

Relevance: The population of patients to whom this measure applies requires clarification. Patients receive chemotherapy for varying reasons (curative, adjuvant, or palliative intent), and the number of admissions/ED visits may vary depending on the population of patients in each category. Stratification of such patients may help clarify the reasons for admission and accelerate prevention and improvement strategies.

Usefulness: This measure lacks sufficient specificity to identify avoidable admissions/ED visits. For example, this measure does not exclude nausea unrelated to chemotherapy administration or some unavoidable nausea, such as nausea associated with tumor progression. Many ED visits and hospital admissions may be the result of disease progression or unrelated conditions, rather than complications of the treatment. It would be useful to develop an algorithm to help in distinguishing such patients as a way of reducing the measurement burden and increasing the accuracy of the measure.

Additionally, this measure does not allow for stratification for more or less toxic chemotherapy regimens, which may result in varying rates of hospital admission. Also, patients on clinical trials may require exclusion or stratification.

A 2013 field test of this measure by several ADCC centers highlighted the need for further testing and validation to address the content validity of this measure. Of note, the measure developers have acknowledged these issues, and we trust that they will be addressed through further field testing. We look forward to evaluating this measure after this has occurred. However, we do not consider this measure to be ready for reporting at this time.

Feasibility: Many of our patients may start outpatient chemotherapy at one of our centers but complete their treatment in their communities. The issue of how to handle attribution for outcomes in such cases has not been addressed. A clearer definition of "avoidable" would need to be created for this measure. As written, the measure does not allow for

stratification for more versus less toxic chemotherapy regimens, which may result in varying rates of hospital admission or ED visits.

We support revision of this measure to incorporate clinically relevant factors that provide greater insight into understanding whether the ED visits and inpatient admissions are avoidable. While this measure has been developed as a claims-based measure, our experience suggests that it will require manual data collection. Therefore, sampling likely would be required to manage data collection burden.

Appendix B: Input on MAP Proposed Measures

1634: Hospital and Palliative Care – Pain Screening

Position: We do not support adoption of a third process measure related to pain. This measure should be harmonized with previously adopted measures that address pain management (NQF #0383—Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology; and, NQF #0384—Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology).

Relevance: Pain screening is a routine process that should be done in both inpatient and outpatient palliative care and hospice consults. Appropriate screening for pain, in turn, leads to patients' pain being addressed and controlled, thus improving patient outcomes.

Usefulness: It would be more useful to focus on the outcome important to patients—pain relief—by utilizing a PRO instrument and broadening the focus to include other symptoms that cause distress in patients (e.g., fatigue). In addition, our experience suggests that pain screening is done consistently for all patients receiving palliative care services in our centers. Screening for other symptoms, such as shortness of breath, fatigue and nausea, may greatly enhance the delivery of comprehensive symptom management. We recommend broader symptom screening to optimize patient quality of life, especially in view of previously-adopted measures that address pain management. Additionally, further definition of "hospital-based palliative care" would be necessary for reporting this measure. For example, some centers do not have an inpatient palliative care unit, but do provide palliative care services in conjunction with the treating oncologist.

Additionally, as noted previously, CMS adopted two paired pain-related measures for our program during its FY2014 Rulemaking and have proposed an additional pain measure (NQF #1628—Patients with Advanced Cancer Screened for Pain at Outpatient Visits) for consideration during FY2015 Rulemaking. The incremental benefit of adopting another pain-related process measure is unclear.

Feasibility: Not all centers have access to outside hospice admission records. Thus, including these data in the denominator presents a problem. Reporting of this measure would be manageable if an appropriate sampling methodology were adopted. However, we reiterate our concerns about the lack of parsimony in adopting this measure.

1637: Hospice and Palliative Care – Pain Assessment

Position: We do not support adoption of a third process measure related to pain assessment.

Relevance: Pain has a direct effect on a patient's functional, psychological, and spiritual abilities. Therefore, addressing pain appropriately can have a significant effect on patient outcomes across multiple domains.

Usefulness: As indicated previously, it would be more useful to focus on the outcome important to patients—pain relief—by utilizing a PRO instrument and broadening the focus to include other symptoms that cause distress in patients (e.g., fatigue). Additionally, further definition of "hospital- based palliative care" would be necessary for reporting this measure (please see comments above). In addition, our experience suggests that pain screening is done consistently for all patients receiving palliative care services in our centers. Assessing other symptoms, such as shortness of breath, fatigue and nausea, may greatly enhance the delivery of comprehensive symptom management. We recommend broader symptom screening to optimize patient quality of life, especially in view of previously-adopted measures that address pain management.

Feasibility: Variability in the definition of a clinical assessment of pain exists. This lack of a common question set or standard and hard-coded data element increases data inconsistency and collection burden. Reporting of this measure would be manageable if an appropriate sampling methodology

were adopted.

0326: Advance Care Plan

Position: Adopt with modifications described below.

Relevance: Advance care planning is the foundation for delivery of care that honors patients' wishes. Presence of an advance care plan can save time, and, for those who do not wish life-sustaining treatments, it can avoid unwanted, costly care. By addressing or discussing advance care directives, we help to ensure that patients' wishes and goals are being honored.

Usefulness: This measure should be revised to apply to all adult patients, not just those over 65 years of age. Advance care planning is an important element of patient-centered care and should be adopted for all patients with cancer.

It would be useful to incorporate a time element in this measure for when these discussions should occur. Frequently, advanced care planning is delayed until patients are near the end of life and patients and their caregivers are coping with the physical and emotional strain of advanced cancer disease. This type of conversation is not one which occurs in discrete visits, but over time. These discussions should occur early in the patient's interaction with his/her oncology provider to ensure that the patient has sufficient time to consider and express his/her preferences regarding life-saving treatment. Furthermore, such assessments, which truly capture goals and wishes as a means of aligning the plan of care, should be revisited routinely to make certain care is being provided consistent with that which is desired.

Feasibility: Typically, the existence of a do not resuscitate (DNR) order is captured and could be queried in some EHRs, but no information on the discussion taking place is captured as discreet data. Instead, a random sampling of our patient population that fits these criteria or an audit of new patients may be a more effective approach. Reporting of this measure would be manageable if an appropriate sampling methodology were adopted.

1641: Hospice and Palliative Care – Treatment Preferences

Position: Adopt with modifications described below.

Relevance: Documentation of treatment preferences facilitates stronger communication between the patient, his/her family, and providers regarding the risks and benefits of life-sustaining treatments. In the absence of an advance care plan or as a supplement, the documentation of preferences for life- sustaining treatments can avoid unwanted, costly care. It is worth considering that, for cancer patients, the definition for life-sustaining treatments and documentation regarding cancer patients' preferences should also include blood transfusions and antibiotics. This is not described in the numerator details available on the NQF website.

Usefulness: This measure may be largely non-applicable as several members of the ADCC do not have in-house hospice or inpatient palliative care units (in these cases, patients commonly are referred for external hospice care). Some organizations provide palliative care services in conjunction with the treating oncologist, so patients seen by those practitioners could be captured. However, this would also present a reporting burden without an appropriate sampling methodology, since this measure goes beyond demonstrating whether patients have a DNR or Full Code order and requires evidence of discussion/communication (even though the presence of a DNR or Full Code order implies that a discussion occurred).

Feasibility: Reporting of this measure would be manageable if an appropriate sampling methodology were adopted.

American Academy of Dermatology

Joshua Nyirenda

The American Academy of Dermatology (the Academy), on behalf of its members, welcomes and appreciates the opportunity to comment on the performance measures recommended for inclusion and exclusion in the Measure Applications Partnership's (MAP) pre rulemaking report. After a careful review of the list of measures, we are concerned that the recommendations result in a significant exclusion of dermatology specific and dermatology related measures to be used for the PQRS, the Physician Compare program, and the Value Based Payment Modifier. Specifically, the pre rulemaking recommendations only recommend one

dermatology-specific measure (of the 5 dermatology specific measures currently in PQRS) and only 4 dermatology-related measures for retention in PQRS. This will create tremendous reporting compliance hardships for our physicians especially now that they are required to report on nine measures.

Two measures, Melanoma Coordination of Care (#138) and Biopsy follow-up (#265) are specifically not being supported due lost NQF endorsement. We request that these measures be supported for the following year as we pursue requirements for re-endorsement with NQF.

Six other measures, Melanoma -Continuity of Care – Recall System (# 137), HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea (#205), Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure) (#245), Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure) (#246), Preventive Care and Screening: Unhealthy Alcohol Use Screening (#173), and Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier (#337), were all not supported with the reason that the measures do not "adequately address any current needs of the program." Only for two of these measures did the document further elaborate on some possible remedial action. These are: #173 and # 337. For #173 preference was given for more inclusive measures, while for #337 it was indicated that the workgroup has previously suggested expanding the measure to all patients on a biological immune response modifier.

We welcome these suggestions but suggest that for the TB measure, until such a broader measure is developed, this measure should be maintained as a reporting option for dermatologists. We further request specific clarification on what remedial action the Academy can take to adequately meet the program's needs for the Academy developed measure Melanoma -Continuity of Care – Recall System (#137) and that until that is resolved, the measure should be given conditional support for inclusion in 2015. We take a keen interest in the other measures as well and would request a phased out approach of elimination in order to give us, and specialties similar to ours, enough time to develop outcome measures.

We would like to appreciate your support for the measures: Melanoma -Overutilization of Imaging Studies in Melanoma (#224), Oncology: Cancer Stage Documented (#194), Pain Assessment and Follow-Up (# 131), Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (# 226) and Documentation of Current Medications in the Medical Record (#130).

We also strongly support your conditional support for two other measures: Prednisone Use with Anabolic Agent (# XDFEG), Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy (# XDFHE). Each of these measures can either be adopted directly or slightly modified to apply to the field of dermatology. More importantly, the measures address safety and care coordination issues that the field of dermatology specifically needs to focus on in order to assist in the overall improvement of our health care system.

The Academy is developing a number of measures and we anticipate that our limited measure inventory issue will be resolved soon. Until then, we request that the measures we currently can report on be maintained.

Thank you for this opportuny

American College of Rheumatology

Amy Miller

Thank you for the opportunity to provide input on the recommendations from the Measure Applications Partnership. As leaders of the American College of Rheumatology, we have several comments:

It is extremely important to preserve the current RA measures group for PQRS in 2015. It was unclear in the document whether all the current RA measures in the measures group will remain recommended for PQRS 2015. Until there are more measures in the rheumatology space, rheumatologists need those measures to remain a viable option for PQRS reporting in 2015. If these measures do not remain, rheumatologists may be adversely impacted.

We appreciate the support for measures XDAFC (Functional Status Assessment and Goal Setting

in Patients with RA), XDFHD (Assessment and Classification of Disease Activity) and XDFHE (TB Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug Therapy) for PQRS and MU. We also appreciate the comment that these measures should potentially replace measures in the RA measure set. We would recommend waiting to replace those measures until the new measures have been implemented for at least a year, but then would agree that the measures could replace those in the current RA measure set.

We appreciate your endorsement of the DMARD measure (#0054) for Physician Compare and the VBM. This is an important measure and allows rheumatologists to have at least one clinically meaningful measure that can be used in these programs; however, we were disappointed that other important and clinically meaningful measures in rheumatology were not supported for these programs. Specifically, 176 Rheumatoid Arthritis: TB Screening; 177 Rheumatoid Arthritis: Periodic Assessment of Disease Activity; and, 178 Rheumatoid Arthritis: Functional Status Assessment. These three measures are clinically meaningful for rheumatologists. The TB measure addresses an important patient safety issue and the Disease Activity and Functional Status measures are important to rheumatologists and lay the foundations in rheumatology to get to outcome measures.

The ACR continues to work on several fronts to help move forward the national quality agenda in rheumatology.

Again, we appreciate the opportunity to provide these comments and would welcome any further dialogue on these or other topics of interest to the MAP or CMS, especially related to providing and measuring quality of care in rheumatology.

American College of Surgeons

David B. Hoyt, MD, FACS

On behalf of the over 79,000 members of American College of Surgeons (ACS), I am writing to provide feedback to the Measure Applications Partnership (MAP) Pre- Rulemaking Report. The ACS is a scientific and educational association of surgeons, founded in 1913, to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The ACS has a strong interest in the development and endorsement of consensus standards that will help surgeons improve the quality and safety of their care and thereby improve outcomes for patients. The comments below are listed by report section.

ACS greatly appreciates the cooperative nature of work between the Centers for Medicare & Medicaid Services (CMS) and the MAP during the development of the January 2014 MAP Pre-Rulemaking Report. CMS' engagement and ability to provide data throughout the MAP meetings greatly improved the process for evaluating the Measures Under Consideration (MUC). As a result, Workgroups were able to make better-informed decisions, compared to previous years. We encourage CMS and the MAP to continue to develop this productive and collaborative relationship in future work.

General Comments

Off-Cycle Work

During the Coordinating Committee Meeting, the Workgroup was asked to discuss the process for the review and evaluation of measures that are off-cycle. Off-cycle refers to measures for programs that cannot be reviewed as part of the MUC for the MAP Pre- Rulemaking Report due to the timing of a given program, such as Meaningful Use. The Coordinating Committee agreed that the implementation of measures should not be delayed because of the timing of the MAP Pre-Rulemaking and these measures should be reviewed off-cycle.

ACS also agrees that off-cycle review of measures is critically important and should not be delayed to meet the Map Pre-Rulemaking timelines. However, because this work is not part of the December MUC list, it is crucial that the MAP promote public

awareness of off-cycle projects, and does so in a very transparent manner. The MAP must be sure that the off-cycle measures are being reviewed with the same amount of rigor as the MAP Pre-Rulemaking process. Additionally, we recommend a continuous open comment period for off-cycle measures so that stakeholders will have the opportunity to add value to the process and not be caught off guard if they miss a twoweek comment period.

Increased transparency and a continuous open comment period will be even more important for the off-cycle review of e-measures. Because e-measures have the ability to include more clinical data than measures which are not e-specified, and because

there is little experience implementing e-measures, it is critical that the review and development of these measures are clinician- and patient-led so that they are clinically valid, lead to quality improvement, are meaningful to the end user, and will help patients in selecting a provider.

Qualified Health Plans in the Health Insurance Marketplaces

Provisions in the Affordable Care Act (ACA) require HHS to create a national Health Insurance Marketplace to offer health insurance to the public. As part of this provision, HHS is required to develop a Quality Rating System (QRS) for Qualified Health Plans. HHS contracted with NQF to provide input on the measures, organization, and hierarchical structure of the QRS. MAP convened a task force to advise the MAP and produce a report on their input. The draft report was open for comment beginning December 23, 2013 – January 6, 2014 and had very few public comments, most likely because the comment period fell over the holiday season. Therefore, we recommend that NQF reopen the comment period to allow for a more transparent review of the recommendations.

If measures are going to be used to rank providers to determine provider inclusion or exclusion in networks, they must be developed with input from providers, and meet the highest standards of validity and reliability to avoid the misclassification. ACS does not support any process that ranks providers or systems on cost in the absence of quality. Measures must be specifically assessed for ranking, must be clinically relevant, fair, and ultimately promote patient access. Without measure adequacy, providers and systems are at significant risk of misclassification, which will have detrimental effects to our national healthcare system, including limiting access to care.

The process for determining the variation between providers and systems, and establishing which data is appropriate for making these determinations, must include multi-stakeholder consensus prior to QRS application. An additional aspect that must be addressed along with measure adequacy regarding network design based on rankability is the challenge of networks having to match the providers (Part B) and the delivery system facilities (Part A). For example, if a surgeon is narrowed out and/or the hospital is narrowed, where will the patient receive care? It will be critical that exchanges have matched rankability. In its initial implementation, the QRS must be very limited in order to test for a variety unintended consequences. ACS strongly believes that the current measures are not adequate for use in ranking providers and delivery systems. ACS also believes that there was insufficient provider input when creating the QRS, which is critical for successful implementation and therefore must be resolved.

Conclusion

We are very appreciative of the opportunity to provide feedback and recognize the volume of work and the strict timeline under which the MAP operates. However, we strongly believe that a two-week comment period is not a reasonable amount of time for public comment for the MAP Pre-Rulemaking Report. A thirty-day comment period would allow for more thoughtful public comment and greater provider participation.

ACS looks forward to continuing dialogue with the MAP on these important issues.

American Hospital Association

Linda Fishman

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) January 2014 pre-rulemaking report. The AHA continues to strongly support the premise of the MAP's work – that is, improvement in our nation's health care system can be catalyzed by selecting quality measures for federal reporting and payment programs that are focused on aspects of care that a broad array of stakeholders believes to be critically important.

We also continue to believe that the MAP must play an aggressive role in fostering alignment among

quality reporting and payment programs across care settings and programs. Broadly defined, alignment means that measurement priority areas are the same across payment programs, and that the decision to use particular measures in a particular program is driven by a consistent set of principles. It could mean, if appropriate, using the same measure in different programs. However, it also may mean using measures that assess different providers' responsibilities in achieving an overall desired goal. At a time when health care resources are under intense scrutiny, an aligned, focused approach to quality measurement and pay-for-performance programs can ensure that such programs are targeted at a precious few priority areas that will truly drive the most meaningful improvements across the health care delivery system.

The AHA is concerned that the MAP's approach to alignment has become too focused on ensuring the exact same measures are recommended for more than one program, rather than an assessment of whether measures truly address overarching health care system-wide improvement priorities. We agree thatusing the same measure in more than one program can promote alignment, but only to the extent that those measures generate reliable, accurate performance results in more than one care setting. Moreover, providers along the care continuum often play complementary, but differing roles in advancing care, which may necessitate differences in measures.

Thus, the AHA urges the MAP to broaden its assessment of alignment to consider whether measures in programs address a consistent set of measurement and improvement priorities across the health care system. To provide a reference point for making such an assessment, we urge the MAP toidentify, in collaboration with federal partners and other stakeholders, a small number of specific national priority areas for measurement each year, and recommend those measures that best address them.

While ensuring alignment is an essential goal of the MAP process, we also believe federal programs must use only measures that have sufficient reliability and validity to generate performance information that is accurate. As the Centers for Medicare & Medicaid Services (CMS) constructs its annual list of Measures Under Consideration (MUC) for the MAP's review, we believe the agency should include only those measures that generate accurate, meaningful data, are feasible to collect, and that do not carry negative unintended consequences.

For these reasons, the AHA is deeply concerned that many of the measures on this year's MUC list do not appear to be truly ready for public reporting or pay-for-performance applications. Indeed, of the 234 measures on this year's MUC list, only 20 percent (47 measures) are endorsed by the National Quality Forum (NQF). The MAP is not constituted in such a way nor given enough time to review measures and assess their technical properties. The MAP relies on NQF endorsement for this assessment, and when CMS presents measures that have not undergone such a review, it is asking the MAP to ignore the importance of knowing whether the measures being presented assess what they purport to assess.

Moreover, several measures – most notably, the readmission and mortality measures proposed for hospital programs – have significant flaws that must be addressed before they are considered appropriate for public reporting or pay-for-performance applications. Finally, CMS has proposed for inclusion in multiple programs several electronic clinical quality measures (eCQMs), but it has yet to demonstrate that hospital electronic health records (EHRs) can generate accurate data appropriate for both quality improvement and accountability. In fact, the available evidence at this point suggests the e-specified measures need a lot more work before they will be sufficiently reliable for public reporting or pay for performance.

The AHA offers the following recommendations to the MAP as it reviews its recommendations before submitting them to CMS, and to CMS as it considers which of the MAP's recommendations to adopt through formal rulemaking and as it selects measures for future MUC lists:

CMS should include on the MUC list measures that are NQF-endorsed or that will at least have undergone a Steering Committee review to assess their reliability, validity and importance prior to the MAP meeting;

The MAP should recommend that CMS suspend

or remove the stroke mortality and readmissions measures from the inpatient quality reporting (IQR) program until the measures adequately account for stroke severity;

The MAP should urge CMS not to proceed with the addition of the hospital-wide all-cause, all-condition readmission measure into the Hospital Readmission Reduction Program (HRRP) until it has fully addressed the question of whether the Patient Protection and Affordable Care Act (ACA) allows for the inclusion of a measure that is not condition-specific, it has analyzed the potential impact and fully understood the implications of including such a measure, and until there is an adequate adjustment for socioeconomic factors; and

CMS should present eCQMs to the MAP with stronger data demonstrating their readiness to implement in programs.

NQF Endorsement is a Fundamental Step

The AHA has repeatedly and consistently urged CMS to use only NQF-endorsed measures in federal quality reporting programs, and is deeply concerned that only 47 of the 234 measures (or 20 percent) on this year's MUC list are NQF-endorsed. In our comments on the January 2013 MAP pre-rulemaking report, the AHA recommended that the MAP use a gradual, step-wise process to add measures into public reporting and pay-for-performance programs, the first step of which is NQF endorsement. We believe the very first step in bringing a measure into a national reporting or pay-for-performance program – even before putting the measure on the MUC list – should be to obtain NQF endorsement. NQF endorsement provides a baseline assurance that the measure has been tested, can reliably and accurately collect data, is feasible to implement, and is usable.

In advocating for the use of only NQF-endorsed measures, we appreciate that there are important measurement gaps in all federal programs that do not yet have NQF-endorsed measures to fill them. CMS appears to have addressed the issue of measure gaps by placing many partially developed, non-NQF endorsed measures on this year's MUC list. During the work group discussions, CMS indicated that obtaining the MAP's input on measures still under development is of value because it can help identify issues that can be addressed before the development process is complete, and presumably, before measures become part of federal programs.

The AHA is concerned that using the MAP process to vet partially developed, unendorsed measures does not produce the well-considered and thoughtful recommendations that CMS is seeking. When a measure on the MUC list lack NQF endorsement, the MAP's workgroups must guess at whether it is be reliable and valid, whether its risk adjustment and other properties are be appropriate, and therefore, whether it is appropriate for inclusion in a program. The MAP simply cannot make informed recommendations when it lacks this vital information. The time spent by MAP workgroups considering a measure's fundamental soundness also takes time away from the evaluation of whether a measure aligns with national priorities and works in complementary fashion with measures in other programs to best encourage improvement.

We do not believe the MAP's deliberations are a substitute for the full consideration of measures in the NQF endorsement process, nor do we believe it is appropriate to ask the MAP to recommend or not recommend a measure when all they know about it is its title. Endorsement committees include multiple stakeholders, but also typically include individuals with considerable clinical and quality measurement expertise in a given topic area. The endorsement process also uses NQF's rigorous criteria to evaluate whether a measure can meet quality improvement or accountability purposes.

Lastly, we are concerned that placing partially developed, unendorsed measures on the MUC list may force the MAP to make premature judgments of the suitability of measures for federal programs. Indeed, under its existing process, the MAP may support a measure conditional on it receiving NQF endorsement, but it does not have an opportunity to reevaluate the measure based on the results of the endorsement process. The endorsement process may uncover limitations of measures when used on certain patient populations or by type of provider. For example, a measure under consideration for long-term acute care hospitals (LTCHs) could be endorsed for "hospital-level" reporting. But, the endorsement process may demonstrate that the measure is less

reliable when applied to the patient population served by LTCHs. This type of information would be indispensable in judging the appropriateness of a measure for a public reporting program, but would be unavailable at the time the measure is presented to the MAP.

For these reasons, we strongly urge CMS to place partially developed, unendorsed measures onto the MUC list on an exceptional basis, for instance, to meet a time-sensitive statutory deadline. Moreover, CMS should ask the MAP to re-review any measures it supported conditional on NQF endorsement so that it can consider any important findings from the NQF endorsement process. By sharply curtailing the number of partially developed measures on the MUC list, and by giving the MAP the opportunity to reconsider measures based on NQF deliberations, we believe the agency will make the highest and best use of the MAP's very limited time to process the MUC list.

American Medical Association

James L. Madara, MD

Dear Doctors Isham and McGlynn:

The American Medical Association (AMA) is pleased to have the opportunity to comment on the Measure Applications Partnership (MAP's) Draft Pre-Rulemaking Report. We commend the MAP staff and workgroups for their skill and dedication in achieving this comprehensive review of the Department of Health and Human Services (HHS) proposed quality measures list, particularly within a very short timeline. Continuing our longstanding commitment to quality improvement initiatives that enhance the quality of care provided to patients, the AMA offers the following comments.

Upstream Recommendations

HHS is required to publish annually a list of measures under consideration for future rulemaking, and to consider recommendations of the MAP/National Quality Forum (NQF) as part of the rulemaking process. Now in its third year of existence, the MAP's work increasingly focuses on and emphasizes "upstream" strategic, global recommendations. The MAP can provide valuable input in this area. We are concerned, however, that this occurs outside the rulemaking process, without the usual safeguards assuring an opportunity for public comment. All other stakeholders receive a mere ten days to review and comment on the strategic direction of HHS quality programs. This overarching issue requires a different aspect and level of analysis than for individual measures. Now that physician quality programs are linked to payment adjustments (i.e., reductions), the stakes have grown even higher. We therefore urge the MAP to issue its upstream and strategic recommendations separately from its annual list of measures, with a public comment period of at least 30 days, similar to other regulatory issues.

We also have concerns with the following upstream initiatives under review by the MAP Quality Rating System: There are significant opportunities to improve the delivery of health care services in the United States. The Exchange and Qualified Health Plans Quality Rating System (QRS) is an important tool to assess current care. However, before the Centers for Medicare & Medicaid Services (CMS) embark upon a new tool to assess care, the agency must first focus on health plan adequacy. While the MAP's proposed measures are not for use and assessment at the physician level, many can be attributed to a physician and require action by a physician. Accurate attribution cannot occur without first ensuring network adequacy.

We also have concerns about using the QRS for measure selection and attribution, as it is based on the new Medicare Advantage 5-Star Rating System. We are already hearing from physicians about significant problems with this system and troubling repercussions. The 5-Star Rating System only publicly reports health plan performance on quality indicators, but the data are derived from claims data. Compliance must be at 100 percent to qualify for a payment incentive regardless of whether the physician is providing appropriate and medically necessary care.

In addition, many exchange health plans create narrow networks, which are not addressed in the proposed measures. Health plans that narrow networks should only have the ability to do so after full transparency on the QRS. For example, if this is on the basis of cost or measurement, how are those defined? We currently do not have the measurement

adequacy (reliability, validity, and depth of measurement) necessary to ensure the accurate ranking of delivery systems and physicians, and avoid the significant risk of misclassification. The troubling issues with the QRS further demonstrate the need for a longer comment period to review strategic issues in the MAP's deliberations, recommendations, and report, apart from the MAP measure list review process.

Additional Comments on MAP Process and Measure Recommendations: The AMA also urges the MAP to reconsider its recommendations concerning various other measures in the MAP Report. Our specific comments on particular measures are highlighted in the attached chart.

Off-Cycle Review of Measures: As part of the MAP deliberations, the NQF Coordinating Committee discussed CMS' need for review of some measures off-cycle, such as the quality measures for the MU program. The AMA understands that off-cycle review of measures will not replace the MAP's annual pre-rulemaking process, and is for exceptional circumstances. We are concerned with the NQF's plan to conduct off-cycle reviews in eight weeks, with just a ten-day comment period. This may not allow enough time for public review and comment pre- and post-MAP deliberations. In addition, MU quality measures are being developed differently from traditional PQRS measures. Many Stage 2 and 3 measures have been developed by outside entities under contract with CMS, so there is the potential for major surprises and concerns by stakeholders. If the NQF moves forward with its timeline, it must provide the public with advance notice of the opportunity to comment, so that interested parties will have enough time and information to follow their issues within MAP deliberations.

The NQF should also keep in mind that review of one or two measures off-cycle does not pose much of a burden on interested stakeholders. However, an entire program suite of measures is a different endeavor. Therefore, we recommend that the NQF consider two tracks for reviewing measures off-cycle, based upon the number of measures in question. An extended timeline is needed if the MAP reviews an entire program measurement set, such as for MU.

Need for Appropriate Experts in Workgroup Discussions

The value of the MAP's workgroup discussions is highly dependent on the input of key experts and stakeholders familiar with the quality measures at issue. We do not believe that the MAP should duplicate the NQF endorsement process. The MAP would benefit greatly, however, from increased participation of qualified experts and stakeholders during the discussions of particular quality measures. The AMA urges the MAP to issue a detailed discussion guide at least three days in advance of each MAP meeting, listing specific measures and the projected time for discussion of each measure. This will allow qualified experts to know in advance when to expect measure discussion and help ensure their availability for the discussion. Having measure developers and clinical experts in the room at the appropriate times will help foster a more accurate and focused discussion of the specific measures under consideration. Many of the AMA-convened Physician Consortium for Performance Improvement® (PCPI®) measures received the recommendation of "do not support." Had they been made aware of this direction prior to the publication of the pre-rulemaking report, PCPI representatives could have easily provided expertise to assist committee deliberations and answer any questions. Many organizations have limited staff handling multiple activities in addition to the NQF deliberations, so they may only follow MAP Coordinating Committee meetings or review the MAP pre-rulemaking report.

We appreciate the opportunity to provide our comments and look forward to continuing our work with the MAP to ensure adoption of quality measures in the PQRS and other federal programs that result in effective and broad participation in these programs and improvements in the delivery of care.

Table A1. AMA Input on Medicare Shared Savings Programs Under Consideration

NQF #	Measure Title	Program under consideration and MAP recommendations	MAP Additional Comments	PCPI® Response to MAP Recommendations
0561 (Not Endorsed)	Melanoma Coordination of Care	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	NQF Endorsement removed (the measure no longer meets the NQF endorsement criteria)	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. As such, the PCPI® recommends against removal from PQRS.
0508 (Endorsed)	Inappropriate Use of "probably Benign" Assessment Category in Mammography Screening	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	Measure does not adequately address any current needs of the program; Performance of the measure may be topped out	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. Further, this measure is NQF-endorsed, demonstrating it meets all four NQF criteria: importance, scientific acceptability, usability and relevance, and feasibility. Finally, the PCPI® believes that PQRS data is not reliably representative of national performance, as it is based on voluntary reporting with about 29% of eligible professionals participating using any reporting option in 2011. As such, the PCPI® recommends against removal from PQRS,.
0088 (Endorsed)	Diabetic Retinopathy: Documentation of Presence of Absence of Macular Edema and Level of Severity of Retinopathy	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	Measure does not adequately address any current needs of the program; Preference for outcome-oriented measures that assess care for diabetes	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. Further, this measure is NQF-endorsed, demonstrating it meets all four NQF criteria: importance, scientific acceptability, usability and relevance, and feasibility. Finally, this measure is an eCQM. As the PQRS and Meaningful Use (MU) programs share measures sets, the removal of this eCQM from PQRS would result in a lack of alignment between PQRS and MU. As such, the PCPI® recommends against removal from PQRS.

NQF #	Measure Title	Program under consideration and MAP recommendations	MAP Additional Comments	PCPI® Response to MAP Recommendations
0563 (Endorsed Time-Limited)	Primary Open Angle Glaucoma (POAG): Reduction of Intraocular Pressure by15% or Documentation of a Plan of Care	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	Measure does not adequately address any current needs of the program	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. Further, this measure is NQF-endorsed, demonstrating it meets all four NQF criteria: importance, scientific acceptability, usability and relevance, and feasibility. As such, the PCPI® recommends against removal from PQRS.
0566 (Endorsed Time-Limited)	Age-Related Macular Degeneration (AMD):Counseling on Antioxidant Supplement	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	Measure does not adequately address any current needs of the program	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. Further, this measure is NQF-endorsed, demonstrating it meets all four NQF criteria: importance, scientific acceptability, usability and relevance, and feasibility. As such, the PCPI® recommends against removal from PQRS.
0240 (Endorsed)	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis (DVT) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	Measure does not adequately address any current needs of the program; Measure may be topped out, if so it should be removed from the PQRS program	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. Further, this measure is NQF-endorsed, demonstrating it meets all four NQF criteria: importance, scientific acceptability, usability and relevance, and feasibility. Finally, the PCPI® believes that PQRS data is not reliably representative of national performance, as it is based on voluntary reporting with about 29% of eligible professionals participating using any reporting option in 2011. As such, the PCPI® recommends against removal from PQRS. Additionally, the title of this measure has been editted. Please update the title to: "Stroke and Stroke Rehabilitation: Venous Thromboembolism (VTE) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage."

NQF #	Measure Title	Program under consideration and MAP recommendations	MAP Additional Comments	PCPI® Response to MAP Recommendations
0325 (Endorsed)	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	Measure does not adequately address any current needs of the program; Preference should be given to outcome measures that address adherence to medications as opposed to measures that just assess if a medication was prescribed. The measure set already includes outcome measures addressing this condition	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. Further, this measure is NQF-endorsed, demonstrating it meets all four NQF criteria: importance, scientific acceptability, usability and relevance, and feasibility.As such, the PCPI® recommends against removal from PQRS.
0104 (Endorsed)	Major Depressive Disorder (MDD): Suicide Risk Assessment	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	Measure does not adequately address any current needs of the program; Preference for other outcome measures that assess care for depression and/or process measures more proximal to outcome that include an engagement and follow-up component	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. Further, this measure is NQF-endorsed, demonstrating it meets all four NQF criteria: importance, scientific acceptability, usability and relevance, and feasibility. Finally, this measure is an eCQM. As the PQRS and Meaningful Use (MU) programs share measures sets, the removal of this eCQM from PQRS would result in a lack of alignment between PQRS and MU. The PCPI® recommends against the removal of this measure from PQRS.
0103 (Endorsed)	Major Depressive Disorder (MDD): Diagnostic Evaluation	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	Measure does not adequately address any current needs of the program; Preference for other outcome measures that assess care for depression and/or process measures more proximal to outcome that include an engagement and follow-up component	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. Further, this measure is NQF-endorsed, demonstrating it meets all four NQF criteria: importance, scientific acceptability, usability and relevance, and feasibility. As such, the PCPI® recommends against removal from PQRS.

NQF #	Measure Title	Program under consideration and MAP recommendations	MAP Additional Comments	PCPI® Response to MAP Recommendations
0001 (Not Endorsed)	Asthma: Assessment of Asthma Control	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	A 'Supported' measure under consideration addresses a similar topic and better addresses the needs of the program; Recommend replacing this measure with the Minnesota Community Measurement measure of Optimal Asthma Care that includes a PRO addressing patient-achieved asthma control	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. As such, the PCPI® recommends against removal from PQRS.
0232 (Not endorsed)	Vital Signs for Community-Acquired Bacterial Pneumonia	PQRS: Remove Physician compare: Do not Support VBPM: Do not support	NQF Endorsement removed (the measure no longer meets the NQF endorsement criteria)	PCPI® measures are developed through cross-specialty, multi-disciplinary work groups who are tasked with developing performance measures that reflect the most rigorous clinical evidence, and address areas most in need of improvement with the eventual aim of improving patient outcomes. As such, the PCPI® recommends against removal from PQRS.

NQF #	Measure Title	Program under consideration and MAP recommendations	MAP Additional Comments	PCPI® Response to MAP Recommendations
XACHC (Not Endorsed)	173 Preventive Care and Screening: Unhealthy Alcohol Use Screening	PQRS: Remove	Measure does not adequately address any current needs of the program; Preference for other, more inclusive, screening measures for unhealthy alcohol use	With regards to the MAP recommendation to remove PQRS measure 173, we would like to advocate that the measure be replaced by the broader version of this measure, titled Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling, which has also been developed by the PCPI to incorporate not only screening but also brief counseling and is currently under review by NQF (NQF #2152) for possible endorsement. We would like to emphasize that measures assessing the provision of preventive health services have the greatest potential to improve health outcomes for the greatest number of people. This focus on population health has been identified as a critically important priority area in national efforts to improve health and the health care delivery system including the National Quality Strategy and the past work of the National Priorities Partnership, convened by NQF. Alcohol misuse is the third leading cause of preventable death in the United States, after tobacco use and being overweight. About 30% of the U.S. population misuse alcohol, with most engaging in what is considered risky drinking. Unhealthy alcohol use contributes to hypertension, cirrhosis, gastritis, gastric ulcers, pancreatitis, breast cancer, neuropathy, cardiomyopathy, anemia, osteoporosis, cognitive impairment, depression, insomnia, anxiety, suicide, injury, and violence. Unhealthy alcohol use screening and brief counseling has been shown to be effective in reducing alcohol consumption, particularly in primary care settings. The importance and need for measure 2152 was just recently highlighted by the January 10th edition of CDC's Morbidity and Mortality Weekly Report (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6301a4.htm?s_cid=mm6301a4_w) which offers the first set of national data on the prevalence of implementation of alcohol screening and brief intervention (ASBI) among U.S. adults. The results of the analysis found that "only one in six U.S. adults overall, one in five current drinkers, and one in four binge drinkers in 44 states and DC reported ever discussing alcohol use with a doctor or other health professional. Further, 65.1% of those who reported binge drinking ≥10 times in the past month had never had this dialogue."
		Physician compare: Do not Support		
		VBPM: Do not support		

Table A4. AMA Input on PQRS Measures Under Consideration

NQF #	Measure Title	Program under consideration and MAP recommendations	MAP Additional Comments	PCPI® Response to MAP Recommendations
XDFCA (Not Endorsed)	Appropriate Use of imaging for non-traumatic Shoulder pain	PQRS: Conditional Support Physician compare: Do not Support VBPM: Do not support	Addresses a measurement area not adequately represented in the program measure set; Not ready for implementation; should be submitted for and receive NQF endorsement	We would like to recommend that the following measures, submitted by PCPI member organizations, be considered for inclusion in PQRS 2015. These measures specifically include Measures #XDFCA, XDFCB, XDFBM, XDFCC, XDFCE, and XDFCL. We have collaborated on the development of these measures and feel strongly that they will enhance the current portfolio of PQRS measures. The measures for diagnostic imaging are in draft form, however we expect them to be completed and PCPI-approved in the coming months.
XDFCB (Not Endorsed)	Appropriate Use of imaging for non-traumatic knee pain	PQRS: Conditional Support Physician compare: Do not Support VBPM: Do not support	Addresses a measurement area not adequately represented in the program measure set; Not ready for implementation; should be submitted for and receive NQF endorsement	
XDFBM (Not Endorsed)	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	PQRS: Support Physician Compare: Conditional Support VBPM: Conditional Support	Addresses a measurement area not adequately represented in the program measure set; Not ready for implementation; should be submitted for and receive NQF endorsement	
XDFCC (Not Endorsed)	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	PQRS: Conditional Support Physician compare: Do not Support VBPM: Do not support	Addresses a measurement area not adequately represented in the program measure set; Not ready for implementation; should be submitted for and receive NQF endorsement	
XDFCE (Not Endorsed)	Appropriate follow-up imaging for incidental thyroid nodules in patients	PQRS: Conditional Support Physician compare: Do not Support VBPM: Do not support	Addresses a measurement area not adequately represented in the program measure set; Not ready for implementation; should be submitted for and receive NQF endorsement	
XDFCL (Not Endorsed)	Appopriate follow-up imaging for incidental simple ovarian cysts	PQRS: Conditional Support Physician compare: Do not Support VBPM: Do not support	Addresses a measurement area not adequately represented in the program measure set; Not ready for implementation; should be submitted for and receive NQF endorsement	

NQF #	Measure Title	Program under consideration and MAP recommendations	MAP Additional Comments	PCPI® Response to MAP Recommendations
XDFBC (Not Endorsed)	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	PQRS: Conditional Support	Not ready for implementation; measure concept is promising but requires modification or further development; Not ready for implementation; should be submitted for and receive NQF endorsement; Further development should explore combining XDFBC, XDFBD, and XDFBE into a composite measure.	We are encouraged by the conditional support of the MAP for use of the screening and referral to treatment measures for hepatitis C virus in the PQRS program. As noted in the CDC recommendations for the identification of chronic hepatitis C, HCV testing is the first step toward improving health outcomes for the estimated 2.7-3.9 million persons infected with HCV given that most persons with HCV do not know they are infected, do not receive needed care (e.g., education, counseling, and medical monitoring), and are not evaluated for treatment. The three measures that were reviewed by the MAP were designed to promote the identification of hepatitis C to ensure early intervention and proper management of the virus. With regards to the suggestion to combine the three measures, the two screening measures address distinct patient populations (at risk individuals and active injection drug users) and, as supported by the evidence, they also incorporate distinct frequencies for testing for HCV (one-time screening and annual). Additionally, the referral to treatment measure also focuses on a separate patient population in that it is only applicable to those patients who were identified as having HCV infection through a screening process. While each of the measures is complementary to one another and share a common goal, there are nuances in how the measures are defined that would make combining the measures infeasible.
		Physician compare: Do not Support		
		VBPM: Do not support		
XDFBD (Not Endorsed)	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	PQRS: Conditional Support	Not ready for implementation; measure concept is promising but requires modification or further development; Not ready for implementation; should be submitted for and receive NQF endorsement; Further development should explore combining XDFBC, XDFBD, and XDFBE into a composite measure.	
		Physician compare: Do not Support		
		VBPM: Do not support		
XDFBE	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	PQRS: Conditional Support	Not ready for implementation; measure concept is promising but requires modification or further development; Not ready for implementation; should be submitted for and receive NQF endorsement; Further development should explore combining XDFBC, XDFBD, and XDFBE into a composite measure.	
		Physician compare: Do not Support		
		VBPM: Do not support		

American Medical Group Association

Donald W. Fisher, PhD

On behalf of the American Medical Group Association, thank you for this opportunity to comment on the draft Measure Applications Partnership (MAP) Pre-Rulemaking Report for 2014. Our comments will focus on an area of expertise and clinical practice in which our Association holds an unique niche in knowledge and experience, that niche being the "systemness" or context and milieu in which the optimal clinical practice and delivery of quality and outcome-based healthcare, as advanced by the majority of MAP recommended measures, can best be conducted.

First, allow us to commend the Measures Application Partnership (MAP) and the National Quality Forum (NQF) staff for the past three years of a yeoman's effort in responding to the relevant directives of the Affordable Care Act (ACA) with regard to assessing and encouraging alignment of clinical measurements across Federal healthcare delivery programs. The accelerated schedule as required by the Department of Health and Human Services (DHHS) for this project notably has been exceedingly challenging and difficult. Yet, MAP has been markedly timely and successful and we want to acknowledge the MAP and the NQF staff for meeting this challenge with substantive depth and professional aplomb.

Second, of particular note, we want to underscore MAP's endeavor to align its overall task in the simulated context of real-time patient presentation, diagnosis, treatment and overall experience. Development of MAP's "Families of Measures" have been a novel approach to identifying and prioritizing the best known performance measures that can be applied across diverse settings, predictive analytics, and select demographics. While the ultimate decision of what measures should be applied in a specific scenario of care remains that of the practitioner in concert with the patient, MAP's thoughtful and decisive approach to creating and bundling "Families of Measures" goes a long way in attaining the overall achievement of increased harmonization and applied focus on high-priority measures as well as the best applications of the varied processes of care that can be employed.

American Nurses Association

Maureen Dailey

The revised MAP voting category, "conditional support," indicating measures, measure concepts, or measure ideas that should be phased into CMS program measure sets over time, subject to contingent factor(s) is an appropriate change supported by ANA. This is important so that there is timely uptake of innovative measures when the identified conditions recommended by MAP are met. ANA also supports consistency in the application of "conditional support" across MAP's work. This is essential to diffusion of evidence-based practice, building a learning health system, and reducing avoidable burden in data collection.

MAP recommendations that measures should be meaningful to consumers, clinicians, and other stakeholder are important. Ensuring that measures are high impact should be independent of NQF's work, including the MAP's work. This evaluation work should be conducted through thoughtful analysis by a balanced stakeholder group, providing a critical feedback loop to NQF. Although uptake of measures recommended by MAP is an informing exercise, the impact of measures is much different. Impact evaluation is not that same as concordance between MAP recommendations and HHS and other payer uptake.

ANA stands ready as a measure developer and leader in quality to participate fully in NQF, CMS, and ONC lean processes (Kaizen) and upcoming efforts to engage with measure developers (e.g., measure incubator). The inclusion of metrics that capture the contributions of team members, including nurses the proximal caregivers, is essential to a meaningful assessment of quality to achieve the goals and targets in the NQS.

American Society for Gastrointestinal Endoscopy

Kenneth K. Wang, MD, FASGE

The American Society for Gastrointestinal Endoscopy (ASGE), a 12,000- member, professional medical society whose mission is to advance patient care and digestive health by promoting excellence in gastrointestinal endoscopy, welcomes the opportunity to provide comments on the National

Quality Forum's (NQF) Measure Application Partnership (MAP) pre-rulemaking report released on January 13, 2014.

ASGE shares NQF's commitment to improve the quality of health for all Americans and the MAP's goal to achieve improvement, transparency, and value in health care in the furtherance of the three-part aim of the National Quality Strategy: better care, affordable care, and healthy people/healthy communities.

Reviewing the volume of measures on the Department of Health and Human Services' (HHS) list of measures under consideration (MUC) for federal programs is an immense undertaking, and ASGE appreciates the MAP's efforts to make its recommendations more meaningful during its third cycle. The improvements NQF has made, in collaboration with CMS and other major stakeholders, in the measurement development, review and endorsement processes were evident. ASGE welcomed the opportunity to provide comments on the MUC list prior to the MAP's deliberations and is pleased to see our input reflected in proposed decisions. In particular, ASGE appreciates the MAP's decision to support or conditionally support non-endorsed measures for inclusion in the Physician Quality Reporting System (PQRS) as the program lacks measures relevant to many clinical specialties, such as endoscopy. As an active member of NQF, ASGE offers its support to these continued process improvement efforts that will lead to greater lead times on national calls relative to measure review and more stability in reporting programs. Such improvements will enhance ASGE's ability to respond and make it more feasible for practitioners to make the often substantial infrastructure changes to participate in quality reporting programs.

Conclusion

The ASGE appreciates the opportunity to offer these comments on the MAP pre-rulemaking report and welcomes the opportunity to continue working with the MAP and CMS to grow the number of gastroenterology measures in CMS quality programs in 2015 and beyond.

American Society of Anesthesiologists

Jane C. K. Fitch, MD

ASA is pleased to offer comments on the Measure Applications Partnership (MAP) Pre-Rulemaking Report. We understand the significance of this report and its impact on quality measurement and measure development.

A majority of MAP-endorsed measures focus on chronic management of medical conditions and fail to involve specialties such as ours sufficiently. For example, the MAP included "Identifying Families of Measures and Core Measure Sets" yet neglected to design a measure family that anesthesiologists can report.

ASA disagrees with the MAP's rationale on not supporting anesthesia care measures. Two of these measures relate to prevention of hospital-acquired infections which, despite quality initiatives, remain a significant cause of morbidity, prolonged hospitalization and death. Surgical site infections are the most common HAIs and appropriately timed pre-surgical antibiotic administration, which NQF #0269 addresses, is essential to preventing such infections. NQF #0464 addresses central line associated bloodstream infections (infections that may increase medical cost by approximately $46,000 per case) and helps to encourage safe practice and enhances patient safety.

ASA cautions MAP from elevating outcome measures at the expense of other measures, including process measures strongly associated with improved primary or secondary outcomes. That includes the strong association between intraoperative maintenance of normothermia and the prevention of surgical complications, as is the aim of NQF #0454. ASA encourages MAP to reconsider endorsement of the anesthesia care measures.

We are also concerned that MAP no longer supports NQF#0236 Preoperative Beta-Blocker in Patients with Isolated CABG Surgery in its current form but rather as part of a composite. As part of a shared accountability initiative, the ASA worked with the appropriate measure steward to allow anesthesiology CPT codes in that measure's denominator for PQRS 2014. We ask that MAP encourage inclusion of anesthesia codes in the other CABG group measures.

We request the MAP further explore shared accountability measures that will allow medical specialties an expanded opportunity to participate in quality programs and report on patient outcomes. This is especially pressing since outcome measures most meaningful to patients and most applicable to anesthesiologists have, to a significant extent, been created, tested and CMS approved. Because these measures were developed in silos, anesthesia CPT codes have not been part of the measures.

ASA commends MAP for implementing the "Conditional Support" mechanism. Conditional support allows the MAP to offer constructive feedback and serves to encourage rather than discourage measure development and refinement.

ASA appreciates your consideration of our comments.

American Society of Nephrology

Thomas H. Hostetter, MD

Additional Comments

ASN supports parsimony in measures. ASN believes that it is necessary and beneficial to have metrics based on important indicators of care quality in ESRD. However, ASN also believes that redundant or discrepant measures, as well as measures that are not validated or do not address a care gap, may actually serve to threaten quality of care. The society observes that, under the Conditions for Coverage (CfC) system for dialysis units, states conduct detailed periodic inspections while CMS maintains well-delineated interpretive guidance. Critically, avoiding discrepancies with the CfCs and minimizing redundant regulations are important for efficiency, and minimizing patient survey burden is important for validity and achieving desired outcomes of measures. It is within these contrasts that we comment on the currently proposed measures.

Again, thank you.

America's Health Insurance Plans

Carmella Bocchino

We recommend a greater representation of Medicaid managed care plans on MAP workgroups to ensure that measure gaps and documented disparities specific to vulnerable populations are adequately addressed and that the core measure sets reflect the specific needs of these populations.

AmeriHealth Caritas

Andrea Gelzer

Medicaid managed care plans should have greater representation on MAP to ensure that measure gaps and documented disparities specific to vulnerable populations are adequately addressed and that the core measure sets adequately reflect the needs of vulnerable populations. We support MAP's continue focus to address quality measurement issues specific to vulnerable populations and encourage MAP to explore Medicaid core measures for children and obstetrical care.

Amgen, Inc

Jason Spangler

By way of our participation in this pre-rulemaking public comment period conducted by the National Quality Forum (NQF) Measure Application Partnership (MAP), Amgen would like to note our appreciation for the opportunity to comment on quality measures under consideration by CMS for potential use in 2014 federal rulemaking. Amgen supports evidence-based quality improvement initiatives and believes that such initiatives offer a valuable opportunity to improve care for patients, especially those with cancer, osteoporosis, and the complications of end-stage renal disease. In particular, Amgen favors comprehensive measures to address the hormonal imbalances associated with chronic kidney disease. Although there are more cancer-specific quality measures than in previous years, we hope CMS and the MAP consider inclusion of more measures that focus on appropriate quality improvement for cancer care going forward. Additionally, Amgen strongly believes that patients with post-menopausal osteoporosis, as well as those at greatest risk for developing post-menopausal osteoporosis and related fracture events, would substantially benefit from the inclusion of related measures in Medicare quality programs that would help improve care and reduce costs. Finally, Amgen supports enhanced collaboration and partnership between measure developers and other engaged

stakeholders to address on-going gaps and suboptimal performance in the prevention, screening, treatment, and reporting of these serious conditions.

Armstrong Institute for Patient Safety and Quality at Johns Hopkins University

Matt Austin

In addition to our comments about specific measures, we feel strongly that performance measurement in healthcare needs some standards that would apply to all measures, such as the need to report out on each measure's validity and realiablity, to have thresholds of validity and reliablity before a measure is used in public reporting and P4P programs, the need to evaluate the feasibilty and burden of measurement, and the need to prioritize which measures are deemed most important for patients.

ASC Quality Collaboration

Donna Slosburg

On behalf of the ASC Quality Collaboration (ASC QC), a cooperative effort of organizations and companies interested in ensuring ASC quality data is appropriately developed and reported, please accept these comments regarding the 2014 Measure Applications Partnership (MAP) Pre-Rulemaking Report: Public Comment Draft. The ASC QC's members and participants include the Accreditation Association for Ambulatory HealthCare; Ambulatory Surgery Foundation; Ambulatory Surgical Centers of America; American College of Surgeons; American Osteopathic Association, Healthcare Facilities Accreditation Program; AmSurg; Association of periOperative Registered Nurses; Covenant Surgical Partners; Florida Society of Ambulatory Surgery Centers; Hospital Corporation of America, Ambulatory Surgery Division; Nueterra Healthcare; Outpatient Ophthalmic Surgery Society; Surgery Partners; Surgical Care Affiliates; Symbion; The Joint Commission; and United Surgical Partners, International.

We appreciate the process changes MAP has implemented over the past year, such as accepting public comment on the List of Measures Under Consideration prior to its in–person meetings to evaluate the measures. We believe additional process changes are needed to facilitate stakeholder engagement. The consideration of public comments during MAP Hospital Workgroup and Coordinating Committee meetings should be scheduled before, rather than after, member discussion and voting on agenda items has been completed. Stakeholders are often in a position to contribute key information that may not have been presented, to clarify points of discussion, or to correct misinformation prior to decision-making. We strongly recommend MAP administrative procedures be revised such that public comment is solicited prior to, rather than after, voting on agenda items.

California Hospital Association

Alyssa Keefe

While the federal government shutdown delayed the release of list of measures under consideration (MUC), CHA appreciates the intentions of CMS in releasing the MUC list earlier in the process and look forward to this change in the 2014 pre-rulemaking cycle.

CHA applauds CMS in its continuous improvement process and in making CMS staff and contractors available for participation in MAP discussions. In many instances it was of added value.

CDC-Division of Viral Hepatitis

Cecily Aleem, JD, LLM

Comments for hepatitis C measures (pages 179-80): XDFBC, XDFBD, XDFBE

Measures XDFBC, XDFBD, XDFBE received conditional support as PQRS measures with the suggestion to merge these three measures. We are concerned about the feasibility of combining these three measures because each one is measuring a different outcome:

- XDFBC (Screening for Hepatitis C Virus (HCV) for Patients at High Risk): this will measure the percentage of persons who received a one-time HCV screening among persons at risk for infection (i.e., having a history of injection drug use, received blood transfusions prior to 1992, undergoing maintenance hemodialysis, OR born in the years 1945–1965). The original title of this PCPI measure was "One-time Screening for Hepatitis C Virus

(HCV) for Patients at High Risk." We suggest the addition of "One-time" to the title to distinguish this measures from XDFBD

- XDFBD (Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users): this will measure the percentage of persons who received an annual HCV screening test among persons who are active injection drug users. Please note, this measure specifies active drug users versus measure XDFBC addresses persons with a history of injection drug use.
- XDFBE (Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection): this will measure the percentage of persons who are referred for treatment among persons identified to be infected with hepatitis C after undergoing screening and testing.

In our assessment, these measures cannot be combined because they address different populations and outcomes (i.e., one time versus annual hepatitis C screening in different populations and linkage to treatment).

Federation of American Hospitals

Jayne Hart Chambers

The Federation of American Hospitals, (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay rehabilitation, and long-term care hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. The FAH is pleased to comment on the Measure Applications Partnership (MAP) 2014 pre-rulemaking report to the Department of Health and Human Services.

The FAH strongly supports the multi-stakeholder deliberation process of the MAP and its work to assist the Department of Health and Human Services by reviewing and making recommendations on the quality measures that are most appropriate for use in public reporting and payment accountability programs. The role of the MAP is a critical tool fostering alignment of quality measurement across federal programs, and its work also informs uses of quality measures in the private sector.

The process for consideration and deliberation of quality measures is evolving, and each year the recommendations from the MAP become more focused and clear. In this, the third year of pre-rulemaking evaluation, the FAH commends CMS for providing greater clarity in the list of "Measures Under Consideration" (MUC list), and offers the following observations and recommended changes to the draft report to the Secretary.

Without the NQF evaluation, it is extremely difficult to evaluate a measure or measure concept for use in a specific program. For instance, a measure concept could be appealing and even important. However, without NQF endorsement, there is no assurance that a concept or idea can progress from the concept stage to implementation and be fit for use in a specific public reporting or payment program without being appropriately specified and evaluated for that setting. The NQF endorsement process also assures that patients, consumers, and providers understand the measure and its purpose prior to its implementation.

Therefore, the FAH believes that the MAP process would be more efficient if its measure recommendations include only those measures that are NQF-endorsed. Recognizing that the Department may need discussions of other topics, it could submit a separate list of concepts for consideration, which would enable the MAP to provide input about which concepts should be prioritized for further measure development -- for instance to fill gaps in measurement. This second list could be submitted at a different time, outside the extremely short December to February MUC review process.

Secondly, the MUC report is replete with references to "alignment" of measurement across settings. The FAH strongly believes alignment is the key to maximizing resources, creating greater efficiency in quality measurement, and facilitating improvement across settings. However, during the MAP considerations, it became clear that the term "alignment" holds different meanings to different constituents.

The FAH suggests that "alignment" be further defined in the MAP report and build more explicitly from the concept of families of measures. To the FAH, alignment means using the most appropriate

measure of care for a particular setting as it works to improve care on a particular priority topic. Accordingly, the FAH recommends that alignment be defined as focusing quality measurement on priority topics/conditions. Although there are times when a specific measure could be used in a multiplicity of programs, The MAP 2014 pre-rulemaking report to the Department of Health and Human Services should clarify that alignment does not mean using exactly the same measure in a multiplicity of programs to assess one specific topic or condition.

Each type of provider has a unique role to play in the continuum of care. A tool that assesses one type of provider may not be specified or be the most appropriate tool for assessing the services of another provider in the continuum, even if both providers are working toward to same priority quality area of care. The tools or quality measures developed to assess each setting or care giver or patient experience must be developed to capture that element of the care provided by that specific provider.

The MAP Families of Measures diagram begins to address the concept, but implies that the Core Measure Set is exactly the same measure used in a variety of different programs. We know from experience that the specifications for measures often differ from setting to setting and the measures need to be tested in each of the settings with its own set of specifications before it can be used for accountability purposes.

For instance, the PAC/Long-term Care chapter begins to address the topic of alignment across heterogeneous PAC/long-term care providers. However, in our view, the report could be stronger in recommending the development of functional status measures that assess the level of functionality that is unique to each of the long-term care settings. By necessity, this would require the development of measures that may examine similar topics, but would be specified and adapted to the specific services offered in each of the long-term care settings. The FAH recommends that the report more forcefully state that such measures should not be recommended for public reporting and accountability programs until they are specified, tested and endorsed specifically for the each of the specified PAC settings.

Florida Hospital

Richard E. Morrison

Florida Hospital welcomes the opportunity to comment on the 2014 MAP Pre-Rulemaking Report: Public Comment Draft. We commend NQF for its commitment to drive health care quality improvement. We appreciate the efforts the NQF has taken to enhance its partnerships with the health care delivery system by supporting provider efforts to achieve better quality through measurement. We have the following response to the Public Comment Draft.

GlaxoSmithKline

Deborah Fritz

GlaxoSmithKiline (GSK) values the opportunity on the 2014 MAP Pre-Rule Making Draft Report. GSK contributed to and agrees with PhRMA public comments on this report. Additional GSK comments are included in this submission

GSK supports MAP conditionally recommending measures that are not NQF endorsed, but only as measure concepts to encourage further development and testing, and clarifying that the specific measure is not to be implemented until it is NQF endorsed for that level of care.

GSK does not support MAP's conditional support or support of the Medicare Cost per Beneficiary measure in PQRS, Physician Compare, VBPM. This stand alone cost measure should not be used because it lacks consideration of Quality and of the concerns raised during the NQF review regarding its scientific acceptability particularly in regard to validity. GSK supports the CG-CAHPS Supplemental Item: Educating Patient about Medication Adherence in the Medicare Shared Savings Program (MSSP). As noted in our comments on gap areas, GSK strongly supports the development of Medication Management Family of Measures and recommend this be part of it.

GSK does not support the proposed removal of measures of medication adherence in order to promote the use of outcomes measures. We support increased development and adoption of outcomes measures. GSK also strongly supports development and adoptions of endorsed medication adherence

measures. Adherence measures are early signals of potential poor patient outcomes and system failures (readmissions) before poor outcomes and failures occur. For this reason, medication adherence measures are an essential part of Comprehensive Medication Management to improve outcomes and provide care at a lower cost.

Greater New York Hospital Association

Lorraine Ryan

Non-NQF-Endorsed Measures

The Greater New York Hospital Association (GNYHA) is concerned about the high number of non-NQF-endorsed measures CMS is considering across all programs. To ensure the integrity of Federal reporting programs, measures must be vetted for their validity, reliability, and feasibility, so that MAP is not forced to make recommendations based on the measures' scientific merit. While MAP workgroups include subject matter experts, MAP should not act as a substitute to the widely accepted NQF-endorsement process. GNYHA urges CMS to heed MAP's concerns about the lack of NQF endorsement for many of the measures, and further urges CMS to have MAP assess the measures that have been conditionally supported pending NQF-endorsement. Short of this, CMS must provide concrete and balanced evidence for including non-endorsed measures.

Information Provided in MAP's Review of Measures

GNYHA commends MAP for convening multiple stakeholders to review the measures. However, in listening to the deliberations, we are concerned that workgroup members often have little or skewed information to base decisions. In many cases, workgroup members are voting simply on the measure topic/title, or may only be provided evidence from one perspective with controversial or conflicting evidence. GNYHA urges MAP to ensure workgroups are given balanced and sufficient information to vote on measures.

Accounting for Socio-economic Status (SES) in Readmissions Measures

Low-income patients often have inadequate access to care outside the hospital, and little ability to navigate a complex, fragmented health care system. Safety net hospitals that care for these challenging populations frequently expend more resources to achieve equal outcomes on readmissions, yet the HRRP does not include risk adjustment or stratification methodologies to account for SES' impact on readmissions. GNYHA supports incorporating a risk-stratification method into HRRP in which CMS would create peer groups of hospitals with similar shares of low-income patients—defined as either dual-eligible or Medicare Supplemental Security Income (SSI) patients—and derive benchmark readmission rates specific to each group. Recognizing population SES differences in this way would improve HRRP's validity and equity. A recent study in Health Services Research, "The Medicare Hospital Readmissions Reduction Program: Potential Unintended Consequences for Hospitals Serving Vulnerable Populations"(Gu et al., 2013) provides evidence of the need to adjust for SES. Additionally, potentially avoidable hospital admissions and readmissions are determined from inpatient claims data, and they do not always result from poor inpatient care or discharge planning, but rather from deficient care management/coordination, primary care, or residential institutional care.

Hospital Associacion of Pennslyvania

Brian Smith

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member institutions, including 125 stand-alone hospitals and another 120 hospitals that comprise 32 health systems across the state, we appreciate this opportunity to comment about the Measure Application Partnership's (MAP) 2014 pre-rulemaking report. This letter focuses on HAP's main concerns which range from non-National Quality Forum (NQF) endorsed measures and all-cause readmission penalty parameters.

HAP strongly supports the premise of the MAP's work: improvement in our nation's health care system can be catalyzed by selecting quality measures in federal reporting and payment programs focused on aspects of care that a broad array of stakeholders believe to be important.

HAP is concerned that the MAP's approach to

alignment has become too focused on ensuring the exact same measures are recommended for more than one program, rather than an assessment of whether measures truly address overarching health care system-wide improvement priorities. We agree thatusing the same measure in more than one program can promote alignment, but only to the extent that those measures generate reliable, accurate performance results in more than one care setting.

Several measures, most notably, the readmission and mortality measures proposed for hospital programs, have significant flaws that must be addressed before they are considered appropriate for public reporting or pay-for-performance applications. CMS has proposed for inclusion in multiple programs several electronic clinical quality measures (eCQM), but it has yet to demonstrate that hospital electronic health records (EHR) can generate accurate data appropriate for both quality improvement and accountability.

HAP has repeatedly and consistently urged CMS to use only NQF-endorsed measures in federal quality reporting programs, and is deeply concerned that only 47 of the 234 measures (or 20 percent) on this year's MUC list are NQF-endorsed. We believe the very first step in bringing a measure into a national reporting or pay-for-performance program, even before putting the measure on the MUC list, should be to obtain NQF endorsement. We are concerned that placing partially developed, unendorsed measures on the MUC list may force the MAP to make premature judgments of the suitability of measures for federal programs.

HAP remains concerned that the all-Cause, all conditions readmissions measure, along with all of CMS' other readmission measures, does not adjust for socioeconomic factors beyond the control of hospitals.

Thank you for consideration of our comments on Measure Applications Partnership Pre-Rulemaking Draft Report.

Medical Imaging and Technology Alliance

Gail Rodriguez, PhD

The Medical Imaging and Technology Alliance (MITA) is pleased to submit comments on the Measures Application Partnership (MAP) 2014 Draft Pre-Rulemaking Report ("draft report") published for public comment in January 2014 which includes 234 measures for consideration to comply with Section 1890A of the Social Security Act. As the leading trade association representing medical imaging, radiotherapy, and radiopharmaceutical manufacturers, we have in-depth knowledge of the significant benefits to the health of Medicare beneficiaries that medical imaging and radiotherapy provide. MITA is pleased to work with MAP to ensure that the reimbursement and quality initiatives under the Department of Health and Human Services (HHS) encourage appropriate use of medical imaging for the early detection, diagnosis, staging, therapy monitoring, and surveillance of many diseases and radiation therapy for the treatment of cancer.

Medical imaging encompasses X-ray imaging, computed tomography (CT) scans, related image acquisitions, diagnostic ultrasound, nuclear medicine imaging (including positron emission tomography (PET)), and magnetic resonance imaging (MRI). Medical imaging is used to diagnose patients with disease, often reducing the need for costly medical services and invasive surgical procedures. In addition, medical imaging equipment often is used to select, guide, and facilitate effective treatment, for example, by using image guidance for surgical or radiotherapeutic interventions. MITA's members also develop and manufacture innovative radiotherapy equipment used in cancer treatment.

Our comments on the 2014 draft report reference our position that HHS should only use measures that are National Quality Forum (NQF) endorsed. MITA supports the inclusion of measures that support use of the right imaging services at the right time. However, without the public transparency and deliberation of the NQF endorsement process, we lack the information to support measures lacking NQF endorsement and are concerned that they may not achieve their stated goals. We encourage HHS to consider measures only after they have received the consideration and approval of the NQF.

We understand and concur with MAP's determination that increased focus should be placed on measures that relate to the affordability of care; however, in the case of medical imaging, we urge MAP to view

with caution measures that relate solely to the volume of diagnostic tests performed. Diagnostic imaging efficiency measures should take into account unnecessary procedures averted through performance of the test at issue. This comprehensive approach is substantially more likely to result in enhanced value for patients.

NQF-Endorsed Measures

The 2014 draft report includes several NQF-endorsed measures on diagnostic imaging and radiation therapy for which MAP states support: 1) Oncology: Radiation Dose Limits to Normal Tissues (0382); 2) Use of Imaging Studies for Low Back Pain (0052); 3) Overutilization of Imaging Studies in Melanoma (0562); 4) Cardiac stress imaging not meeting appropriate use criteria: Preoperative evaluation in low risk surgery patients (0670); 5) Cardiac stress imaging not meeting appropriate use criteria: Routine testing after percutaneous coronary intervention (PCI) (0671); 6) Cardiac stress imaging not meeting appropriate use criteria: Testing in asymptomatic, low risk patients (0672); and 7) Ultrasound determination of pregnancy location for pregnant patients with abdominal pain (0651). We support the inclusion of these measures. Of these measures, NQF 0651 has time-limited NQF-endorsement. If NQF endorsement is withdrawn, we believe CMS should remove the measure.

In addition, MAP does not support several NQF-endorsed measures because MAP has determined that they do not address any of the current needs of the program: 1) Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (0383) (paired with 0384); 2) Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older (0046); 3) Stenosis measurement in carotid imaging studies (0507); and 4) Exposure time reported for procedures using fluoroscopy (0510). We support measures that drive quality imaging and radiation therapy services. As such, we urge MAP to continue consideration of NQF endorsed measures that meet these important goals.

Measures Without NQF Endorsement

MAP considered five radiation dose optimization measures that were not NQF endorsed and determined that they do not adequately address any current needs of the program. As such, MAP does not support the following measures: 1) Radiation Dose Optimization: Cumulative Count of Potential High Dose Radiation Imaging Studies: CT Scans and Cardiac Nuclear Medicine Scans (XBLLC); 2) Radiation Dose Optimization: Utilization of a Standardized Nomenclature for CT Imaging Description (XBLLD); 3) Radiation Dose Optimization: Search for Prior Imaging Studies through a Secure, Authorized, Media-free, Shared Archive (XBLLL); 4) Radiation Dose Optimization: Images Available for Patient Follow-up and Comparison Purposes (XCEEC); and 5) Radiation Dose Optimization: Reporting to a Radiation Dose Index Registry (XCEED). We support the goal of dose optimization, but agree that these measures are not NQF endorsed and should not be utilized by MAP at this time.

MAP considered five dementia related measures and suggested compiling them into two composite measures - one composite for staging, cognitive assessment, and functional assessment; and another composite for the two neuropsychiatric symptom measures: 1) 280 Dementia: Staging of Dementia (XBAEA); 2) 281 Dementia: Cognitive Assessment (XBAEB); 3) 282 Dementia: Functional Status Assessment (XBAEC); 4) 283 Dementia: Neuropsychiatric Symptom Assessment (XBAED); and 5) 284 Dementia: Management of Neuropsychiatric Symptoms (XBAEE). We agree with MAP that these measures do not currently meet the needs of the program. We support the use of dementia diagnostics, including beta amyloid PET, that improve quality and treatment potential for patients.

In addition, MAP notes that a dementia measure is promising, but not ready for implementation: Draft: Dementia Condition Episode for CMS Episode Grouper (XDEEA). MAP notes that this measure should be paired with relevant clinical outcome measures. We agree with MAP's assessment and urge MAP consideration of this measure, only after NQF endorsement of the measure.

MAP determined that two measures are neither NQF endorsed nor do they meet MAP program goals, and as such, MAP does not support: 1) American Board of Radiology/American Board of Medical Specialties/ American College of Radiology/Physician Consortium

for Performance Improvement: [DRAFT] Radiation Dose Optimization: Appropriateness: Follow-up CT Imaging for Incidental Pulmonary Nodules A; and 2) 262 Image Confirmation of Successful Excision of Image-Localized Breast Lesion (XBAMM). We agree that these measures should not be used at this time. However, we support the appropriate use of imaging technologies and encourage MAP to consider NQF-approved measures that support quality imaging services in patient care.

MAP notes that some oncology related measures are promising but not ready for implementation. Included in this set are: 1) Draft: Breast Cancer Condition Episode for CMS Episode Grouper (XDEDC); 2) Draft: Breast Cancer Treatment Episode for CMS Episode Grouper (XDEDD); 3) Draft: Lung Cancer Condition Episode for CMS Episode Grouper (XDEDE); 4) Draft: Lung Cancer Treatment Episode for CMS Episode Grouper (XDEDF); 5) Draft: Prostate Cancer Treatment Episode for CMS Episode Grouper (XDEDG); 6) Draft: Prostate Cancer Condition Episode for CMS Episode Grouper (XDEDH); 7) Draft: Colon Cancer Condition Episode for CMS Episode Grouper (XDEDL); and 8) Draft: Colon Cancer Treatment Episode for CMS Episode Grouper (XDEDM). MAP notes these measures should be paired with relevant clinical outcome measures. As manufacturers of live-saving diagnostic imaging and radiation therapy equipment, we encourage MAP to consider the value of these technologies to the clinical outcomes. We agree with MAP's assessment that these measures are not ready for implementation, and reiterate our position that measures should be NQF endorsed before inclusion in the program.

MAP notes several early detection measures are promising but not ready for implementation: 1) Repeat Colonoscopy due to poor bowel preparation (XDFGL); 2) Appropriate age for colorectal cancer screening colonoscopy (XDFGM); and 3) Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile (XDEGH). We support the value of screening appropriate populations and agree with MAP that these measures should not yet be implemented.

MAP notes that imaging measures are promising but not ready for implementation: 1) Overuse of Diagnostic Imaging for Uncomplicated Headache (XDAFA); 2) Appropriate use of imaging for non-traumatic shoulder pain (XDFCA); 3) Appropriate use of imaging for non-traumatic knee pain (XDFCB); 4) Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques (XDFBM); 5) Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy (XDFCC); 6) Appropriate follow-up imaging for incidental thyroid nodules in patients (XDFCE); 7) Composite measure: 1- Appropriate follow-up imaging for incidental liver lesions (XDFCF); 8) Composite measure: 2- Appropriate follow-up imaging for incidental kidney lesions composite measure (XDFCG); 9) Composite measure: 3- Appropriate follow-up imaging for incidental adrenal lesions composite measure (XDFCH); 10) Appropriate follow-up imaging for incidental simple ovarian cysts (XDFCL); 11) Utilization of ultrasonography in children with clinically suspected appendicitis (XDFBL); and 12) Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis (XDBLG). We agree that these measures are not ready for implementation and should be NQF endorsed before consideration by MAP.

MAP notes two imaging measures are not NQF endorsed and MAP has endorsed similar measures that better address the needs of the program: 1) Avoidance of inappropriate use of head CT in ED patients with minor head injury (XDFDL); and 2) Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain (XDFGF). As such MAP does not support these measures and suggests other NQF endorsed measures are included. We agree that these measures should not be used and that NQF endorsed measures are preferable.

NQF endorsement was removed from Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy (0511) and as such, MAP does not support this measure. We agree with the measure should not be included in the program without NQF endorsement.

The draft report notes that the measure entitled Colonoscopy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4: Measures Group Colonoscopy) is neither NQF endorsed nor supported by MAP. MAP states the

measure does not adequately address any current needs of the program. We believe the complications from colonoscopy should be considered as a quality measure and encourage further consideration of similar measures that account for complications of colonoscopy, if those measures are NQF endorsed.

* * * *

MITA appreciates this opportunity to comment on the 2014 draft report. We would be pleased to answer any questions you might have about these comments. Please contact me at (703) 841-3235 if MITA can be of any assistance.

National Kidney Foundaton

Joseph Vassalotti, MD

The National Kidney Foundation (NKF) appreciates the opportunity to comment on the Measures Application Partnership (MAP) Pre-Ruling Making Report for 2014. NKF is America's largest and oldest health organization dedicated to the awareness, prevention and treatment of kidney disease for hundreds of thousands of healthcare professionals, millions of patients and their families, and tens of millions of people at risk. In addition, NKF is the founding sponsor of the Kidney Disease Improving Global Outcomes (KDIGO) initiative and has provided evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD) and related complications since 1997 through the NKF Kidney Disease Outcomes Quality Initiative (NKF KDOQI). NKF supports the development and use of evidence based quality measures to drive improvements in diagnosis, treatment, and ultimately outcomes for people with chronic kidney disease. We are pleased to offer guidance and comments on both the list of Measures Under Consideration (MUC) for the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and on the MAP's recommendations for clinician level measures related to CKD.

Appendix

MUC ID	Measure Title	NKF Comments
XDGBA	ESRD Vaccination – Lifetime Pneumococcal Vaccination	Support with modification: the measures proposed should be modified to align with the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) recommendation. We recommend that Arbor either revise the measures to align with ACIP recommendations that for people with severe kidney disease should receive the PCV13 and the PPSV23, but for those who are vaccine naïve, the PCV13 should be given first with the PPSV23 not given for at least 8 weeks. For individuals previously vaccinated with PPSV23, the PPV13 should not be given for at least 1 year after the last PPSV23 dose.1 These timing considerations should be detailed explicitly into the measure specifications. Our preference is that Arbor modifies the Lifetime Pneumococcal Vaccination measure to include these specifications rather than have a separate measure for each vaccine type. In addition we are concerned about the "offered but declined" portion of the measure and recommend it be removed. While patients may decline the vaccine initially, many more will accept if they are properly educated. The inclusion of this clause could actually result in lower immunization rates than if it were not included. Including the clause also dilutes the measure making it a process of care measure rather than actual measures of immunization rates.
XDEFL	ESRD Vaccination - Pneumococcal Vaccination (PPSV23)	See Above Comments
XDEGA	ESRD Vaccination - Timely Influenza Vaccination	Oppose: NKF questions the need and evidence base for the Timely Influenza Vaccine in addition to the measure of Full Season Influenza Vaccination. No evidence is provided that administering the vaccine prior to December 31, results in a reduction of hospitalization and mortality related to influenza. While well intended, at this time we cannot support the measure due to the lack of evidence for it.
XDEFM	Full-Season Influenza Vaccination (ESRD Patients)	Support with modification: While supportive of the Full-Season Influenza Vaccine we suggest CMS work through requesting a modification of the currently NQF endorsed #0226 Influenza Immunization in the ESRD Population rather than introduce an entirely new measure. We see this as a more successful path for implementation. In addition we are concerned about the "offered but declined" portion of the measure and recommend it be removed. While patients may decline the vaccine initially, many more will accept if they are properly educated. The inclusion of this clause could actually result in lower immunization rates than if it were not included. Including the clause also dilutes the measure making it a process of care measure rather than actual measures of immunization rates.
XCBMM	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V	Support
XDGAM	Pediatric Peritoneal Dialysis Adequacy: Frequency of Measurement of Kt/V	Support
XDEGB	Percentage of Dialysis Patients with Dietary Counseling	Support: NKF supports the Mineral and bone disorder: Percentage of Dialysis Patients with Dietary Counseling. Many measures related to mineral and bone disorder also involves patient compliance. Patients that are appropriately educated on their role in managing their health are more likely to follow the guidance of healthcare professionals and have better outcomes.

MUC ID	Measure Title	NKF Comments
XDEFH	Pneumococcal Vaccination Measure (PCV13)	Support with modification: the measures proposed should be modified to align with the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) recommendation. We recommend that Arbor either revise the measures to align with ACIP recommendations that for people with severe kidney disease should receive the PCV13 and the PPSV23, but for those who are vaccine naïve, the PCV13 should be given first with the PPSV23 not given for at least 8 weeks. For individuals previously vaccinated with PPSV23, the PPV13 should not be given for at least 1 year after the last PPSV23 dose.1 These timing considerations should be detailed explicitly into the measure specifications. Our preference is that Arbor modifies the Lifetime Pneumococcal Vaccination measure to include these specifications rather than have a separate measure for each vaccine type. In addition we are concerned about the "offered but declined" portion of the measure and recommend it be removed. While patients may decline the vaccine initially, many more will accept if they are properly educated. The inclusion of this clause could actually result in lower immunization rates than if it were not included. Including the clause also dilutes the measure making it a process of care measure rather than actual measures of immunization rates.
XDEFF	Standardized Kt/V	Opposed: While the Standard Kt/V Reporting Measure allows one to assess adequacy of dialysis in those receiving hemodialysis on a schedule different from the traditional three times per week. This measure is based on a mathematical model that has not been sufficiently validated. It also appears that this measure is being proposed to require data collection to validate the Standard Weekly Kt/V as a measure of adequacy. NKF believes this is an inappropriate use of a clinical performance measure and that validation should occur through following the appropriate NQF guidance. However, NKF does encourage CMS to require dialysis centers to report standard Kt/V values for patients receiving dialysis outside of the traditional three times per week schedule, but this should be a reporting requirement and not a measure used in the QIP.
XDEFE	Surface Area Normalized Kt/V	Oppose: there is no evidence that the Surface Area Normalized Standard Kt/V Reporting Measure represents a validated quality metric. While the data that needs to be reported to meet this metric is innocuous, it appears that this measure is being proposed to require data collection in order to validate Surface Area Normalized standard Kt/V as a measure of adequacy.
XAHMH	Ultrafiltration Rate (UFR)	Oppose: We disagree with the Ultrafiltration Rate > 13 ml/kg/hr measure as it is based on relatively low level evidence. The data for this statement is also confounded by patient size and some of the studies have not accounted for residual renal function in assessing outcomes. There is also a significant risk of adverse patient selection or poor patient care if ultrafiltration is limited based on this measure.
N/A Not endorsed	Comorbidity Reporting	Oppose: This is not a quality measure and CMS should look for other opportunities outside of the QIP to collect this information

National Partnership for Women & Families

Alison Shippy

MAP is only a couple of years old and C-P Alliance is proud to have witnessed improvements every year, with NQF and CMS continuously improving their processes and communication. We applaud a new process that was employed this year, which provided an additional public comment period in the beginning of the process that allowed for upstream input from stakeholders that typically do not have representation at the MAP. This was an attempt to address that many stakeholders felt the January public comment period was too late in the process and that the report was fairly finalized when released to the public. C-P Alliance urges NQF to continue to implement process improvements such as this.

Pharmaceutical Research and Manufacturers of America

Kelsey Lang

A. Progress on the MAP Strategic Plan

Feedback Loops/Stakeholder Engagement

PhRMA appreciates that MAP continues to encourage and foster stakeholder engagement in its processes. PhRMA commends MAP for instituting an early public comment period prior to MAP review of the measures under consideration. In addition, PhRMA supports the new function in NQF's new online Quality Positioning System (QPS) which allows stakeholders to share information on use and implementation on a regular basis. PhRMA encourages MAP to continue to identify ways to bring stakeholders, including the pharmaceutical industry, together to advance national performance measurement goals.

C. New Measures Supported or Conditionally Supported by MAP

MAP Support for Measures that are not NQF-Endorsed

PhRMA commends MAP for, in general, supporting the use of measures in federal programs that have attained stakeholder consensus endorsement (such as NQF-endorsement). To that end, we urge MAP to reconsider recommendations to support measures that are not NQF-endorsed in the draft report, particularly those that have been reviewed by NQF and did not receive endorsement (in contrast to those that have never been submitted for endorsement). Furthermore, we recommend that MAP reconsider its policy to conditionally support measures that are in the "measure concept" stage. While in most cases MAP support for these measures is contingent on NQF review and endorsement, we believe that in many cases the information available about these measure concepts is insufficient for MAP to make a recommendation regarding the measure concept. While we appreciate that due to the urgency of CMS programmatic needs measures are often reviewed by MAP before they have been reviewed by NQF, measures supported by MAP should at a minimum be fully specified and tested.

Draft Episode Grouper Measures

PhRMA supports efforts to encourage high quality health care through the implementation of several value-based payment programs. PhRMA commends MAP for acknowledging that there are several potential technical issues with the draft episode grouper measures under consideration for the Value-Based Payment Modifier (VBPM) program, including attribution of costs across an episode of care to an individual clinician and accounting for severity of disease. In addition, PhRMA agrees that appropriate outcomes measures must be identified to complement these cost measures. Additionally, PhRMA agrees that resource use/cost measures and their paired quality measures should be endorsed by a multi-stakeholder, consensus-based organization like NQF before they are implemented to ensure that they meet the rigorous standards for these measures.

Society of Hospital Medicine

Eric Howell, MD

The Society of Hospital Medicine (SHM) welcomes the invitation to comment on the "List of Measures Under Consideration December 2013." SHM represents the more than 40,000 hospitalists currently practicing in the US. Hospitalists provide care to more hospitalized patients, including Medicare beneficiaries, than any other specialty. Hospitalists have a distinctive role in facilitating both the individual physician-level and the hospital-level performance agendas. SHM has been active in educating and encouraging our members to

participate in many of the 20 applicable programs for which these performance measures are being considered, as appropriate for hospital medicine practice.

SHM has a goal to broaden the performance measures used for performance improvement or accountability in the Medicare programs including the Hospital-Acquired Condition (HAC) Reduction, Hospital Inpatient Quality Reporting (IQR), Hospital Readmission Reduction, Hospital Value-Based Purchasing, Medicare Shared Savings Program, Medicare Physician Quality Reporting System (PQRS), Physician Compare, Physician Feedback/ Quality and Resource Utilization Reports (QRUR), and the Physician Value-Based Modifier Programs. This will allow more robust participation by hospitalists, as the current measures do not always adequately represent the scope of our work.

The Joint Commission

Sharon Sprenger

The Joint Commission appreciates the many process enhancements that have been put in place by the MAP. For example, during this year's cycle the public was invited to provide comments on the HHS List of Measures Under Consideration. The public's comments were read during the review of measures by each of the workgroups. The process could have been enhanced by providing stakeholders an opportunity to provide additional public comment following the workgroups discussion, but prior to voting.

We support many of the comments made throughout the document regarding eMeasures and agrees with the MAP's decision not to support several eMeasures that were either not ready, or not right for the program. Importantly, the Joint Commission agrees that measures assessing use or adoption of an electronic medical record may not address the needs of quality reporting programs and may be better aligned with other measurement initiatives.

The Joint Commission supports efforts to advance health information technology and explore its use in simplifying and streamlining the reporting of data that can be used to assess quality. However, the reporting of quality data through health information technology (IT) still requires a significant investment in the development of the technical frameworks and alignment of health IT standards before the benefits of simplification and streamlined reporting can be realized by pertinent stakeholders. Before information can reliably be extracted for electronic measures, further consensus on the expression and modeling of structured data elements for nursing documentation, patient preferences, provider-provider and provider-patient communication, care plan data, and evidence-based assessment scales is required.

Prior to the MAP providing input on the selection of eMeasures for federal quality reporting and payment programs, robust testing and validation is required and should then be followed by NQF endorsement.

The Leapfrog Group

Melissa Danforth

The Leapfrog Group is one of the few organizations that collects and publicly reports quality data on a national level, so we bring a perspective from the trenches on what measures would be most effectively collected and reported. Thus we appreciate the opportunity to submit comments to the Measurement Applications Partnership (MAP) prior to their final report to CMS.

Based on the current CMS MUC List and this draft MAP report, Leapfrog, our board, and our members remain concerned regarding the significant gap in the public reporting of hospital-acquired conditions. Since CMS' decision to remove the eight hospital-acquired conditions measures from the IQR program, we continue to await promised replacement measures, and none have emerged. Though we support the addition of the PSI measures listed below to the HAC Reduction Program, there are still gaps in information for consumers and purchasers. We have serious concerns about the following gaps:

1) Adequate reporting on (a) Foreign Object Retained After Surgery (b) Air Embolism, and (c) Falls and Trauma. CMS removed these Hospital Acquired Conditions from the IQR and announced the intention to remove them from all public reporting. These are very important errors and accidents that the public deserves to know about.

2) The absence of measures that focus on medication errors, which are the most common error made in health care.

3) The inadequacy of measures of surgical site infections that occur in the range of surgical procedures performed in the country;

4) The absence of measures that address appropriate use, a problem identified by the National Priorities Partnership as one of the six priority challenges in U.S. healthcare;

5) The inadequacy of measures of pediatric and maternity care,

We remain concerned about the alignment between public sector (both federal- and state-levels) and private sector purchasers' value-based efforts, and urge the MAP to encourage CMS to aggressively pursue opportunities to work with private purchasers. To achieve the improvements in safety, quality, and resource use the U.S. healthcare system desperately needs, it's imperative that all purchasers work together to send a strong signal to the market. This starts with communicating aligned priorities through measurement, payment, and public reporting programs as this will ultimately enable providers to focus on improvement, rather than on fulfilling multiple, disparate measurement requests.

In closing, we would strongly urge the MAP to continue its work with the stakeholders represented on its committee to identify and priorities gaps in the current measurement and public reporting landscape, and develop strategize to fill these gaps in the near-term.

UnitedHealth Care

Rhonda Robinson Beale

We have reviewed CMS report of Measures under Consideration (MUC). There are 234 measures proposed that focus on 9 areas (the table below). They are proposed to be used by 20 CMS Medicare programs. The comments below are mainly based on our measure experience in commercial population.

- We are pleased to see that CMS is moving from Process Measures (99) to Outcome (57), Cost/ Resource Use (46), and Efficiency measures (5), and urge CMS to call for and continue to add, where and when developed further outcome, cost, resource use, and efficiency measures.
- We support the inclusion of outcome measures indicating defects in care for common outpatient procedures, including unplanned admissions following cataract procedures (XDEMB) and colonoscopy procedures (XDEMA)
- We also are pleased by the proposed additions of outcome measures indicating potentially defective care for certain inpatient conditions and procedures, including the following AHRQ safety measures:
  - XDDLA - PSI 10: Postoperative Physiologic and Metabolic Derangement Rate
  - E0533 - PSI 11: Post-Operative Respiratory Failure
  - E0349 - PSI 16: Transfusion Reaction
  - XAFLG - PSI 9: Perioperative Hemorrhage or Hematoma Rate
  - E0450 - PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate
  - Most of these are currently used for CMS Hospital Inpatient Quality Reporting, but are applicable to other programs as well
- For Cost Efficiency measures, it is good that CMS includes episode costs of various chronic conditions. We suggest to include total cost of care for physicians with applicable specialties such PCP and surgical episode cost for surgeons.
- We support the potential expansion of CMS measures for 30-day all-cause readmission rates for specific conditions and procedures, including CABG procedures (XBELG), vascular procedures (XBGDL) and acute ischemic stroke (F2027). Condition-specific readmission measures allow for targeted assessments and feedback to hospitals and physicians.
- Similarly, the two risk-standardized 30-day episode-of-care measures – for heart failure (XDELH) and for pneumonia (XDELG) – provide for focused value assessments while comparing variations in resource use associated with these conditions. Several other undeveloped CMS episode-of-care measures included in the list of MUCs are proposed based on the CMS Episode Grouper, which has yet to be fully developed. These are less compelling and their inclusion should probably be eschewed. In any case, it is important that, before finalizing any

CMS episode-of-care measures, the CMS episode grouper be thoroughly tested and the results reviewed by a broad cross-section of stakeholders.

- We are encouraged by the addition of several inappropriate use measures, including the following:
  - E0471 - Cesarean Rate for low-risk first birth women
  - XDAFA - Overuse of Diagnostic Imaging for Uncomplicated Headache
  - XDBLG - Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis
  - XDFDL - Avoidance of inappropriate use of head CT in ED patients with minor head injury
  - XDFGF - Avoidance of inappropriate use of imaging for adult ED patients with a traumatic low back pain.

All of these measures are important insofar as they address common areas of overuse. Complex imaging for low back pain in non-ED setting should also be included.

We urge CMS to call for, and then use and support, further appropriate use measures, especially in parallel to services deemed less valuable by the ACP and other specialty societies, including the "Choosing Wisely" services.

- Some of the "Process" measures are misclassified, they should be in Cost/Resource Use/Efficiency category. Following are two examples
- Lastly, to improve quality end-of-life care, Advanced Directives should be encouraged. Should CMS add a measure to encourage physicians to work with patients to get advanced directives?

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