NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership

Clinician Workgroup In-Person Meeting

December 10-11, 2012

NQF Conference Center at 1030 15th Street NW, 9th Floor, Washington, DC 20005

Remote Participation Instructions:

Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com.
- Under "Enter a Meeting" type in the meeting number for Day 1: **194653** or for Day 2: **550336.**
- In the "Display Name" field, type in your first and last names and click "Enter Meeting."

Teleconference

- Dial (888) 802-7237 for workgroup members or (877) 303-9138 for public participants; use conference ID code for Day 1: **72631133** or for Day 2: **72674636** to access the audio platform.

Meeting Objectives:

- Review and provide input on current finalized program measure sets for federal programs applicable to clinician measurement;
- Review and provide input on measures under consideration for federal programs applicable to clinician measurement;
- Identify priority measure gaps for each program measure set; and
- Finalize input to the MAP Coordinating Committee on measures for use in the federal programs.

Day 1: December 10, 2012

8:30 am **Breakfast**

9:00 am **Review Meeting Objectives, Disclosures of Interest, and Pre-Rulemaking Approach**

Mark McClellan, Workgroup Chair
Ann Hammersmith, General Counsel, NQF
Tom Valuck, Senior Vice President, Strategic Partnerships, NQF
Aisha Pittman, Senior Program Director, Strategic Partnerships, NQF
Sarah Lash, Senior Program Director, Strategic Partnerships, NQF

9:40 am **Pre-Rulemaking Input on Medicare Shared Savings Program Measure Set**

10:10 am **Pre-Rulemaking Input on Measures for the Medicare and Medicaid EHR Incentive Program for Eligible Professionals**

10:50 am	**Opportunity for Public Comment**
11:00 am	**Overview of the Physician Quality Reporting System, Physician Feedback/Value-Based Payment Modifier, and Physician Compare** *Kate Goodrich, Acting Director Quality Measurement and Health Assessment Group, CMS*
12:00 pm	**Lunch**
12:30 pm	**Pre-Rulemaking Input on Resource Use and Efficiency Measures Under Consideration** *Ashlie Wilbon, Senior Project Manager, Performance Measures, NQF* *Kate Goodrich*
2:00 pm	**Opportunity for Public Comment**
2:10 pm	**Pre-Rulemaking Input on Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare**
4:00 pm	**Opportunity for Public Comment**
4:15 pm	**Day 1 Summary**
4:30 pm	**Adjourn for the Day**

Day 2: December 11, 2012

8:30 am	**Breakfast**
9:00 am	**Welcome and Review of Day 1**
9:10 am	**Pre-Rulemaking Input on Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare (continued)**
12:00 pm	**Lunch**
12:30 pm	**Pre-Rulemaking Input on Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare (continued)**
2:00 pm	**Opportunity for Public Comment**
2:15 pm	**Wrap Up**
2:30 pm	**Adjourn**

Measure Applications Partnership

Clinician Workgroup In-Person Meeting

December 10-11, 2012

NATIONAL QUALITY FORUM

Agenda: Day 1

- Welcome, Review of Meeting Objectives, Disclosures of Interest, and Pre-Rulemaking Approach
- Pre-Rulemaking Input on the Medicare Shared Savings Program Measure Set
- Pre-Rulemaking Input on Measures for the Medicare and Medicaid EHR Incentive Program for Eligible Professionals
- Opportunity for Public Comment
- Overview of the Physician Quality Reporting System, Physician Feedback/Value-Based Payment Modifier, and Physician Compare
- Pre-Rulemaking Input on Resource Use and Efficiency Measures Under Consideration
- Pre-Rulemaking Input on Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare
- Opportunity for Public Comment
- Summary of Day 1 and Adjourn

Meeting Objectives

- Review and provide input on current finalized program measure sets for federal programs applicable to clinician measurement;
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Disclosures of Interest

MAP Pre-Rulemaking Approach

2012-2013 Goals for Pre-Rulemaking

- Continue to promote alignment across HHS programs and with private sector efforts
- Incorporate measure use and performance information into MAP decision-making
- Provide more granular recommendations
- Expand the number of programs MAP considers

Pre-Rulemaking Approach

1. Build on MAP's prior recommendations
2. Evaluate each current finalized program measure set using MAP Measure Selection Criteria
3. Evaluate HHS' measures under consideration for what they would add to the current finalized program measure sets
4. Identify high-priority measure gaps for programs and settings

1. Build on MAP's Prior Recommendations

MAP's prior efforts serve as guidance for pre-rulemaking decisions

- Coordination Strategies
  - Key recommendations included in Discussion Guide
- Gaps identified across all MAP efforts
  - MAP Previously Identified Gaps list in background materials
- 2012 pre-rulemaking decisions
  - Measure charts and Discussion Guide note prior pre-rulemaking decisions
- Families of measures
  - Measure charts note measures that are included in families
  - Core measure sets available in background materials

Families of Measures and Core Measure Sets

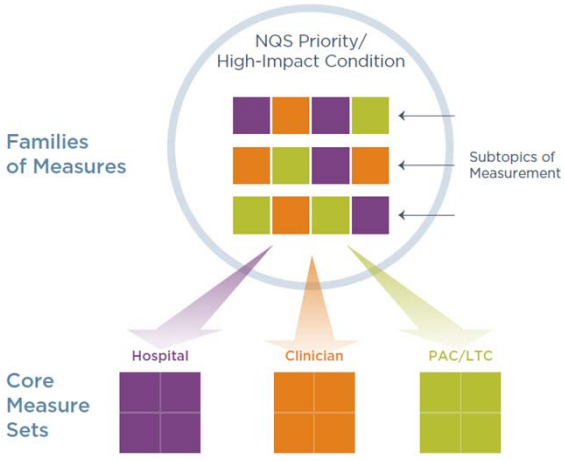
Families of Measures

"Related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS " (e.g., care coordination family of measures, diabetes care family of measures)

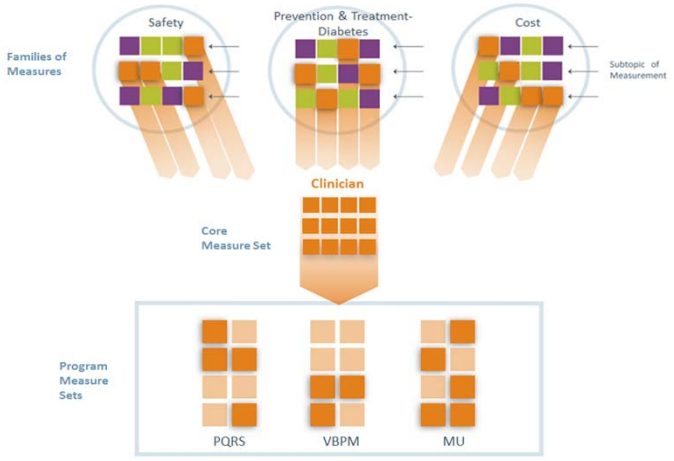
Core Measure Sets

"Available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., ambulatory clinician measure set, hospital core measure set, dual eligible beneficiaries core measure set)

Families of Measures



Families of Measures Populating Core Sets and Program Sets



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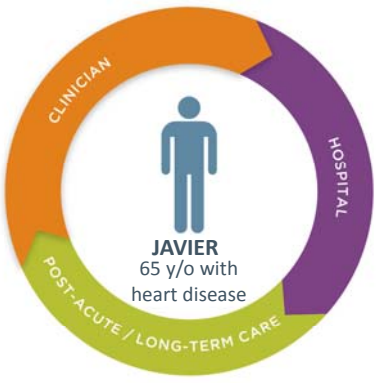
A Patient-Centered Approach to Core Measure Sets

Physician Quality Reporting System (PQRS)

NQF #0018 **Blood Pressure Control** (Cardiovascular and Diabetes Families)
NQF #0326 **Advance Care Plan** (Care Coordination, Hospice, and Dual Eligible Beneficiaries Families)



Hospital Inpatient Quality Reporting Program (IQR)

NQF #0289 **Median Time to ECG** (Care Coordination and Cardiovascular Families)
NQF #0141 **Patient Fall Rate** (Safety Family)

Inpatient Rehabilitation Facilities Quality Reporting Program (IRF)

NQF #0418 **Screening for Clinical Depression** (Dual Eligible Beneficiaries Family)
NQF #0648 **Timely Transmission of Transition Record** (Care Coordination, Hospice, and Dual Eligible Beneficiaries Families)

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2. Evaluate Current Finalized Program Measure Set Using MAP Measure Selection Criteria

Through pre-meeting assignments, you were asked to complete evaluations to determine:

- Potential measures for inclusion (e.g., from core sets, newly endorsed measures)
- Potential measures for removal
- Gaps—implementation gaps (core measures not in the set) and other gaps (e.g., development, endorsement) along the measure lifecycle
- Additional programmatic considerations (e.g., guidance on implementing MAP recommendations, data collection and transmission, attribution methods)

2. Evaluate Current Finalized Program Measure Set Using MAP Measure Selection Criteria

Process for Meeting:

A. Staff will review program summary, 2012 uptake of MAP recommendations, and initial staff evaluation of each finalized program measure set

B. Workgroup members assigned to the program will provide a brief summary of their evaluation of the current finalized program measure set

C. Workgroup will discuss and make recommendations about the current finalized measure set

3. Evaluate Measures Under Consideration

MAP will indicate a decision and rationale for each measure under consideration:

MAP Decision Category	Rationale (Examples)
Support	• Addresses a NQS priority not adequately addressed in the program measure set • Core measure not currently included in the program measure set • Promotes alignment across programs, settings, and public and private sector efforts
Support Direction	• 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
Phased Removal	• A 'Supported' measure under consideration addresses a similar topic and better addresses the needs of the program promotes alignment • NQF endorsement removed or retired
Do Not Support	• Measure does not adequately address any current needs of the program
Insufficient Information	• MAP has insufficient information (e.g., specifications, measure testing, measure use) to evaluate the measure

4. Identify High-Priority Measure Gaps for Programs and Settings

Process for Meeting:

- Workgroup will identify gaps in the program measure set
  - Staff will capture any new gaps raised during the course of discussion
- Workgroup will discuss gap priorities for the program
- Workgroup members should use the MAP Gap-Filling Form to:
  - Note measure ideas to spur development
  - Capture barriers to gap-filling and potential solutions

Pre-Rulemaking Input on Medicare Shared Savings Program Measure Set

Medicare Shared Savings Program

- **Program Type:** Performance-Based Payment with Public Reporting
- **Incentive Structure Options:**
  - One-sided risk model, with sharing of savings only for the first two years and sharing of savings and losses in the third year
  - Two-sided risk model, with sharing of savings and losses for all three years
- **Statutory Requirements for Measures:**
  - Appropriate clinical processes and outcomes measures
  - Patient, and wherever practicable, caregiver experience of care measures
  - Utilization measures, such as rates of hospital admission for ambulatory-sensitive conditions

Pre-Rulemaking Input on Measures for the Medicare and Medicaid EHR Incentive Program for Eligible Professionals

CMS Medicare and Medicaid EHR Incentive Program for Eligible Professionals

- **Program Type**: Incentive Program
- **Incentive Structure**:
  - Medicare- Up to $44,000 from 2011- 2014; penalties begin in 2015
  - Medicaid- Up to $63,750 from 2011- 2021
- **Statutory Requirements for Measures:**
  - Processes, experience, and/or outcomes of patient care
  - Observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care
  - Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries
  - Preference should be given to quality measures endorsed by NQF

CMS Medicare and Medicaid EHR Incentive Program for Eligible Professionals

HHS Uptake of MAP 2012 Pre-Rulemaking Recommendations

- MAP provided input on 93 measures under consideration
  - MAP "Supported" 63 measures
    - » 20 were finalized
    - » 43 were not finalized
  - MAP "Did Not Support" 26 measures
    - » 21 were not finalized
    - » 5 were finalized
  - MAP "Supported Direction" of 4 measures, noting the measures should be NQF-endorsed before finalizing
    - » All 4 measures were not finalized

Opportunity for Public Comment

Overview of the Physician Quality Reporting System, Physician Feedback/Value-Based Payment Modifier, and Physician Compare

Physician Quality Reporting System

- **Program Type**: Pay for Reporting
- **Incentive Structure**:
  - 2012-2014: bonus – 2% of total charges in 2010, gradually decreasing to 0.5% in 2014
  - 2015 and beyond: penalty – 1.5% in 2015; 2% in later years
- **Statutory Requirements for Measures:**
  - No specific types of measures required

PQRS Participation by Specialty

Individual Measures via Claims Option

Specialty	%
Emergency Medicine	65.0
Anesthesiology	47.6
Family Practice	16.1
Radiologist	38.8
Internal Medicine	15.6
Nurse Anesthetist	34.7
Physician Assistant	22.8
Other eligible professiona	17.4
Ophthalmology	39.9
Optometry	22.4

Registry Option

Specialty	%
Family Practice	12.1
Internal Medicine	11.1
Cardiology	18.7
Nurse Practitioner	5.8
Other eligible professional	5.0
Physician Assistant	4.8
Radiologist	4.6
Nephrology	19.3
Obstetrics/Gynecology	5.1
Orthopedic Surgery	6.8

Physician Feedback Program/Value-Based Payment Modifier Program

- **Program Type**: Performance-Based Payment
- **Incentive Structure**: For groups of physicians of 100 or more eligible professionals payment adjustment amount is built on satisfactory reporting through PQRS
  - Successfully reporting through PQRS:
    - Option for no quality tiering: **0% adjustment**
    - Option for quality tiering: **up to -1% for poor performance, reward for high performance to be determined**
  - Not successfully reporting through PQRS: **-1% adjustment**
- **Statutory Requirements for Measures:**
  - Must include a composite of appropriate, risk-based quality measures and a composite of appropriate cost measures.
  - Final rule indicated, for 2013 and beyond, the use of all individual measures under PQRS

Physician Compare

- **Program Type**: Public Reporting
- **Incentive Structure**: None
- **Statutory Requirements for Measures:** Measures from PQRS with a focus on:
  - Patient health outcomes and functional status
  - Continuity and coordination of care and care transitions
    - Episodes of care
    - Risk adjusted resource use
  - Efficiency
  - Patient experience and patient, caregiver, and family engagement
  - Safety, effectiveness, and timeliness of care

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS goals for MAP input on Clinician Reporting Programs

Kate Goodrich, MD, MHS
Acting Director, Quality Measurement and Health Assessment Group
Center for Clinical Standards and Quality

December 10, 2012

Our Approach

- In developing the list of measures for potential use in programs, we considered the following questions:
  - What were the 2011 MAP recommendations?
  - Which measures meet national priorities?
  - Which measures fill measurement gaps?
  - Which measures best support alignment across programs?
  - Which measures best support specific program needs?

Things to Consider

- We value this process and your time and expertise.
- We would like for you to consider the following while reviewing the list:
  - Which measures are more appropriate for payment programs vs. quality reporting programs?
  - Are there remaining measure gaps within quality dimensions?
    - If so, are there measures you would recommend to close those gaps?
  - How best to align measures across programs?

Goals for Alignment of Physician Quality Reporting Programs

Goals

- **Improve quality of care** using robust quality measures, timely feedback to physicians, and through registry reporting and meaningful use of EHRs.
- **Minimize burden by**
  - synchronizing performance and reporting periods.
  - reducing the number of submissions required of participating professionals for their data down to one.
- **Maximize efficiency** by utilizing eCQM, registry or claims-based reported data submitted once for multiple quality programs.
- **Increase reporting through registries and EHRs** while decreasing reporting based on claims ("G codes")

Specific Topics for Consideration

- All MUC and existing measures for PQRS are under consideration for Physician Compare – 2013 PFS rule finalizes targeting reporting of individual physician measures on Physician Compare in 2015 – those measures must be proposed in the 2014 PFS rule
- The MUC and existing IQR and OQR measures are submitted for consideration for PQRS and PVM. These measures could be proposed for both programs for use by hospital-based physicians (would use the hospital performance rate)
  - Desired by some hospital-based physician groups, as they feel current PQRS measures are not applicable to them
  - Would align improvement efforts between hospital-based physicians and hospitals which could further drive systems-based improvement
- We would value MAP input on either specific measures or types/categories of measures that would be most valuable for payment purposes

"Deeming" PQRS entities

- CMS is considering undertaking a "deeming" approach for entities to report measures to CMS and for other purposes (MOC, regional quality collaboratives, specialty societies, etc.)
- Builds on our registry reporting efforts
- We must identify criteria that these entities would be required to meet (transparency of measures, frequent feedback reports, agree to audit, etc.)
- Goal is for providers to report once for multiple purposes
- CMS plans to issue a Request for Information (RFI) late Dec/early Jan for input on this approach

Cost/Resource Use measures

- Total per capita cost measures (all cause and disease-specific) finalized for the VBM in 2013 PFS rule
- Episode grouper is still under development
  - Expect to have a limited number of conditions for the supplementary reports to the 2012 group QRURs (to be released spring 2013)
  - Would value MAP input on most important conditions to add in 2014

Discussion Questions

- What characteristics qualify a measure for public reporting? For payment incentives? For both?
- Which measures are best suited for:
  - Payment incentives (i.e., VBPM)
  - Public reporting (i.e., Physician Compare)
  - PQRS only, at this time
  - None of these

Pre-Rulemaking Input on Resource Use and Efficiency Measures Under Consideration

Consensus Standards for Cost and Resource Use

Taroon Amin, MA, MPH
Senior Director, Performance Measures

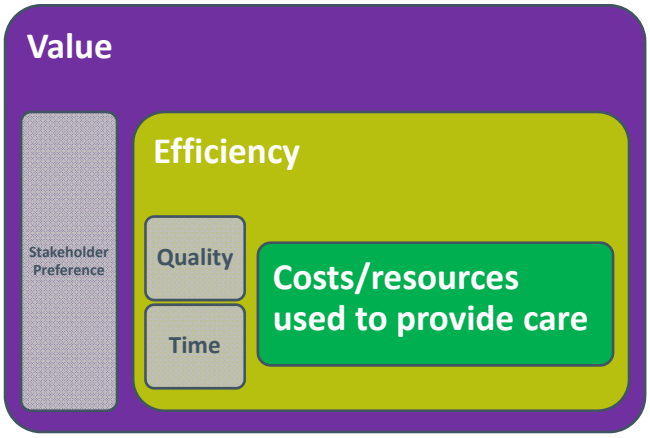
Ashlie Wilbon, RN, MPH
Senior Project Manager, Performance Measures

December 10-11, 2012

Defining Resource Use Measures

- Broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (may include diagnoses, procedures, or encounters).
  - A resource use measure counts the frequency of defined health system resources; some further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource.

Resource Use: A Building Block



Endorsed Resource Use Measures

- Endorsed January 30, 2012:
  - 1598: Total Resource Use Population-based PMPM Index (HealthPartners)
  - 1604: Total Cost of Care Population-Based PMPM Index (HealthPartners)
  - 1558: Relative Resource Use for People with Cardiovascular Conditions (NCQA)
  - 1557: Relative Resource Use for People with Diabetes (NCQA)
- Endorsed March 30, 2012:
  - 1560: Relative resource use for people with asthma (*NCQA*)
  - 1561: Relative resource use for people with COPD (*NCQA*)
  - 1609: ETG-based hip/knee replacement cost-of-care *(Ingenix)*
  - 1611: ETG-based pneumonia cost-of-care (*Ingenix*)

Comparing Approaches

	Per-Capita	Episode-Based
Costs Counted	All costs/resources for each person	Only costs/resources specifically related to the condition/ procedure/admission
Measurement focus	Broadly defined	Narrowly defined to condition
Measurement Timeframe	Usually 1 year	Episode-dependent
Care Settings	Cross-setting	Episode-dependent
Types of measures	Condition-specific, Total cost	Groupers, individual episodes

Overarching Issues

- Reliability and validity testing at the individual physician level
- Appropriateness of actual/standardized costing in various applications
- Evaluating single measures that are part of a grouper system
- Proprietary components within measures
- Implications of carve out arrangements (e.g., mental health, pharmacy)
- Linking quality and cost measures to determine efficiency

Measurement Gaps

- All populations
  - Expanded condition-specific measures
- Measures using actual prices
- Linking cost/resource use measures and quality

Challenges in Implementing Cost/Resource Use Measures as National Consensus Standards

- Intended use matters –Align with appropriate:
  - Level of analysis
  - Costing approach
  - Sample size
  - Attribution approach
  - Care Setting

Current Work in Cost and Resource Use Measurement

- Resource Use Endorsement Project 2012
  - Non-condition specific total cost measures
    - *Evaluation of cost per beneficiary and total cost measures for Medicare*
  - Potential follow up work for evaluation of condition-specific measures in a second phase
  - Measure review begins March 2012

Questions?

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Ashlie Wilbon, RN, MPH
- Senior Project Manager
- awilbon@qualityforum.org
- 202-559-9478

Discussion Questions

- What are the best uses for per capita cost approaches?
  - Best uses for condition-specific per capita cost measures?
  - Best uses for total per capita cost measures?
- What are the best uses for episode-based approaches (e.g., condition-specific grouper)?
- What types of quality measures should be used with the cost/resource measures under consideration to provide a broader understanding of efficiency?
- For each measure:
  - What specific quality measures should be used with the measure?
  - Will the measure results be useful for the program's intended purpose?
  - Do the measures under consideration align with private sector efforts? How can we promote alignment with private sector efforts?
  - Are there any implementation concerns with the measures under consideration?
  - What risks do these measures pose for unintended consequences, and how can the risks be mitigated?

Opportunity for Public Comment

Pre-Rulemaking Input on Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare

Opportunity for Public Comment

Summary of Day

Agenda: Day 2

- Welcome, Review of Day 1
- Pre-Rulemaking Input on Measures Under Consideration for:
  - Physician Quality Reporting System
  - Value-Based Payment Modifier, and
  - Physician Compare
- Opportunity for Public Comment
- Wrap Up
- Adjourn

Day 1 Themes

Pre-Rulemaking Input on Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare

Opportunity for Public Comment

Next Steps

Next Steps

- **January 8-9**: MAP Coordinating Committee In-Person Meeting
- **Mid-January**: 2-week public comment period on draft MAP Pre-Rulemaking Report
- **February 1**: MAP Pre-Rulemaking Report due to HHS

Adjourn

NATIONAL QUALITY FORUM

Clinician Workgroup: Pre-Rulemaking Discussion Guide

Meeting Objectives:

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Day 1: December 10, 2012

Time	Issue/Question	Considerations
9:00 am	**Review Meeting Objectives, Disclosures of Interest, and Pre-Rulemaking Approach**	
9:40 am	**Pre-Rulemaking Input on Medicare Shared Savings Program Measure Set (Tab #2)**	

9:40 am	Review program summary and current finalized measure set.	• 33 measures are finalized; 0 measures under consideration.
		• Evaluation of the program measure set using the MAP Measure Selection Criteria:
		  o Three measures in the set are not endorsed. MAP previously recommended that these measures be submitted for endorsement and that if the measures are not endorsed, the measures should be removed from the program.
		  ▪ M1170: ACO 8 (CMS): Risk-Standardized, All Condition Readmission
		  ▪ M1204: ACO 21 (ACO-Prev-11) (CMS): Preventive Care and Screening: Screening for High Blood Pressure
		  ▪ M2117: ACO 11 (CMS): Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment
		  o The measures address all of the NQS priorities except for making care more affordable.
		  o 13 finalized measures are also in a MAP Family of Measures.
		• The current finalized set addresses the following:
		  o Provider EHR qualification – 1 measure
		  o COPD – 1 measure

Time	Issue/Question	Considerations
		o CAHPS – 6 measures o Cardiovascular conditions – 7 o Diabetes – 6 measures o Safety (falls) – 1 measure o Medication reconciliation – 1 measure o Prevention – 7 measures o Readmission – 1 measure o Depression – 1 measure o Functional status – 1 *Pre-Meeting Assignment Report Out* • Darryl Gray • Janet Brown
9:50 am	Additional recommendations about the current finalized measure set.	• Should any current finalized measures be removed? o One measure is not endorsed—M1990: Breast Cancer Screening (endorsement removed) • Are there any system core measures that would enhance the program measure set? • Are there any other measures that would enhance the program measure set? • Should any Medicare Advantage 5-Star Quality Measures be incorporated into the program measure set: <u>Arthritis</u> o NQF #0054 Arthritis: disease modifying antirheumatic drug (DMARD) therapy in rheumatoid arthritis <u>Cardiovascular</u> o NQF #0071 Acute Myocardial Infarction (AMI): Persistence of Beta-Blocker Treatment After a Heart Attack <u>Care Coordination</u> o NQF #0576 Follow-Up After Hospitalization for Mental Illness o NQF #1768 Plan All-Cause Readmissions <u>COPD</u> o NQF #0577 Use of Spirometry Testing in the Assessment and Diagnosis of COPD <u>Diabetes</u> o NQF #0055 Diabetes: Eye exam

Time	Issue/Question	Considerations
		o NQF #0062 Diabetes: Urine protein screening o NQF #0064 Diabetes Measure Pair: A Lipid management: low density lipoprotein cholesterol (LDL-C) <130, B Lipid management: LDL-C <100 o NQF #1780 HbA1c control for a selected population <u>Healthy Living</u> o NQF #0029 Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity o NQF #0035 Fall Risk Management o NQF #0037 Osteoporosis testing in older women o NQF #0040 Flu Shot for Older Adults o NQF #0053 Osteoporosis management in women who had a fracture o NQF #1690 Adult BMI Assessment <u>Medication Management</u> o NQF #0021 Annual monitoring for patients on persistent medications o NQF #0105 Antidepressant Medication Management o NQF #0553 Care for Older Adults – Medication Review <u>Urinary</u> o NQF #0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment
10:00 am	Identify priority measure gaps.	• MAP previously cited the following gaps: o Patient-reported measures o Health and functional status measures • What gaps remain in the program measure set? • What gaps are the highest priorities for this program? • *Please use the MAP Gap-Filling Form to capture gaps, suggest potential numerator and denominator descriptions, and highlight potential gap-filling barriers or any other considerations.*
10:10 am	**Pre-Rulemaking Input on Measures in the Medicare and Medicaid EHR Incentive Program for Eligible Professionals (Tab #3)**	
10:10 am	Review program summary and current finalized measures.	• 74 finalized measures for Stages 1 and 2 (44 measures included in Stage 1; 64 measures include in Stage 2). • Evaluation of the program measure set using the MAP Measure Selection Criteria: o The measure set lacks cost measures.

Time	Issue/Question	Considerations
		o 22 finalized measures are also in a MAP Family of Measures. • The current finalized measures addresses the following: o Stage 1 finalized set contains the following: ▪ Asthma – 3 ▪ Cardiovascular – 11 ▪ Diabetes – 9 ▪ Eye Care – 1 ▪ Imaging – 2 ▪ Medication management – 1 ▪ Oncology – 2 ▪ Pediatric – 1 ▪ Prenatal/maternal – 2 ▪ Prevention/screening – 10 ▪ Tobacco/alcohol/drug – 2 o Stage 2 finalized set contains the following: ▪ Asthma – 1 ▪ Cardiovascular – 8 ▪ Diabetes – 8 ▪ Eye care – 3 ▪ Functional status – 3 ▪ HIV/AIDS – 3 ▪ Imaging – 2 ▪ Medication management – 5 ▪ Mental health – 5 ▪ Oncology – 3 ▪ Pediatrics –5 ▪ Prenatal/maternal – 2 ▪ Prevention/screening – 13 ▪ Referrals – 1 ▪ Safety – 1

Time	Issue/Question	Considerations
		▪ Tobacco/alcohol/drug – 1 *Pre-Meeting Assignment Report Out* • Paul Casale • Cheryl DeMars
10:20 am	Review measures under consideration—Two measures under consideration are not endorsed.	M3041 Annual Wellness Assessment: Assessment of Health Risks (Draft) M3042 Annual Wellness Assessment: Management of Health Risks (Draft) • Neither measure is currently used or under consideration for use in other federal programs. • M3041 assesses whether patients received age appropriate screenings. Multiple endorsed measures assess similar screenings; for example, the measure includes tobacco use and obesity screening—the following NQF-endorsed measures assess those aspects of care, and are included in the program: o NQF #0028 Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention o NQF #0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up • M3042 assesses whether patients received management of identified risks and age appropriate measures. Multiple endorsed measures assess similar concepts; for example the measure assesses age appropriate screenings for falls and pneumonia—the following NQF- endorsed measures assess similar concepts, and are included in the program: o NQF #0043 Pneumonia vaccination status for older adults o NQF #0101 Falls: Screening for Future Fall Risk
10:30 am	Revisit the current finalized program measures.	• Should any current finalized measures be removed? o 17 measures are not endorsed: ▪ M299 Heart Failure (HF) : Warfarin Therapy Patients with Atrial Fibrillation(endorsement removed) ▪ M1426 Asthma assessment (endorsement removed) ▪ M1429 Prenatal Screening for Human Immunodeficiency Virus (HIV) (endorsement removed) ▪ M1430 Hypertension: Blood Pressure Control (endorsement removed) ▪ M1431 Prenatal Anti-D Immune Globulin (endorsement removed)

Time	Issue/Question	Considerations
		▪ M1990 Breast Cancer Screening (endorsement removed) ▪ M2262 Pregnant women that had HBsAg testing (endorsement removed) ▪ M2271: Functional Status Assessment for Knee Replacement ▪ M2272: Functional Status assessment for Hip Replacement ▪ M2273: Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) ▪ M2274: Hypertension: Improvement in Blood Pressure ▪ M2275: Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented ▪ M2276: Functional Status Assessment for Complex Chronic Conditions ▪ M2277: Closing the Referral Loop: Receipt of Specialist Report ▪ M2287: Dementia: Cognitive Assessment ▪ M3008: Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed ▪ M3009: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range • Are there any clinician core measures that would enhance the program measure set? • Are there any other measures that would enhance the program measure set?
10:40 am	Identify priority measure gaps.	• What gaps remain in the program? • What gaps are the highest priorities for this program? • *Please use the MAP Gap-Filling Form to capture gaps, suggest potential numerator and denominator descriptions, and highlight potential gap-filling barriers or any other considerations.*
10:50 am	**Opportunity for Public Comment**	
11:00 am	**Overview of the Physician Quality Reporting System, Physician Feedback/Value-Based Payment Modifier, and Physician Compare (Tab #4)**	
12:00 pm	**Lunch**	
12:30 pm	**Pre-Rulemaking Input on Resource Use and Efficiency Measures Under Consideration (Tab #5)**	

Time	Issue/Question	Considerations
1:00 pm	Review resource use measures finalized for the Value-Based Payment Modifier.	M2147: Total Per Capita Cost M2148: Condition-Specific Per Capita Cost Measures for COPD, Diabetes, HF, and CAD • What specific quality measures should be used with the measure? • Will the measure results be useful for the program's intended purpose? • Do the measures align with private sector efforts? How can we promote alignment with private sector efforts? • Are there any implementation concerns with the measures? • What risks do these measures pose for unintended consequences, and how can the risks be mitigated?
1:20 pm	Review measures under consideration for the Physician Feedback Program, Value-Based Payment Modifier, and Physician Compare.	M2876: Episode Grouper: Acute Myocardial Infarction (AMI) M2878: Episode Grouper: Pneumonia M2879: Episode Grouper: Coronary Artery Bypass Graft (CABG) M2880: Episode Grouper: Percutaneous Coronary Intervention (PCI) M2882: Episode Grouper: Coronary Artery Disease M2844: Episode Grouper: Congestive Heart Failure (CHF) M2885: Episode Grouper: Chronic Obstructive Pulmonary disease (COPD) M2887: Episode Grouper: Asthma M2698: AMI Episode Of Care (Inpatient Hospitalization + 30 Days Post-Discharge) M1643: Medicare Spending Per Beneficiary • What specific quality measures should be used with the measure? • Will the measure results be useful for the program's intended purpose? • Do the measures under consideration align with private sector efforts? How can we promote alignment with private sector efforts? • Are there any implementation concerns with the measures under consideration? • What risks do these measures pose for unintended consequences, and how can the risks be mitigated?
2:00 pm	**Opportunity for Public Comment**	
2:10 pm	**Pre-Rulemaking Input on Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare (Tab #6)**	

Time	Issue/Question	Considerations

2:10 pm	Review Physician Quality Reporting System (PQRS)— current finalized measures.	• 322 current finalized measures.
		• Evaluation of the program measure set using the MAP Measure Selection Criteria:
		  o 143 (44%) of the measures are not endorsed (179 are endorsed).
		  o There is a dearth of cost and patient experience measures.
		• 41 current finalized measures are also in a MAP Family of Measures.
		
		Pre-Meeting Assignment Report Out
		• Marshall Chin
		• Ronald Stock
		• Kate Goodrich
		• Mary Jo Goolsby/Jan Towers
		• David Seidenwurm
		• Rachel Grob
		• David Hopkins
		• Jesse James
		• Bruce Bagley
		• Karen Sepucha

2:15 pm	Review Physician Feedback/Value-Based Payment Modifier (VBPM)—current finalized measures.	• 19 current finalized measures.
		• Evaluation of the program measure set using the MAP Measure Selection Criteria:
		  o The NQS priority patient and family engagement is not addressed.
		  o The measure set lacks cost, experience, and patient-reported outcomes measures.
		  o The measure set lacks follow-up care measures.
		  o 3 finalized measures are also in the a MAP Family of Measures.
		
		Pre-Meeting Assignment Report Out
		• Dolores Yanagihara
		• Joseph Francis
		• Joanne Conroy
		• Mark Metersky

	Cardiovascular Health	<u>Acute Myocardial Infarction (rows 2-13)</u>
		• Endorsed (rows 2-13)
		  o Included in a MAP Family (rows 2-6)
		  o Used in private and public sector programs (rows 7-9)

Time	Issue/Question	Considerations
		o Used in any program (rows 10-13) <u>Atrial Fibrillation (rows 14-20)</u> • Endorsed (rows 14-16) o Included in a MAP Family (rows 14-15) o Used in private and public sector programs (rows 14, 16) o Used in any program (row 15) • Not Endorsed (rows 17-20) o Used in any program (rows 17) o Use unknown (rows 18-20) <u>Cardiovascular (row 21)</u> • Endorsed; used in private and public sector programs (row 21) <u>CHF (rows 22-33)</u> • Endorsed (rows 22-29) o Included in a MAP Family (rows 22-24) o Used in private and public sector programs (rows 22-26) o Used in any program (rows 27-29) • Not Endorsed (rows 30-33) o Used in private and public sector programs (rows 30-31) o Used in any program (rows 32-33) <u>Hypertension (rows 34-49)</u> • Not Endorsed (rows 34-49) o Used in private and public sector programs (rows 35-42) o Used in any program (rows 43-48) o Use unknown (rows 49) <u>Ischemic Heart Disease (rows 50-81)</u> • Endorsed (rows 50-69) o Included in a MAP Family (rows 50-54) o Used in private and public sector programs (rows 50-62) o Used in any program (rows 63-68) • Not Endorsed (rows 70-81)

Time	Issue/Question	Considerations
		o Used in private and public sector programs (rows 70-76) o Used in any program (rows 77-79) o Use unknown (rows 80-81) <u>Vascular Disease (rows 82-97)</u> • Endorsed, used in a program (rows 89-92) • Not Endorsed (rows 82-88, 93-97) o Used in any program (rows 82-88) o Use unknown (rows 93-97) <u>Venous Ulcer (rows 98-99)</u> • Not endorsed; use unknown <u>Perioperative/Procedure (rows 100)</u> • Not Endorsed; use unknown
	Endocrine/Renal	<u>Chronic Renal Disease (rows 2-17)</u> • Endorsed; used in any program (rows 2-4) • Not Endorsed (rows 5-17) o Used in in private and public sector programs (row 5) o Used in any program (rows 6-9) o Use unknown (rows 10-17) <u>Diabetes (rows 18-49)</u> • Endorsed (rows 18-34) o Included in a MAP Family (rows 18-20) o Used in private and public sector programs (rows 21-29) o Used in any program (rows 29-33) o Use unknown (row 34) • Not Endorsed (rows 35-49) o Used in private and public sector programs (row 35-36) o Used in any program (rows 36-43) o Use unknown (rows 44-49) <u>Endocrine Disease (rows 50-53)</u>

Time	Issue/Question	Considerations
		• Not endorsed; use unknown <u>Nephropathy (row 54)</u> • Not endorsed; used in any program
	Primary Prevention	<u>Overweight/Obesity (rows 2-19)</u> • Endorsed; Included in a MAP Family (rows 2-3) • Not endorsed; use unknown (rows 4-19) o The following measures are used in the American College of Surgeon's (ACS) National Surgical Quality Improvement Program (NSQIP), ACS Surgeon Specific Registry (SSR), and the Metabolic and Bariatric Surgical Association Quality Improvement Program (MBSAQIP) as well as multiple other registries: M2826, M2827, M2829, M2831, M2832, M2833, M2834, M2835, M2836, M2837, M2838, M2839, M2840 o The following measures are used in ACS SSR: M2828, M2830
4:00 pm	**Opportunity for Public Comment**	
4:15 pm	**Summary of Day 1**	
4:30 pm	**Adjourn for the Day**	

Time	Issue/Question	Considerations
9:00 am	**Welcome and Review of Day 1**	
9:10 am	**Pre-Rulemaking Input on Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare (continued) (Tab #7)**	
	Safety	<u>Composite (row 2)</u> • Endorsed; used in any program <u>C.diff (rows 3-4)</u> • Not endorsed; use unknown (row 3) <u>CAUTI (rows 5-7)</u> • Endorsed; used in private and public sector programs (row 5-6) • Not endorsed; use unknown (row 7) <u>CLABSI (rows 8-11)</u> • Endorsed (row 8-9) o Used in private and public sector programs (row 8) o Used in any program (row 9) • Not endorsed; use unknown (rows 10-11) o The following measures are used in the American College of Surgeons (ACS) Surgeon Specific Registry (SSR): M2920 <u>MRSA (row 12-13)</u> • Not Endorsed o Used in private and public sector programs (row 12) o Use unknown (rows 13) <u>SSI (rows 15-33)</u> • Endorsed (rows 15-26) o Included in a MAP Family; Used in private and public sector programs (rows 17-18) o Used in private and public sector programs (rows 15-16) o Used in any program (rows 19-26) • Not endorsed; use unknown (rows 27-33)

Time	Issue/Question	Considerations
		○ The following measures are used in the American College of Surgeon's (ACS) National Surgical Quality Improvement Program (NSQIP), ACS Surgeon Specific Registry (SSR), and multiple other registries: M2789, M2791, M2849, M2855, M2943 ○ The following measures are used in ACS SSR: M2825 <u>VAP (row 34)</u> • Endorsed; used in private and public sector programs <u>Complications-Related Mortality (rows 35-37)</u> • Endorsed; used in any program (row 35) • Not Endorsed; use unknown (rows 36-37) ○ The following measure is used in the ACS NSQIP, ACS SSR, and multiple other registries: M2852 ○ The following measures is used in the ACS SSR: M2822 <u>ED Throughput (rows 38-42)</u> • Endorsed; used in any program (38-40) • Not endorsed (row 41-42) ○ Used in private and public sector programs (row 41) ○ Used in any program (row 42) <u>Falls (rows 43-45)</u> • Endorsed; included in a MAP Family; used in any program (row 43) • Not endorsed; used in any program (rows 44-45) <u>Perioperative/Procedural Safety (rows 46-97)</u> • Endorsed (rows 46-50) ○ Used in private and public sector programs (rows 46-49) ○ Used in any program (rows 50) • Not Endorsed (rows 51-97) ○ Included in a MAP Family; used in any program (row 53) ○ Used in any program (rows 51-52) ○ Use unknown (rows 54-97) ▪ The following measures are used in the ACS NSQIP, ACS SSR, and

Time	Issue/Question	Considerations
		multiple other registries: M2790, M2818, M2819, M2850, M2851, M2853, M2854, M2867, M2868, M2869, M2870, M2896, M2897, M2941, M2942, M2945, M2946, M2947, M2948, M2949 ▪ The following measures are used in the ACS SSR: M2792, M2817, M2823, M2824, M2846, M2856, M2858, M2864, M2865, M2895, M2916, M2919, M2921, M2940, M2954, M2956, M2957 <u>Pressure Ulcer (row 98)</u> • Not Endorsed; use unknown <u>VTE (rows 99-111)</u> • Endorsed (rows 99-108) o Included in a MAP Family (row 99, rows 101-102) o Used in private and public sector programs (row 100, rows 103-104) o Used in any program (rows 105-108) • Not Endorsed (rows 109-111) o Used in any program (rows 109-110) o Use unknown (row 111) ▪ The following measures are used in ACS SSR: M2955
	Care Coordination	<u>Care Follow-up (rows 2-3)</u> • Not Endorsed (row 2-3) o Used in in private and public sector programs (row 2) o Use unknown (row 3) <u>Medication Management (rows 4-13)</u> • Endorsed (rows 4-7) o Included in a MAP Family (rows 4-7) o Used in private and public sector programs (rows 4, 7) o Used in any program (rows 4-6) • Not Endorsed (rows 8-13) o Used in in private and public sector programs (row 8) o Used in any program (rows 8-10, 12) o Use unknown (rows 11, 13)

Time	Issue/Question	Considerations
		Readmissions (rows 14-16) • Endorsed; included in a MAP Family; used in a program (row 14) • Not undorsed; used in a program (rows 15-16) Transitions (rows 17-20) • Endorsed (rows 17-20) o Included in a MAP Family (rows 17-20) o Used in private and public sector programs (row 17) o Used in any program (rows 18-20)
	Behavioral Health	ADHD (rows 2-4) • Endorsed o Used in private and public sector programs (row 2) o Used in any program (rows 3-4) Behavior or Conduct Problems (row 5) • Not Endorsed; use unknown Depression (rows 6-23) • Endorsed (rows 6-16) o Included in a MAP Family (row 6) o Used in private and public sector programs (rows 7-9) o Used in any program (rows 10-16) • Not Endorsed (rows 17-23) o Used in any program (row 17) o Use unknown (rows 18-23) Mental Illness (rows 24-25) • Endorsed o Included in a MAP Family (row 24) o Used in private and public sector programs (row 25) Substance Use/Abuse (rows 26-30) • Endorsed; included in a MAP Family (row 26) • Not Endorsed (rows 27-30)

Time	Issue/Question	Considerations
		o Used in any program (rows 27-29) o Use unknown (row 30) <u>Tobacco Use (rows 31-35)</u> • Endorsed (row 31-32) o Included in a MAP Family (row 31) o Used in private and public sector programs (row 32) • Not Endorsed (rows 33-35) o Used in in private and public sector programs (row 33) o Used in any program (rows 34-35)
	Neurological	<u>ALS (rows 2-10)</u> • Not Endorsed; use unknown <u>Alzheimer's Disease (rows 11-19)</u> • Not Endorsed; used in any program <u>Epilepsy (rows 20-27)</u> • Not Endorsed o Used in any program (rows 20-22) o Use unknown (rows 23-27) <u>Neurological Disease (rows 28-29)</u> • Not Endorsed; use unknown <u>Neuropathy (rows 30-32)</u> • Not Endorsed; use unknown <u>Parkinson's Disease (rows 33-40)</u> • Not Endorsed o Used in any program (rows 33-38) o Use unknown (rows 39-40) <u>Stroke/TIA (rows 42-70)</u> • Endorsed (rows 42-54) o Included in a MAP Family (rows 42-43)

Time	Issue/Question	Considerations
		○ Used in private and public sector programs (row 44-48) ○ Used in any program (rows 49-54) • Not Endorsed (rows 55-70) ○ Used in in private and public sector programs (rows 55-57) ○ Used in any program (rows 58-64) ○ Use unknown (rows 65-70)
	Pulmonary	<u>Asthma (rows 2-15)</u> • Endorsed (rows 2-3) ○ Used in private and public sector programs (row 2) ○ Used in any program (row 3) • Not Endorsed (rows 4-15) ○ Used in any program (rows 4-6) ○ Use unknown (rows 7-15) <u>COPD (rows 16-21)</u> • Endorsed (rows 16-19) ○ Used in private and public sector programs (rows 16-17) ○ Used in any program (rows 18-19) • Not endorsed; used in a program (rows 20-21) <u>Dyspnea(rows 22-23)</u> • Endorsed; included in a MAP Family (rows 22-23) <u>Pulmonary disease (row 24)</u> • Not endorsed; use unknown (rows 24) <u>Sleep Apnea (rows 25-29)</u> • Not endorsed; used in a program (rows 25-29)
	Cancer	<u>Breast Cancer (rows 2-24)</u> • Endorsed (row 2, rows 5-8) ○ Included in a MAP Family (row 2) ○ Used in any program (rows 5-8) • Not Endorsed (rows 3-4, rows 9-24)

Time	Issue/Question	Considerations
		o Used in in private and public sector programs (rows 3-4) o Used in any program (rows 9-13) o Use unknown (rows 14-24) ▪ The following measures are used in the American College of Surgeon's (ACS) National Surgical Quality Improvement Program (NSQIP), ACS Surgeon Specific Registry (SSR), and multiple other registries: M2902, M2903, M2904, M2911, M2912, M2913 ▪ The following measures are used in the ACS SSR: M2901, M2910 <u>Cancer (rows 25-31)</u> • Endorsed (rows 25-30) o Included in a MAP Family (row 25-26) o Included in a MAP Family (row 29) o Used in any program (rows 27-28) o Use unknown (row 30) • Not endorsed; use unknown (row 31) <u>Cervical cancer (row 32)</u> • Endorsed; used in private and public sector programs <u>Colorectal cancer (rows 33-39)</u> • Endorsed (rows 33-37) o Included in a MAP Family (row 33) o Used in private and public sector programs (rows 34-37) • Not endorsed; use unknown (rows 38-39) o The following measure is used in the American Gastroenterological Association (AGA) and American College of Gastroenterology (ACG)/American Society of Gastrointestinal Endoscopy (ASGE) registries: M2448 <u>Hematologic cancer (rows 40-43)</u> • Endorsed (rows 40-43) o Included in a MAP Family (row 40) o Used in any program (rows 41-43) <u>Lung cancer (rows 44-48)</u>

Time	Issue/Question	Considerations
		• Endorsed (rows 44-46) o Included in a MAP Family (rows 44) o Used in any program (rows 45-46) • Not Endorsed; Use unknown (rows 47-48) <u>Prostate cancer (rows 49-53)</u> • Endorsed (rows 50-52) o Included in a MAP Family (rows 50-51) o Used in any program (row 52) • Not Endorsed (row 49, row 53) o Used in in private and public sector programs (row 49) o Used in any program (row 53) <u>Skin cancer (rows 54-57)</u> • Endorsed; used in any program (rows 54-55) • Not Endorsed (rows 56-57) o Used in any program (row 56) o Use unknown (row 57)
	Musculoskeletal/Dermatology	<u>Dermatitis (rows 2-6)</u> • Not endorsed; use unknown <u>Hernia (rows 7-8)</u> • Not endorsed; use unknown o The following measures are used in the American College of Surgeon's (ACS) National Surgical Quality Improvement Program (NSQIP), ACS Surgeon Specific Registry (SSR), and multiple other registries: M2958, M2959 <u>Hip/Pelvic Fracture (row 9)</u> • Not endorsed; used in any program <u>Low back pain (rows 10-17)</u> • Endorsed o Included in a MAP Family (rows 10-11) o Used in private and public sector programs (rows 12-14)

Time	Issue/Question	Considerations
		○ Used in any program (rows 15-17) <u>Musculoskeletal Impairment (rows 18-34)</u> • Endorsed (rows 18-27) ○ Used in private and public sector programs (rows 18) ○ Used in any program (rows 19-27) • Not Endorsed (28-34) ○ Used in any program (rows 28-33) ○ Use unknown (row 34) <u>Osteoporosis (rows 35-50)</u> • Endorsed (rows 35-40) ○ Used in private and public sector programs (rows 35-37) ○ Used in any program (rows 37-40) • Not Endorsed (rows 41-50) ○ Used in in private and public sector programs (rows 41-46) ○ Used in any program (rows 47-50) <u>Psoriasis (rows 51-52)</u> • Not endorsed; use unknown <u>Rheumatoid Arthritis (rows 53-58)</u> • Endorsed; used in private and public sector programs (row 53) • Not endorsed; used in any program (rows 54-58) <u>Osteoarthritis (rows 59-61)</u> • Endorsed; used in any program (rows 59-60) • Not endorsed; use unknown (row 61)
12:00 pm	**Lunch**	
12:30 pm	**Pre-Rulemaking Input on Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare (continued) (Tab #7)**	
	HEENT	<u>Cataract (rows 2-5)</u> • Endorsed; used in any program (rows 2-4)

Time	Issue/Question	Considerations
		• Not endorsed; used in any program (row 5) <u>Dizziness (row 6)</u> • Not endorsed; used in any program <u>Ear Infections (rows 7-12)</u> • Endorsed (rows 7-11) o Included in a MAP Family (row 7-11) o Used in private and public sector programs (rows 8-9) o Used in any program (row 10) • Not endorsed; used in any program (row 12) <u>Glaucoma (rows 13-15)</u> • Endorsed; used in any program (rows 13-14) • Not endorsed; use unknown (row 15) <u>Hearing Problems (rows 16-19)</u> • Endorsed; used in any program (row 16) • Not endorsed; used in any program (rows 17-19) <u>Macular Degeneration (rows 20-23)</u> • Endorsed; used in any program (rows 20-21) • Not endorsed; use unknown (rows 22-23) <u>Oral Health (rows 24-25)</u> • Endorsed o Used in private and public sector programs (row 24) o Used in any program (row 25) <u>Pharyngitis (row 26)</u> • Endorsed; included in a MAP Family; used in private and public sector programs <u>Sinusitis (rows 27-36)</u> • Not Endorsed; Use unknown

Time	Issue/Question	Considerations

	Patient Engagement	<u>Function (rows 2-4)</u>
		• Not endorsed; used in a program (rows 2-4)
		
		<u>Pain (rows 5-10)</u>
		• Endorsed (rows 5-8)
		  o Included in a MAP Family (rows 5-8)
		  o Used in any program (rows 5-7)
		• Not Endorsed (rows 9-10)
		  o Used in any program (row 9)
		  o Use unknown (row 10)
		
		<u>Patient Preferences (rows 11-14)</u>
		• Endorsed (rows 11-13)
		  o Included in a MAP Family (rows 11-13)
		  o Used in any program (rows 11)
		• Not endorsed; used in a program (row 14)
		
		<u>Patient Satisfaction (rows 15-16)</u>
		• Not endorsed; used in a program (rows 15-16)
		
		<u>Patient Satisfaction Surveys (rows 17-24)</u>
		• Endorsed (rows 17-19)
		  o Included in a MAP Family (rows 17-19)
		  o Used in private and public sector programs (row 18)
		  o Used in any program (rows 17)
		• Not Endorsed (rows 20-24)
		  o Used in any program (rows 20)
		  o Use unknown (rows 21-24)

	Infectious Disease	<u>Infectious Diseases - Respiratory (rows 2-17)</u>
		• Endorsed (rows 2-13)
		  o Included in a MAP Family (rows 2-3)
		  o Used in private and public sector programs (rows 4-8)
		  o Used in any program (rows 9-13)
		• Not Endorsed (rows 14-17)

Time	Issue/Question	Considerations
		○ Used in any program (rows 14-16) ○ Use unknown (rows 17) <u>Infectious Diseases (rows 18-19)</u> • Not endorsed; used in in private and public sector programs <u>Infectious Diseases – Hepatitis C (rows 20-29)</u> • Endorsed (rows 20-29) ○ Used in private and public sector programs (row 20) ○ Used in any program (rows 21-29) <u>Infectious Diseases – STI (rows 30-45)</u> • Endorsed (rows 30-40) ○ Included in a MAP Family (row 35) ○ Used in private and public sector programs (rows 30-31) ○ Used in any program (rows 32-34; 36-40) • Not Endorsed (rows 41-45) ○ Used in in private and public sector programs (row 41) ○ Used in any program (rows 42-45) <u>Infectious Diseases – (rows 46-47)</u> • Not Endorsed (rows 46-47) ○ Used in any program (rows 46) ○ Use unknown (rows 47)
	GI/GU	<u>Incontinence (rows 2-4)</u> • Endorsed; used in any program <u>IBD (rows 5-11)</u> • Not endorsed; used in any program <u>GI Disease (rows 12-21)</u> • Not endorsed; use unknown ○ The following measures are used in the American College of Surgeon's (ACS) National Surgical Quality Improvement Program (NSQIP), ACS Surgeon Specific

Time	Issue/Question	Considerations
		Registry (SSR), and multiple other registries: M2847, M2848 o The following measures are used in the ACS SSR: M2857, M2859
	Maternity-Perinatal	<u>Maternal/Perinatal (rows 2-4, 10-18, row 22)</u> • Endorsed (2-4) o Included in a MAP Family (rows 2-3) o Used in private and public sector programs (row 4) • Not Endorsed (rows 10-18, row 22) o Used in any program (row 22) o Use unknown (rows 10-18) <u>Gynecologic Health (row 5)</u> • Endorsed; used in private and public sector programs <u>Perinatal Health (row 6-9)</u> • Endorsed; used in any program (rows 6-7) • Not endorsed; used in private and public sector programs (rows 8-9) <u>Gynecologic Disease (rows 19-21)</u> • Not endorsed; use unknown
	Other	<u>Clinical (rows 2-4)</u> • Endorsed; used in a program (rows 2-3) • Not endorsed; use unknown (row 3) <u>Efficiency (rows 5-8)</u> • Endorsed; included in a MAP Family (rows 5-6) • Not endorsed; used in a program (rows 7-8) <u>HIT (rows 9-16)</u> • Endorsed (rows 9-11) o Included in a MAP Family (row 9) o Used in private and public sector programs (row 10) o Used in any program (rows 11)

Time	Issue/Question	Considerations
		• Not endorsed; used in a program (rows 12-16) <u>Imaging (rows 17-29)</u> • Endorsed (rows 17-21) o Included in a MAP Family (row 17) o Used in any program (rows 18-20) • Not Endorsed (rows 22-29) o Used in any program (rows 22-27) o Use unknown (rows 28-29) <u>Mortality (row 30)</u> • Not endorsed; used in a program (row 30) <u>Referrals (row 31)</u> • Not endorsed; used in a program (row 31) <u>Skin Ulcer (rows 32-33)</u> • Not endorsed; used in a program (row 32-33)
	Identify priority measure gaps.	• What gaps remain in the programs? • What gaps are the highest priorities for these programs? • *Please use the MAP Gap-Filling Form to capture gaps, suggest potential numerator and denominator descriptions, and highlight potential gap-filling barriers or any other considerations.*
2:00 pm	**Opportunity for Public Comment**	
2:15 pm	**Wrap Up**	
2:30 pm	**Adjourn**	

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 2012 Pre-Rulemaking Program-Specific Input:

- In comparison to the other federal clinician performance measurement programs, MAP determined that the MSSP measure set approximates an ideal measure set as it addresses patient experience, multiple cross-cutting priorities and high-impact conditions, as well as key quality outcomes.
- MAP suggested that the program measure set be further aligned with the Medicare Advantage 5-star quality rating system measure set and private-sector measurement efforts for health plans and accountable care organizations.
- MAP recognized that the MSSP program is designed to generate cost savings; however, the measure set should incorporate cost measures to encourage transparency.
- MAP noted that the MSSP measure set could be improved by addressing community supports and patient-reported measures of health and functional status.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Most (30) of the finalized measures are NQF endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The measures address all of the NQS priorities except making care more affordable.

3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Over half (19) of the measures address high-impact conditions.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Over half (19) of the measures are used in private programs; most (24) of the measures are used in other Federal programs.
5. Program measure set includes an appropriate mix of measure types	The measure set is comprised of process, outcome, and patient experience measures, but lacks cost measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care. Additionally, two measures are patient-reported outcome measures (PRO).
7. Program measure set includes considerations for healthcare disparities	A small number (5) of measures are disparities sensitive.
8. Program measure set promotes parsimony	The measure set addresses many of the MAP Measure Selection Criteria with 33 measures; however, the measure set could be enhanced with additional measures of cost, functional status, and patient-reported outcomes.

Note: The MSSP program includes 33 finalized measures; however, only 24 measures are listed in the Table of Current Finalized measures. MSSP counts 6 of the *CAHPS Clinician/Group Survey* (NQF#005) rates as separate measures. Additionally *Optimal Diabetes Care* (NQF#0729) is considered 5 separate measures in MSSP.

[1] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Guide-Quality-Performance-2012.PDF
[2] http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html
[3] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
[4] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf

Medicare and Medicaid EHR Incentive Program for Eligible Professionals

Program Type:

Payment incentive program for using EHRs.

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.[1]

- 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. Penalty payment adjustments do not apply to Medicaid.[2]

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 physicians assistances furnishing services in a federally qualified health center or rural health clinic.[3]

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, experience, and outcomes of patient care that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.[4] Preference should be given to quality measures endorsed by NQF.[5]

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:[6]

- Eligible Professionals must report on six total clinical quality measures: three required core measures (substituting alternate core measures where necessary), and three additional measures (selected from a set of 38 clinical quality measures).

For Stage 2 (2014 and beyond):[7]

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

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP concluded that it supports the use of disease-specific eMeasures and patient-centered, cross-cutting measures that enhance interoperability and coordination to encourage a more robust health IT infrastructure. Initially, the meaningful use measures should be broad enough to generally encourage eMeasurement. Over time, as health IT becomes more effective and interoperable, the Meaningful Use program should have a greater focus on two types of measures:
    - health IT-sensitive measures (i.e., measures that provide information on whether electronic health records are changing care processes)
    - health IT-enabled measures (i.e., measures that require data from multiple settings/providers or are longitudinal and would require an health IT-enabled collection platform to be fully operational).
- MAP recommended measures without e-specifications to be re-tooled as eMeasures prior to inclusion in the program.
- To reduce clinician burden, MAP suggests that HHS consider establishing a process in the Meaningful Use program that will allow clinicians to receive credit for electronically reporting measures through PQRS, provided the measures are in the Meaningful Use program.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Three-quarters (56) of finalized measures are NQF endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	All NQS priorities are addressed.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Two-thirds (50) of measures address high-impact conditions.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Over two-thirds (60) of measures are used in other Federal programs; over half (43) are used in private programs.
5. Program measure set includes an appropriate mix of measure types	Over two-thirds (60) of measures are process measures; outcome measures are included, but the

	set does not include cost or experience measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care. Additionally, five measures are patient-reported outcome measures.
7. Program measure set includes considerations for healthcare disparities	A small number (8) of measures are disparities sensitive.
8. Program measure set promotes parsimony	The measure set addresses many of the MAP Measure Selection Criteria with 76 measures; however, the measure set could be enhanced with additional outcomes and cost measures.

FYI: Note the MU-EP program includes 76 finalized measures covering both Stage 1 and Stage 2. The table of Current Finalized measures notes the stage(s) to which each measure applies.

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[1] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html
[2] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Getting_Started.html
[3] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/
[4] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm
[5] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf
[6] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm
[7] http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

NATIONAL QUALITY FORUM

Approach for Reviewing Measures Under Consideration for the Physician Quality Reporting System, Value-Based Payment Modifier, and Physician Compare

MAP has been asked to provide input on measures for use in the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBPM), and Physician Compare. The discussion of measures for these programs will be combined as the same measures are under consideration for all of these programs; that is, any current finalized measure or measure under consideration for PQRS is also under consideration for VBPM and/or Physician Compare.

Adding Measures to Encourage Clinician Participation

An overarching goal of these programs is to engage all clinicians to participate in quality reporting. In 2010, only 25% of eligible clinicians participated in PQRS[1]; in 2015, eligible clinicians who do not participate will begin receiving payment penalties.

To allow for broad clinician participation, HHS has asked MAP to consider a large number of measures for inclusion in PQRS. In addition, HHS has asked MAP to consider all quality measures that are currently finalized or are under consideration for PQRS, Hospital Inpatient Quality Reporting (IQR), and Hospital Outpatient Quality Reporting (OQR) for inclusion in the VBPM and/or Physician Compare.

To help identify specialties of eligible professionals who may not have measures relevant to their practices in the programs at this time, the Table below highlights the conditions addressed by the current finalized measures for the PQRS and VBPM programs.

Review of Measures Under Consideration

To support your review of this volume of hundreds of measures, we have provided condition-specific measure tables. Within each table, we have ordered the measures by endorsement status and factors relevant to alignment with other initiatives.

As we review the measures by condition, the workgroup will be asked to identify measures that are best for:

- Payment; that is, suitable for VBPM
- Public reporting; that is, suitable for Physician Compare
- Suitable for PQRS only, at this time
- None of these

Throughout discussion, we will capture your rationale regarding the fit of the measures for the purposes of the programs. This will provide actionable input to HHS, as well as support MAP's future efforts to refine the MAP Measure Selection Criteria.

TABLE. NUMBER OF CURRENT FINALIZED MEASURES IN PQRS AND VBPM BY CONDITION

Condition	PQRS	VBPM
Behavioral Health		
ADHD	1	-
Depression	9	1
Mental illness	1	1
Substance use/abuse	4	-
Tobacco use	4	-
Cardiovascular Health		
Acute myocardial infarction	1	-
Atrial fibrillation	3	-
CHF	6	-
Ischemic heart disease	27	4
Hypertension	14	-
Vascular disease	6	-
Venous ulcer	1	-

Cancer		
Breast cancer	10	1
Cancer	3	-
Cervical cancer	1	-
Colorectal cancer	5	-
Hematologic cancer	4	-
Lung cancer	3	-
Prostate cancer	4	-
Skin cancer	3	-
Infectious Diseases		
Acute otitis externa	3	-
Bronchitis	1	-
Childhood immunization	1	-
Chlamydia	1	-
Hepatitis C	9	-
HIV/AIDS	10	-
Influenza immunization	1	-
Pneumonia	5	-
URI	1	-
Other (ambulatory sensitive condition composite [dehydration, bacterial pneumonia, or urinary tract infection])	-	1
Pulmonary		
Asthma	4	-
COPD	3	1
Sleep apnea	4	-
HEENT		
Cataract	4	-
Dizziness	1	-
Glaucoma	2	-
Hearing problems	3	-
Oral health	2	-
Pharyngitis	2	-
Endocrine/Renal		
Chronic renal disease	8	-
Diabetes	17	5
Musculoskeletal/Dermatological		
Hip/pelvic fracture	1	-
Low back pain	5	-
Musculoskeletal	12	-
Rheumatoid arthritis/osteoarthritis	8	-
Osteoporosis	11	1
Neurological		
Alzheimer's disease	9	-
Epilepsy	3	-
Parkinson's disease	6	-
Stroke/TIA	15	-
Primary Prevention		
Overweight/obesity	2	-
GI/GU		
IBD	7	-
Incontinence	3	-
Maternity, Perinatal, Reproductive Health		
Maternal/perinatal health	1	-
Perinatal health	4	-
Safety		
Pulmonary embolus	1	
Skin ulcer	2	

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/NationalImpactAssessmentofQualityMeasuresFINAL.PDF

Physician Quality Reporting System

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.[1] 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.[2].[3]

Care Settings Included:

Multiple. Eligible professionals include:

- Physicians—medicine, osteopathy, podiatric med, optometry, oral surgery, dental med, 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[4]

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.[5]

Statutory Requirements for Measures:

No specific types of measures required. Individual clinicians participating in the PQRS may select three measures (out of more than 200 measures) to report or may choose to report a specified measure group.

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP considered how to incorporate measures that would increase clinician participation, while selecting measures that drive quality, are meaningful to consumers, and support parsimony.
- MAP aimed to avoid non-discriminating, "low-bar" measures that would be difficult to remove from clinician performance measurement programs in the future.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are	Slightly more than half (179) of finalized measures

	NQF-endorsed or meet the requirements for expedited review	are NQF-endorsed.
2.	**Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities**	All NQS priorities are addressed with fewer measures for the affordability and patient- and family-engagement priorities.
3.	**Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)**	Half (165) of measures address high-impact conditions.
4.	**Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Two-thirds (205) of measures are used in other Federal programs; over one-quater (86) of measures are used in private programs .
5.	**Program measure set includes an appropriate mix of measure types**	The measure set is mostly comprised of process and outcome measures with a few cost measures and no patient experience measures.
6.	**Program measure set enables measurement across the person-centered episode of care**	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care. Additionally, 14 measures are patient-reported outcome measures (PRO).
7.	**Program measure set includes considerations for healthcare disparities**	A small number (15) have considerations of disparities.
8.	**Program measure set promotes parsimony**	The PQRS measures address nearly all of the MAP Measure Selection Critieria; however, any three measures a clinician chooses to report may not address the criteria.

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html
[3] CY 2013 PFS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1
[4] CMS.gov. Downloads Eligible professionals 03-08-2011. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
[5] CY 2013 PFS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

Physician Compare

Program Type:

Public Reporting[1]

Incentive Structure:

None.

Care Settings Included:

Multiple. Eligible professionals include[2]:

- Physicians—medicine, osteopathy, podiatric med, optometry, oral surgery, dental med, 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

Statutory Mandate:

Section 10331 of the Patient Protection and Affordable Care Act of 2010. The web site was launched on December 30, 2010. Performance information will be reported on the website beginning on January 1, 2013.

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[3]:

- 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

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

There are no measures currently finalized for Physician Compare. Accordingly, a table of finalized measures is not included.

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[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html

[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

[3] PFS Final Rule 2013

Physician Feedback Program/Value-Based Payment Modifier

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 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. [1]

Value-Based Payment Modifier

The modifier begins in 2015 for groups of 100 or more eligible professionals, and is applicable to all physicians and groups of physicians on or after January 1, 2017. The modifier payment adjustment varies over time and must be implemented in a budget neutral manner. Payment adjustment amount is built on satisfactory reporting through PQRS.[2]

- Successfully reporting through PQRS:
    - Option for no quality-tiering: 0% adjustment
    - Option for quality-tiering: up to -1% for poor performance; reward for high performance to be determined
- Not successfully reporting through PQRS: -1% adjustment

In 2015 and 2016, the value-based payment modifier will not be applied to groups of physicians that are participating in the Medicare Shared Savings Program, testing of the Pioneer ACO model, or other Innovation Center or CMS initiatives.[3] Additionally, future rulemaking cycles will determine a value-based payment modifier for individuals, smaller groups, and hospital-based physicians. [4]

Care Settings Included:

Multiple. Eligible professionals include:

- Physicians—medicine, osteopathy, podiatric med, optometry, oral surgery, dental med, chiropractic

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[1] U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Medicare Program; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME
Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (Final Rule)
[2] Ibid
[3] Ibid
[4] Ibid

- 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

Statutory Mandate:

Section 1848(p) of the Social Security Act (the Act) as established by Section 3003 and 3007 of the Affordable Care Act of 2010 (ACA). [5]

Statutory Requirements for Measures:

The program must include a composite of appropriate, risk-based quality measures and a composite of appropriate cost measures.[6] 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 PQRS.

MAP 2012 Pre-Rulemaking Program-Specific Input:

MAP noted that the majority of the measures under consideration have not yet been tested for individual clinician-level measurement, and therefore may have feasibility issues with regard to attribution and risk adjustment.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Most (13) of the finalized measures are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The measures address all of the NQS priorities except Patient and Family Engagement.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Majority (13) of the measures address high-impact conditions.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Majority of the measures (13) are used in private programs; all of the measures are currently used in Federal programs.
5. Program measure set includes an appropriate	The measure set is comprised of process, outcome,

[5] Ibid

[6] U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Medicare Program; Payment Policies under the Physician Fee Schedule, Five-Year Review of Work Related Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and other Revisions to Part B for CY 2012, *Fed Reg,* 2011, 76 (228): 73026-73474.

mix of measure types	and cost/resource use measures, but lacks patient experience/patient-reported measures.
6. Program measure set enables measurement across the person-centered episode of care	The measures address two portions of the episode of care—primary prevention and evaluation and management—but the set lacks follow-up care measures. Additionally, the measure set does not include patient-reported outcome measures (PRO).
7. Program measure set includes considerations for healthcare disparities	A small number of measures (2) are disparities-sensitive measures.
8. Program measure set promotes parsimony	The measure set addresses many of the MAP Measure Selection Criteria with 19 measures; however, the measure set could be enhanced with additional measures of patient-reported outcomes to address the gap in the NQS priority of Patient and Family Engagement and measures to enable measurement across the person-centered episode of care.

NATIONAL QUALITY FORUM

Resource Use and Efficiency Measures Under Consideration

Resource use and efficiency are building blocks for understanding value (see graphic below). MAP has continually cited resource use and efficiency measures as critical measure gaps. Additionally, several federal public reporting programs (e.g., Hospital Inpatient Quality Reporting, Hospital Outpatient Quality Reporting) and value-based purchasing initiatives (e.g., Hospital Value-Based Purchasing, Physician Value-Based Payment Modifier, Medicare Shared Savings Programs) have statutory requirements to include measures of cost, resource use, or efficiency.

This year, MAP has been asked to consider whether several resource use and efficiency measures would add value to the program measure sets of several federal programs (see table below for a list of these measures). None of these measures have been considered for NQF endorsement, so they have not been assessed against the endorsement criteria of importance, scientific acceptability, usability, and feasibility. Despite the absence of such information, MAP will need to provide input to HHS on the suitability of these measures for the identified programs.

Background

NQF's Cost and Resource Use Consensus Development Project is an ongoing effort to evaluate resource use measures for NQF endorsement. The initial phase of the project sought to understand resource use measures and identify the important attributes to consider in their evaluation. This project generated the NQF Resource Use Measure Evaluation Criteria. Additionally, this project established key definitions for resource use:

> **Resource Use:** Broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (may include diagnoses, procedures, or encounters). A resource use measure counts the frequency of defined health system resources; some further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource.
>
> **Efficiency:** The resource use (or cost) associated with a specific level of performance with respect to the other five Institute of Medicine (IOM) aims of quality: safety, timeliness, effectiveness, equity, and patient-centeredness. Time is sometimes used to define efficiency when determining efficiency of throughput processes or applying time-driven activity based costing methods.

Finally, this project highlighted key considerations for resource use and cost measures:

- Efficiency measurement approaches should be patient-centered, building on previous efforts such as the NQF Patient-Centered Episodes of Care (EOC) Efficiency Framework.

- NQF supports using and reporting resource use measures in the context of quality performance, preferably outcome measures. Using resource use measures independent of quality measures does not provide an accurate assessment of efficiency or value and may lead to adverse unintended consequences.
- Given the diverse perspectives on cost and resource use measurement, it is important to know the purpose and perspectives these measures represent when evaluating the measures for endorsement.

Reviewing Measures Under Consideration

When reviewing the cost and resource use measures under consideration, please consider the following issues regarding the implementation of the measures.

- What are the best uses for per capita cost approaches?
    - Best uses for condition-specific per capita cost measures?
    - Best uses for total per capita cost measures?
- What are the best uses for episode-based approaches (e.g., condition-specific grouper)?
- What types of quality measures should be used with the cost/resource measures under consideration to provide a broader understanding of efficiency?
- For each measure listed below:
    - What specific quality measures should be used with the measure?
    - Will the measure results be useful for the program's intended purpose?
    - Do the measures under consideration align with private sector efforts? How can we promote alignment with private sector efforts?
    - Are there any implementation concerns with the measures under consideration?
    - What risks do these measures pose for unintended consequences, and how can the risks be mitigated?

TABLE: RESOURCE USE AND EFFICIENCY MEASURES UNDER CONSIDERATION

Measure Title	Program Under Consideration
Total Per Capita Cost Measure	Physician Feedback/Value-Based Payment Modifier Program
Condition-Specific Per Capita Cost Measures for COPD, Diabetes, HF, and CAD	Physician Feedback/ Value-Based Payment Modifier Program
Episode Grouper: Acute Myocardial Infarction (AMI)	Physician Feedback
Episode Grouper: Coronary Artery Bypass Graft (CABG)	Physician Feedback
Episode Grouper: Percutaneous Coronary Intervention (PCI)	Physician Feedback
Episode Grouper: Coronary Artery Disease	Physician Feedback
Episode Grouper: Congestive Heart Failure (CHF)	Physician Feedback
Episode Grouper: Chronic Obstructive Pulmonary disease (COPD)	Physician Feedback
Episode Grouper: Asthma	Physician Feedback
Episode Grouper: Pneumonia	Physician Feedback
Medicare Spending Per Beneficiary	Hospital Inpatient Quality Reporting Hospital Value-Based Purchasing Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting Long-term Care Hospital Quality Reporting Value-Based Payment Modifier Program/Physician Compare
AMI episode of care (inpatient hospitalization + 30 days post-discharge)	Hospital Inpatient Quality Reporting Value-Based Payment Modifier Program/Physician Compare

MAP "WORKING" MEASURE SELECTION CRITERIA

NATIONAL QUALITY FORUM

1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review

Measures within the program measure set are NQF-endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF-endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree

Measures within the program measure set are NQF-endorsed or meet requirements for expedited review (including measures in widespread use and/or tested)

Additional Implementation Consideration: Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences.

2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities

Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:

Subcriterion 2.1	Safer care
Subcriterion 2.2	Effective care coordination
Subcriterion 2.3	Preventing and treating leading causes of mortality and morbidity
Subcriterion 2.4	Person- and family-centered care
Subcriterion 2.5	Supporting better health in communities
Subcriterion 2.6	Making care more affordable

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree:

NQS priority is adequately addressed in the program measure set

3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)

Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Refer to tables 1 and 2 for Medicare High-Impact Conditions and Child Health Conditions determined by the NQF Measure Prioritization Advisory Committee.)

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree:

Program measure set adequately addresses high-impact conditions relevant to the program.

4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

Demonstrated by a program measure set that is applicable to the intended care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 4.1	Program measure set is applicable to the program's intended care setting(s)
Subcriterion 4.2	Program measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.3	Program measure set is applicable to the program's population(s)

5. 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, and structural measures necessary for the specific program attributes.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 5.1	Outcome measures are adequately represented in the program measure set
Subcriterion 5.2	Process measures are adequately represented in the program measure set
Subcriterion 5.3	Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)
Subcriterion 5.4	Cost/resource use/appropriateness measures are adequately represented in the program measure set
Subcriterion 5.5	Structural measures and measures of access are represented in the program measure set when appropriate

6. Program measure set enables measurement across the person-centered episode of care [1]

Demonstrated by assessment of the person's trajectory across providers, settings, and time.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 6.1	Measures within the program measure set are applicable across relevant providers
Subcriterion 6.2	Measures within the program measure set are applicable across relevant settings
Subcriterion 6.3	Program measure set adequately measures patient care across time

1 National Quality Forum (NQF), Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care, Washington, DC: NQF; 2010.

7. Program measure set includes considerations for healthcare disparities[2]

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, age disparities, or geographical considerations 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).

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 7.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Subcriterion 7.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Program measure set promotes parsimony

Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 8.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)

Subcriterion 8.2 Program measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

2 NQF, *Healthcare Disparities Measurement*, Washington, DC: NQF; 2011.

Table 1: National Quality Strategy Priorities

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

Table 2: High-Impact Conditions:

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer's Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes
6. Asthma
7. Depression
8. Behavior or Conduct Problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger's, PDD, ASD
11. Developmental Delay (diag.)
12. Environmental Allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety Problems
15. ADD/ADHD
16. Vision Problems not Corrected by Glasses
17. Bone, Joint, or Muscle Problems
18. Migraine Headaches
19. Food or Digestive Allergy
20. Hearing Problems
21. Stuttering, Stammering, or Other Speech Problems
22. Brain Injury or Concussion
23. Epilepsy or Seizure Disorder
24. Tourette Syndrome

MAP "WORKING" MEASURE SELECTION CRITERIA INTERPRETIVE GUIDE

NATIONAL QUALITY FORUM

Instructions for applying the measure selection criteria:

The measure selection criteria are designed to assist MAP Coordinating Committee and workgroup members in assessing measure sets used in payment and public reporting programs. The criteria have been developed with feedback from the MAP Coordinating Committee, workgroups, and public comment. The criteria are intended to facilitate a structured thought process that results in generating discussion. A rating scale of *Strongly Agree, Agree, Disagree, Strongly Disagree* is offered for each criterion or sub-criterion. An open text box is included in the response tool to capture reflections on the rationale for ratings.

The eight criteria areas are designed to assist in determining whether a measure set is aligned with its intended use and whether the set best reflects 'quality' health and healthcare. The term "measure set" can refer to a collection of measures--for a program, condition, procedure, topic, or population. For the purposes of MAP moving forward, we will qualify all uses of the term measure set to refer to either a "program measure set," a "core measure set" for a setting, or a "condition measure set." The following eight criteria apply to the evaluation of program measure sets; a subset of the criteria apply to condition measure sets.

FOR CRITERION 1 – NQF ENDORSEMENT:

The optimal option is for all measures in the program measure set to be NQF endorsed or ready for NQF expedited review. The endorsement process evaluates individual measures against four main criteria:

1. **'Importance to measure and report"**–how well the measure addresses a specific national health goal/ priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;
2. **'Scientific acceptability of the measurement properties'** – evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.
3. **'Usability'-** the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.
4. **'Feasibility'** – the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

To be recommended by MAP, a measure that is not NQF-endorsed must meet the following requirements, so that it can be submitted for expedited review:

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use
- whether the scope of the project/measure set is relatively narrow
- time-sensitive legislative/regulatory mandate for the measure(s)
- Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges

and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated with the use of the performance measure. Additional consideration and discussion by the MAP workgroup or Coordinating Committee may be appropriate prior to selection. To raise concerns on particular measures, please make a note in the included text box under this criterion.

FOR CRITERION 2 – PROGRAM MEASURE SET ADDRESSES THE NATIONAL QUALITY STRATEGY PRIORITIES:

The program's set of measures is expected to adequately address each of the NQS priorities as described in criterion 2.1-2.6. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. This assessment should consider the current landscape of NQF-endorsed measures available for selection within each of the priority areas.

FOR CRITERION 3 – PROGRAM MEASURE SET ADDRESSES HIGH-IMPACT CONDITIONS:

When evaluating the program measure set, measures that adequately capture information on high-impact conditions should be included based on their relevance to the program's intended population. High-priority Medicare and child health conditions have been determined by NQF's Measure Prioritization Advisory Committee and are included to provide guidance. For programs intended to address high-impact conditions for populations other than Medicare beneficiaries and children (e.g., adult non-Medicare and dual eligible beneficiaries), high-impact conditions can be demonstrated by their high prevalence, high disease burden, and high costs relevant to the program. Examples of other on-going efforts may include research or literature on the adult Medicaid population or other common populations. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria.

FOR CRITERION 4 – PROGRAM MEASURE SET PROMOTES ALIGNMENT WITH SPECIFIC PROGRAM ATTRIBUTES, AS WELL AS ALIGNMENT ACROSS PROGRAMS:

The program measure sets should align with the attributes of the specific program for which they intend to be used. Background material on the program being evaluated and its intended purpose are provided to help with applying the criteria. This should assist with making discernments about the intended care setting(s), level(s) of analysis, and population(s). While the program measure set should address the unique aims of a given program, the overall goal is to harmonize measurement across programs, settings, and between the public and private sectors.

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.
- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.
- **Populations include:** Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

FOR CRITERION 5 – PROGRAM MEASURE SET INCLUDES AN APPROPRIATE MIX OF MEASURE TYPES:

The program measure set should be evaluated for an appropriate mix of measure types. The definition of "appropriate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. The evaluated measure types include:

1. **Outcome measures** – Clinical outcome measures reflect the actual results of care.[1] Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[2]
2. **Process measures –** Process denotes what is actually done in giving and receiving care. [3] NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[4] Experience of care measures—Defined as patients' perspective on their care.[5]
3. **Cost/resource use/appropriateness measures** –

   a. Cost measures – Total cost of care.

   b. Resource use measures – Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).[6]

   c. Appropriateness measures – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[7]
4. **Structure measures** – Reflect the conditions in which providers care for patients.[8] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure

1 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

2 Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance

3 Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

4 National Quality Forum. (2011). Consensus development process. Retrieved from http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx

5 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

6 National Quality Forum (2009). National voluntary consensus standards for outpatient imaging efficiency. Retrieved from http://www.qualityforum.org/Publications/2009/08/National_Voluntary_Consensus_Standards_for_Outpatient_Imaging_Efficiency__A_Consensus_Report.aspx

7 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

8 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

(such as medical staff organizations, methods of peer review, and methods of reimbursement).[9] In this case, structural measures should be used only when appropriate for the program attributes and the intended population.

FOR CRITERION 6 – PROGRAM MEASURE SET ENABLES MEASUREMENT ACROSS THE PERSON-CENTERED EPISODE OF CARE:

The optimal option is for the program measure set to approach measurement in such a way as to capture a person's natural trajectory through the health and healthcare system over a period of time. Additionally, driving to longitudinal measures that address patients throughout their lifespan, from health, to chronic conditions, and when acutely ill should be emphasized. Evaluating performance in this way can provide insight into how effectively services are coordinated across multiple settings and during critical transition points.

When evaluating subcriteria 6.1-6.3, it is important to note whether the program measure set captures this trajectory (across providers, settings or time). This can be done through the inclusion of individual measures (e.g., 30-day readmission post-hospitalization measure) or multiple measures in concert (e.g., aspirin at arrival for AMI, statins at discharge, AMI 30-day mortality, referral for cardiac rehabilitation).

FOR CRITERION 7 – PROGRAM MEASURE SET INCLUDES CONSIDERATIONS FOR HEALTHCARE DISPARITIES:

Measures sets should be able to detect differences in quality among populations or social groupings. Measures should be stratified by demographic information (e.g., race, ethnicity, language, gender, disability, and socioeconomic status, rural vs. urban), which will provide important information to help identify and address disparities.[10]

Subcriterion 7.1 seeks to include measures that are known to assess healthcare disparities (e.g., use of interpreter services to prevent disparities for non-English speaking patients).

Subcriterion 7.2 seeks to include disparities-sensitive measures; these are measures that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (e.g., race/ethnicity, language).

FOR CRITERION 8 – PROGRAM MEASURE SET PROMOTES PARSIMONY:

The optimal option is for the program measure set to support an efficient use of resources in regard to data collection and reporting for accountable entitles, while also measuring the patient's health and healthcare comprehensively.

Subcriterion 8.1 can be evaluated by examining whether the program measure set includes the least number of measures required to capture the program's objectives and data submission that requires the least burden on the part of the accountable entitles.

Subcriterion 8.2 can be evaluated by examining whether the program measure set includes measures that are used across multiple programs (e.g., PQRS, MU, CHIPRA, etc.) and applications (e.g., payment, public reporting, and quality improvement).

9 Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

10 Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance.

2012/2013 Pre-Rulemaking Guidance to Clinician Workgroup from Dual Eligible Beneficiaries Workgroup

In providing input to HHS regarding the selection of measures for Federal payment and public reporting programs, MAP must consider how the programs may impact the quality of care delivered to Medicare-Medicaid dual eligible beneficiaries. More than 9 million Americans eligible for both Medicare and Medicaid comprise a heterogeneous group that includes many of the poorest and sickest individuals covered by either program. Despite their particularly intense and complex needs, the healthcare and supportive services accessed by these individuals are often highly fragmented. HHS is pursuing several strategies to improve the quality of care provided to dual eligible beneficiaries, including tasking MAP with considering the implications of existing Federal measurement programs affecting this vulnerable group.

General Principles for Measure Selection

The Dual Eligible Beneficiaries Workgroup has identified the subject areas in which performance measurement can provide the most leverage in improving the quality of care: **quality of life, care coordination, screening and assessment, mental health and substance use,** as well as **structural measures**. The core set was updated in 2012 to reflect current priorities and the best available measures.

MAP workgroups should consider that the following issues are strongly related to quality of care in the dual eligible beneficiary population, regardless of the type of care being provided.

- **Setting goals for care:** Wherever possible, measurement should promote a broad view of health and wellness. Person-centered plans of care should be developed in collaboration with an individual, his/her family, and his/her care team. A plan of care should establish health-related goals and preferences for care that incorporate medical, behavioral, and social needs.
- **Chronicity of care:** More than 60 percent of dual eligible beneficiaries have three or more chronic conditions, with the most common being cardiovascular disease, diabetes, Alzheimer's disease and related disorders, arthritis, and depression. Many people with disabilities require long-term supports and services, of varying intensity, throughout their lifetimes.
- **Cognitive status**: More than 60 percent of dual eligible beneficiaries are affected by a mental or cognitive impairment. Etiologies of these impairments are diverse and may include intellectual/developmental disability, mental illness, dementia, substance abuse, or stroke.
- **Care transitions and communication:** Many factors, including those listed above, make dual eligible beneficiaries more vulnerable to problems that arise during all types of care transitions. Communication and coordination across all providers is vital. Transactions between the medical system and the community-based services system are particularly important for beneficiaries who use long-term supports.

Considerations for Clinician Programs

The Clinician Workgroup should consider the overarching factors identified by the Dual Eligible Beneficiaries Workgroup that are linked to high-quality care for clinicians. A primary role for any clinician, but especially for those practicing in primary care, is to screen, assess, and manage chronic conditions. For the dual eligible population, those chronic illnesses are more likely to include a mental health problem, substance use disorder, or other cognitive impairment. Because the conditions themselves are so diverse, measures that apply across clinical conditions or to individuals with multiple chronic conditions should be considered. These would include measures of functional status, quality of life, communication, care coordination, medication management, patient experience, etc. When certain high-impact conditions like diabetes or heart disease need to be evaluated, Federal programs should emphasize outcome and composite measures.

The Dual Eligible Beneficiaries Workgroup noticed the abundance of measures related to screening and disease monitoring. They cautioned that appropriate exclusions should be in place for such measures. For example, a 90-year old man with advanced Alzheimer's disease does not need to have his cholesterol under tight control. In addition, maternal and pediatric measures generally do not apply to the dual eligible population.

Evolving Core Set of Measures for Dual Eligible Beneficiaries

The Dual Eligible Beneficiaries Workgroup identified an evolving core set of measures from an extensive and ongoing search of currently available measures. It was most recently updated in October 2012 to inform 2012/2013 pre-rulemaking deliberations. The overall frequency of evolving core set measure use in HHS programs is currently as follows:

- Proposed/finalized in two or more HHS programs: 12 measures
- Proposed/finalized in one HHS program: 6 measures

HHS uptake of measures in proposed and final rules in 2012 was generally consistent with MAP's specific recommendations made as a result of input from the Dual Eligible Beneficiaries Workgroup. Related to measures supported by the Dual Eligible Beneficiaries Workgroup for Clinician programs, we observed the following concordance:

- Value-Based Payment Modifier Program
    - MAP supported retention of four measures from the Dual Eligible Beneficiaries Set in the Value Modifier program; HHS concurred.
- Physician Quality Reporting System (PQRS)
    - MAP supported retention of five measures from the Dual Eligible Beneficiaries Set in the PQRS program.
    - MAP supported addition of *Optimal Diabetes Care (0729)* to the PQRS set. The measure is still under consideration for addition to PQRS.
- Meaningful Use for Eligible Professionals
    - MAP supported retention of three measures from the Dual Eligible Beneficiaries Set in the Meaningful Use program for Eligible Professionals; HHS concurred.
    - MAP supported and HHS finalized inclusion of *Screening for Clinical Depression and Follow-Up Plan (0418)* in the Meaningful Use set for Stage 2.

The appropriateness and feasibility of any single measure depends upon the program context in which it is being considered for use. Careful consideration should be given to the care setting and level of analysis for which a measure is specified and endorsed. Many measure gaps and limitations in current measures were identified during the process of compiling and revising the core set. The Dual Eligible Beneficiaries Workgroup will continue to consider a range of potential modifications to measures that would make them more appropriate for use with the dual eligible beneficiary population.

Clinician Measures for Potential Gap-filling from Evolving Core Set for Dual Eligible Beneficiaries

The table below lists measures from the Evolving Core Set for Dual Eligible Beneficiaries that are **specified for use at the individual clinician or group practice level and that are not already included in the PQRS program**. These measures are potential candidates for filling program gaps. The Dual Eligible Beneficiaries Workgroup would be especially interested in uptake of measures related to communication and cultural competency, including NQF numbers 1902, 1904, and 1919.

NQF# and Status	Measure Title and Description	Programs With Measure Under Consideration
0005 Endorsed	*CAHPS Adult Primary Care Survey: Shared Decision Making* 37 core and 64 supplemental question survey of adult outpatient primary care patients.	Physician Compare
0430 Endorsed	*Change in Daily Activity Function as Measured by the AM-PAC* The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing.	
1626 Endorsed	*Patients Admitted to ICU who Have Care Preferences Documented* Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Physician Quality Reporting System (PQRS)
1641 Endorsed	*Hospice and Palliative Care – Treatment Preferences* Patients whose medical record includes documentation of life sustaining preferences.	Hospice Quality Reporting, PQRS
1741 Endorsed	*CAHPS® Surgical Care Survey* The following 6 composites and 1 single-item measure are generated from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey. Each measure is used to assess a particular domain of surgical care quality from the patient's perspective. Measure 1: Information to help you prepare for surgery (2 items) Measure 2: How well surgeon communicates with patients before surgery (4 items) Measure 3: Surgeon's attentiveness on day of surgery (2 items) Measure 4: Information to help you recover from surgery (4 items) Measure 5: How well surgeon communicates with patients after surgery (4 items) Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items) Measure 7: Rating of surgeon (1 item) The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey is administered to adult patients (age 18 and over) having had a major surgery as defined by CPT codes (90 day globals) within 3 to 6 months prior to the start of the survey.	PQRS
1825 Endorsed	*COPD - Management of Poorly Controlled COPD* The percentage of patients age 18 years or older with poorly controlled COPD, who are taking a long acting bronchodilator.	
1902 Endorsed	*Clinicians/Group Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy* These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician & Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms. Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the core Clinician/Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifiers). Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items).	

NQF# and Status	Measure Title and Description	Programs With Measure Under Consideration
1904 Endorsed	*Clinician/Group Cultural Competence Based on the CAHPS® Cultural Competence Item Set* These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey that includes the following domains: Patient-provider communication; Complementary and alternative medicine; Experiences of discrimination due to race/ethnicity, insurance, or language; Experiences leading to trust or distrust, including level of trust, caring and confidence in the truthfulness of their provide; and Linguistic competency (Access to language services). Samples for the survey are drawn from adults who have at least one provider visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the Core Clinician/Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifiers). Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 Items).	
1909 Endorsed (formerly 0494)	*Medical Home System Survey* The following 6 composites are generated from the Medical Home System Survey (MHSS). Each measure is used to assess a particular domain of the patient-centered medical home. Measure 1: Enhance access and continuity Measure 2: Identify and manage patient populations Measure 3: Plan and manage care Measure 4: Provide self-care support and community resources Measure 5: Track and coordinate care Measure 6: Measure and improve performance The MHSS survey is used by NCQA to determine eligibility for the NCQA Recognized PCMH program.	
1919 Endorsed	*Cultural Competency Implementation Measure* The Cultural Competence Implementation Measure is an organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed® cultural competency practices prioritized for the survey. The target audience for this survey includes healthcare organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. Information from the survey can be used for quality improvement, provide information that can help health care organizations establish benchmarks and assess how they compare in relation to peer organizations, and for public reporting.	
Not Endorsed	*Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment* A. Patients screened annually for alcohol misuse with the 3-item AUDIT-C with item-wise recording of item responses, total score, and positive or negative result of the AUDIT-C in the medical record. B. Patients who screen for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.	

NATIONAL QUALITY FORUM

Core Measure Set: Individual Clinician and Group Levels of Analysis

Setting- and level-of analysis-specific core measure sets are drawn from the MAP Families of Measures. These core measure sets may assist in identifying measures that could be added to program measure sets or measures that could replace previously finalized measures in program measure sets. MAP's core measure sets serve as guidance for pre-rulemaking decisions; however, MAP is not restricted to considering only these measures.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	1741	Care Coordination, Duals	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Hospital/Acute Care Facility	Individual, Group/Practice
Appropriate testing for children with pharyngitis	0002	Safety	Clinician Office/Clinic, Urgent Care	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	Duals	Clinician Office/Clinic, Hospital/Acute Care Facility	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	0005	Care Coordination, Duals	Clinician Office/Clinic	Individual
NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)	0007	Care Coordination, Duals	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Controlling High Blood Pressure	0018	Cardiovascular, Diabetes	All settings, Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Hospital/Acute Care Facility, Urgent Care, Clinician Office/Clinic	Group/Practice, Individual
Body Mass Index (BMI) 2 through 18 years of age	0024	Cardiovascular, Diabetes	Clinician Office/Clinic	Individual

Note: The Individual Clinician and Group Core Measure Set includes all measures within the various MAP Families of Measures that are specified for the individual and group-practice levels of analysis.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	0028	Cardiovascular, Diabetes, Duals	Clinician Office/Clinic	Individual
Use of Imaging Studies for Low Back Pain	0052	Safety	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Diabetes Measure Pair: A Lipid management: low density lipoprotein cholesterol (LDL-C) <130, B Lipid management: LDL-C <100	0064	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)	0066	Cardiovascular	Assisted Living, Clinician Office/Clinic, Outpatient, Home Health, Urgent Care, Nursing Home/Skilled Nursing Facility, Clinician Office/Clinic	Group/Practice, Individual
Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic	0068	Cardiovascular	All settings, Clinician Office/Clinic	Group/Practice, Individual
Appropriate treatment for children with upper respiratory infection (URI)	0069	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Chronic Stable Coronary Artery Disease: Beta-Blocker Therapy--Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	0070	Cardiovascular	Assisted Living, Clinician Office/Clinic, Outpatient, Home Health, Urgent Care, Nursing Home/Skilled Nursing Facility, Clinician Office/Clinic	Group/Practice, Individual
IVD: Complete Lipid Profile and LDL Control <100	0075	Cardiovascular	All settings, Clinician Office/Clinic	Group/Practice, Individual

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	0081	Cardiovascular	Assisted Living, Clinician Office/Clinic, Outpatient, Home Health, Hospital/Acute Care Facility, Urgent Care, Nursing Home/Skilled Nursing Facility, Clinician Office/Clinic	Group/Practice, Individual
Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction	0083	Cardiovascular	Urgent Care, Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility, Group/Practice, Individual
Medication Reconciliation	0097	Hospice, Duals	Urgent Care, Clinician Office/Clinic	County or City, Group/Practice, Individual, Integrated Delivery System
Falls: Screening for Fall Risk	0101	Duals	Clinician Office/Clinic	Individual
Risk-Adjusted Operative Mortality for CABG	0119	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State
Risk-Adjusted Operative Mortality MV Replacement + CABG Surgery	0122	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State, Team
Patient Fall Rate	0141	Safety	Hospital/Acute Care Facility	Group/Practice
Pressure ulcer prevalence (hospital acquired)	0201	Safety	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, Team
Falls with injury	0202	Safety	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Team

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Proportion receiving chemotherapy in the last 14 days of life	0210	Hospice	Clinician Office/Clinic, Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion with more than one emergency room visit in the last days of life	0211	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to the ICU in the last 30 days of life	0213	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion not admitted to hospice	0215	Care Coordination	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to hospice for less than 3 days	0216	Care Coordination, Hospice	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	0241	Cardiovascular	Hospital/Acute Care Facility	Individual
Patient Fall	0266	Safety	Ambulatory Surgery Center, Hospital/Acute Care Facility	Individual
Median Time to Transfer to Another Facility for Acute Coronary Intervention	0290	Care Coordination	Hospital/Acute Care Facility, Urgent Care	Can be measured at all levels, Facility, National
LBP: Surgical Timing	0305	Safety	Clinician Office/Clinic	Group/Practice, Individual
LBP: Appropriate Use of Epidural Steroid Injections	0309	Safety	Clinician Office/Clinic	Group/Practice, Individual
LBP: Shared Decision Making	0310	Care Coordination	Clinician Office/Clinic	Group/Practice, Individual

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Advance Care Plan	0326	Care Coordination, Hospice, Duals	Ambulatory Surgery Center (ASC), Clinic/Urgent Care (renamed to "Urgent Care"), Clinician Office (renamed to "Clinician Office/Clinic"), Home Health, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation (renamed to "Inpatient Rehabilitation Facility")	Individual
Multiple Myeloma – Treatment with Bisphosphonates	0380	Cancer	Urgent Care, Clinician Office/Clinic	Group/Practice, Individual, Team
Oncology: Radiation Dose Limits to Normal Tissues	0382	Cancer	Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0383	Hospice, Cancer	Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)	0384	Hospice, Cancer	Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Oncology: Cancer Stage Documented	0386	Cancer	Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients	0389	Cancer	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients	0390	Cancer	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Screening for Clinical Depression	0418	Duals	Clinician Office/Clinic, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Individual

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Documentation of Current Medications in the Medical Record	0419	Safety	Clinician Office/Clinic, Dialysis Facility, Home Health, Nursing Home/Skilled Nursing Facility, Other, Outpatient, Inpatient Rehabilitation Facility	Individual, National
Adult Weight Screening and Follow-Up	0421	Cardiovascular, Diabetes, Duals	All settings	Can be measured at all levels
Change in Daily Activity Function as Measured by the AM-PAC:	0430	Duals	Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility, Individual
Adoption of Medication e-Prescribing	0486	Safety	Clinician Office/Clinic, Other	Group/Practice, Individual
Prophylactic antibiotics discontinued within 24 hours after surgery end time	0529	Safety	Hospital/Acute Care Facility	Can be measured at all levels, Facility, National, Regional
Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	0572	Cancer	Clinician Office/Clinic, Other	County or City, Group/Practice, Health Plan, Individual
Comprehensive Diabetes Care: HbA1c control (<8.0%)	0575	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Follow-Up After Hospitalization for Mental Illness	0576	Care Coordination, Duals	Clinician Office/Clinic, Inpatient, Outpatient	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Deep Vein Thrombosis Anticoagulation >= 3 Months	0581	Safety	Clinician Office/Clinic	County or City, Group/Practice, Health Plan, Individual, Integrated Delivery System

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Pulmonary Embolism Anticoagulation >= 3 Months	0593	Safety	Clinician Office/Clinic	County or City, Group/Practice, Health Plan, Individual, Integrated Delivery System
Cardiac Rehabilitation Patient Referral From an Inpatient Setting	0642	Cardiovascular	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System
Otitis Media with Effusion: Systemic corticosteroids – Avoidance of inappropriate use	0656	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Individual, Team
Otitis Media with Effusion: Systemic antimicrobials – Avoidance of inappropriate use	0657	Safety	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic	Group/Practice, Individual, Team
Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	0659	Safety	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic, Hospital/Acute Care Facility	Group/Practice, Individual, Team
Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	0667	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice
Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury	0668	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice
The STS CABG Composite Score	0696	Cardiovascular	Hospital/Acute Care Facility	Community, County or City, Facility, Group/Practice, National, Regional, State, Team
Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0705	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, National, Regional, State
Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.	0709	Cardiovascular, Care Coordination	Clinician Office/Clinic, Other	County or City, Group/Practice, Health Plan, National, Regional, State

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Healthy Term Newborn	0716	Safety	Hospital/Acute Care Facility	Facility, Integrated Delivery System, Regional, State, Team
Inpatient Consumer Survey (ICS) consumer evaluation of inpatient behavioral healthcare services	0726	Care Coordination		
Optimal Diabetes Care	0729	Diabetes, Duals	Clinician Office/Clinic	Group/Practice, Integrated Delivery System
Comprehensive Diabetes Care	0731	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual
Appropriate Cervical Spine Radiography and CT Imaging in Trauma	0755	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice, National,Regional, State
Risky Behavior Assessment or Counseling by Age 13 Years	1406	Cardiovascular, Diabetes	Clinician Office/Clinic, Outpatient	Group/Practice, Individual, National, Regional, Team
Chronic Anticoagulation Therapy	1525	Cardiovascular	Clinician Office/Clinic	Individual
Total Resource Use Population-based PMPM Index	1598	Cardiovascular, Diabetes	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Dialysis Facility, Emergency Medical Services/Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Inpatient, Laboratory, Nursing Home/Skilled Nursing Facility, Outpatient, Pharmacy, Rehabilitation (renamed to "Inpatient Rehabilitation Facility"), Urgent Care	Community, Group/Practice

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Total Cost of Care Population-based PMPM Index	1604	Cardiovascular, Diabetes	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Dialysis Facility, Emergency Medical Services/Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Inpatient, Laboratory, Nursing Home/Skilled Nursing Facility, Outpatient, Pharmacy, Rehabilitation (renamed to "Inpatient Rehabilitation Facility"), Urgent Care	Community, Group/Practice
Patients Treated with an Opioid who are Given a Bowel Regimen	1617	Safety, Hospice	Clinician Office/Clinic, Hospital/Acute Care Facility	Community, Group/Practice
Hospice and Palliative Care -- Pain Screening	1634	Safety, Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Pain Assessment	1637	Safety, Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Dyspnea Treatment	1638	Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Dyspnea Screening	1639	Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care – Treatment Preferences	1641	Hospice, Duals	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
COPD - Management of Poorly Controlled COPD	1825	Duals	Urgent Care, Clinician Office/Clinic, Home Health, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	County or City, Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	1902	Duals	Clinician Office/Clinic, Urgent Care	Group/Practice, Individual
Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	1904	Duals	Clinician Office/Clinic, Urgent Care	Group/Practice, Individual
Medical Home System Survey (MHSS)	1909	Care Coordination, Duals	Clinician Office/Clinic	Group/Practice, Individual, Team
OP-25 Safe Surgery Checklist	N/A	Safety	Hospital/Acute Care Facility	
Unhealthy Alcohol Use: Screening and Brief Counseling		Duals	Clinician Office/Clinic	

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Core Measure Set: System Level of Analysis

Setting- and level-of analysis-specific core measure sets are drawn from the MAP Families of Measures. These core measure sets may assist in identifying measures that could be added to program measure sets or measures that could replace previously finalized measures in program measure sets. MAP's core measure sets serve as guidance for pre-rulemaking decisions; however, MAP is not restricted to considering only these measures.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Appropriate testing for children with pharyngitis	0002	Safety	Clinician Office/Clinic, Urgent Care	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	Duals	Clinician Office/Clinic, Hospital/Acute Care Facility	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
CAHPS Health Plan Survey v 4.0 - Adult questionnaire	0006	Care Coordination, Duals	Clinician Office/Clinic	Health Plan
NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)	0007	Care Coordination, Duals	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	0008	Care Coordination, Duals	Clinician Office/Clinic	Health Plan
CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement	0009	Care Coordination	Clinician Office/Clinic	Health Plan
Young Adult Health Care Survey (YAHCS)	0010	Care Coordination	Clinician Office/Clinic	County or City, Health Plan, National, Regional, State
Use of High Risk Medications in the Elderly	0022	Safety, Duals	Clinician Office/Clinic, Pharmacy	Health Plan, Integrated Delivery System

Note: The System Core Measure Set includes all measures within the various MAP Families of Measures that are specified for the health plan, integrated delivery system, community, county/city, regional, state, and national levels of analysis.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Use of Imaging Studies for Low Back Pain	0052	Safety	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Diabetes Measure Pair: A Lipid management: low density lipoprotein cholesterol (LDL-C) <130, B Lipid management: LDL-C <100	0064	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Appropriate treatment for children with upper respiratory infection (URI)	0069	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Medication Reconciliation	0097	Hospice, Duals	Urgent Care, Clinician Office/Clinic	County or City, Group/Practice, Individual, Integrated Delivery System
Risk-Adjusted Operative Mortality for CABG	0119	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State
Risk-Adjusted Operative Mortality MV Replacement + CABG Surgery	0122	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State, Team
National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138	Safety, Cancer	Hospice, Hospital/Acute Care Facility, Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, National, State
National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	0139	Safety, Cancer	Hospice, Hospital/Acute Care Facility, Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, National, State

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Primary PCI received within 90 minutes of Hospital Arrival	0163	Cardiovascular, Care Coordination	Hospital/Acute Care Facility	Facility, National, Regional
Fibrinolytic Therapy received within 30 minutes of hospital arrival	0164	Care Coordination	Hospital/Acute Care Facility	Facility, National, Regional
Increase in number of pressure ulcers	0181	Safety	Home Health	Facility, Other
Family Evaluation of Hospice Care	0208	Care Coordination, Hospice, Cancer	Hospice	Facility, National
Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	0209	Safety, Hospice, Cancer, Duals	Hospice	Facility, National
Proportion receiving chemotherapy in the last 14 days of life	0210	Hospice	Clinician Office/Clinic, Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion with more than one emergency room visit in the last days of life	0211	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to the ICU in the last 30 days of life	0213	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion not admitted to hospice	0215	Care Coordination	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to hospice for less than 3 days	0216	Care Coordination, Hospice	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	0288	Cardiovascular, Care Coordination	Hospital/Acute Care Facility, Urgent Care	Facility, National

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Median Time to ECG	0289	Cardiovascular	Hospital/Acute Care Facility, Urgent Care	Facility, National
Median Time to ECG	0289	Care Coordination	Hospital/Acute Care Facility, Urgent Care	Facility, National
Median Time to Transfer to Another Facility for Acute Coronary Intervention	0290	Care Coordination	Hospital/Acute Care Facility, Urgent Care	Can be measured at all levels, Facility, National
HIV/AIDS: Medical Visit	0403	Care Coordination	Urgent Care, Clinician Office/Clinic	Integrated Delivery System
Documentation of Current Medications in the Medical Record	0419	Safety	Clinician Office/Clinic, Dialysis Facility, Home Health, Nursing Home/Skilled Nursing Facility, Other, Outpatient, Inpatient Rehabilitation Facility	Individual, National
Adult Weight Screening and Follow-Up	0421	Cardiovascular, Diabetes, Duals	All settings	Can be measured at all levels
Thrombolytic Therapy	0437	Cardiovascular	Hospital/Acute Care Facility	Facility, Integrated Delivery System, National
Assessed for Rehabilitation	0441	Cardiovascular	Hospital/Acute Care Facility	Facility, Integrated Delivery System, National
PC-01 Elective Delivery	0469	Safety	Hospital/Acute Care Facility	Facility, National
PC-02 Cesarean Section	0471	Safety	Hospital/Acute Care Facility	Facility, National
Under 1500g infant Not Delivered at Appropriate Level of Care	0477	Safety	Hospital/Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State
Severe Sepsis and Septic Shock: Management Bundle	0500	Safety	Hospital/Acute Care Facility	Facility, Integrated Delivery System
Prophylactic antibiotics discontinued within 24 hours after surgery end time	0529	Safety	Hospital/Acute Care Facility	Can be measured at all levels, Facility, National, Regional
Medication Reconciliation Post-Discharge	0554	Safety	Clinician Office/Clinic	County or City, Health Plan, Integrated Delivery System, National, Regional

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	0572	Cancer	Clinician Office/Clinic, Other	County or City, Group/Practice, Health Plan, Individual
Comprehensive Diabetes Care: HbA1c control (<8.0%)	0575	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Follow-Up After Hospitalization for Mental Illness	0576	Care Coordination, Duals	Clinician Office/Clinic, Inpatient, Outpatient	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Deep Vein Thrombosis Anticoagulation >= 3 Months	0581	Safety	Clinician Office/Clinic	County or City, Group/Practice, Health Plan, Individual, Integrated Delivery System
Pulmonary Embolism Anticoagulation >= 3 Months	0593	Safety	Clinician Office/Clinic	County or City, Group/Practice, Health Plan, Individual, Integrated Delivery System
Cardiac Rehabilitation Patient Referral From an Inpatient Setting	0642	Cardiovascular	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System
Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0646	Safety	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0647	Care Coordination, Duals	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648	Care Coordination, Hospice, Duals	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0649	Care Coordination	Urgent Care, Hospital/Acute Care Facility	Facility, Integrated Delivery System
Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	0669	Cardiovascular	Urgent Care	Facility, National
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	0674	Safety	Nursing Home/Skilled Nursing Facility	Facility, National
Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument	0691	Care Coordination, Duals	Nursing Home/Skilled Nursing Facility	Facility, National
Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument	0692	Care Coordination, Duals	Nursing Home/Skilled Nursing Facility	Facility, National
The STS CABG Composite Score	0696	Cardiovascular	Hospital/Acute Care Facility	Community, County or City, Facility, Group/Practice, National, Regional, State, Team
30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	0698	Care Coordination	Hospital/Acute Care Facility	National
30-Day Post-Hospital HF Discharge Care Transition Composite Measure	0699	Care Coordination	Hospital/Acute Care Facility	National

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Proportion of Patients Hospitalized with AMI that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0704	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State
Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0705	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, National, Regional, State
30-day Post-Hospital PNA (Pneumonia) Discharge Care Transition Composite Measure	0707	Care Coordination	Hospital/Acute Care Facility	National
Proportion of Patients Hospitalized with Pneumonia that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0708	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State
Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.	0709	Cardiovascular, Care Coordination	Clinician Office/Clinic, Other	County or City, Group/Practice, Health Plan, National, Regional, State
Healthy Term Newborn	0716	Safety	Hospital/Acute Care Facility	Facility, Integrated Delivery System, Regional, State, Team
Inpatient Consumer Survey (ICS) consumer evaluation of inpatient behavioral healthcare services	0726	Care Coordination		
Optimal Diabetes Care	0729	Diabetes, Duals	Clinician Office/Clinic	Group/Practice, Integrated Delivery System
Comprehensive Diabetes Care	0731	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual
American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753	Safety	Hospital/Acute Care Facility	Facility, National, State
Appropriate Cervical Spine Radiography and CT Imaging in Trauma	0755	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice, National, Regional, State

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Asthma Emergency Department Visits	1381	Care Coordination	Hospital/Acute Care Facility	County or City, Health Plan
Risky Behavior Assessment or Counseling by Age 13 Years	1406	Cardiovascular, Diabetes	Clinician Office/Clinic, Outpatient	Group/Practice, Individual, National, Regional, Team
Total Resource Use Population-based PMPM Index	1598	Cardiovascular, Diabetes	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Dialysis Facility, Emergency Medical Services/Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Inpatient, Laboratory, Nursing Home/Skilled Nursing Facility, Outpatient, Pharmacy, Rehabilitation (renamed to "Inpatient Rehabilitation Facility"), Urgent Care	Community, Group/Practice
Total Cost of Care Population-based PMPM Index	1604	Cardiovascular, Diabetes	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Dialysis Facility, Emergency Medical Services/Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Inpatient, Laboratory, Nursing Home/Skilled Nursing Facility, Outpatient, Pharmacy, Rehabilitation (renamed to "Inpatient Rehabilitation Facility"), Urgent Care	Community, Group/Practice
Patients Treated with an Opioid who are Given a Bowel Regimen	1617	Safety, Hospice	Clinician Office/Clinic, Hospital/Acute Care Facility	Community, Group/Practice

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Bereaved Family Survey	1623	Hospice	Hospice, Nursing Home/Skilled Nursing Facility	Facility, National, Regional
Patients Admitted to ICU who Have Care Preferences Documented	1626	Care Coordination, Hospice, Duals	Hospital/Acute Care Facility	Facility, Health Plan, Integrated Delivery System
CARE - Consumer Assessments and Reports of End of Life	1632	Care Coordination, Hospice, Duals	Home Health, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Community, Facility, National, Regional
TOB-1 Tobacco Use Screening	1651	Cardiovascular, Diabetes	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility, National
TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	1654	Cardiovascular, Diabetes	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility, National
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	1716	Safety	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, National, State
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717	Safety	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, National, State
Plan All-Cause Readmissions	1768	Care Coordination, Duals	Hospital/Acute Care Facility, Inpatient	Health Plan

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
COPD - Management of Poorly Controlled COPD	1825	Duals	Urgent Care, Clinician Office/Clinic, Home Health, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	County or City, Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Cultural Competency Implementation Measure	1919	Duals	Urgent Care, Clinician Office/Clinic, Dialysis Facility, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Health Plan, Integrated Delivery System
SNP6: coordination of Medicare and Medicaid Coverage	N/A	Duals		Health Plan
Unhealthy Alcohol Use: Screening and Brief Counseling		Duals	Clinician Office/Clinic	

NATIONAL QUALITY FORUM

MAP Previously Identified Measure Gaps

This document provides a synthesis of 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)
- 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 paired with patient experience and balanced by overuse/misuse monitoring
- 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 non-compliant patients

Shared Decision-Making 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 (nausea, shortness of breath, nutrition)
- 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

- Life enjoyment
- Community inclusion/participation 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)
- Consideration of total cost of care, including patient out of pocket cost
- Appropriateness for admissions, treatment, over-diagnosis, under-diagnosis, misdiagnosis, imaging, procedures
- Chemotherapy appropriateness, including dosing
- Avoiding unnecessary end-of-life care
- 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

MAP Decision Categories and Rationale

MAP Decision (Standardized Options)	MAP Rationale (Standardized Options)	MAP Findings (Open Text)
Support	• NQF-endorsed measure • Addresses a NQS priority not adequately addressed in the program measure set • Addresses a high-impact condition not adequately addressed in the program measure set (*Note: for PAC/LTC high-impact condition will be replaced with PAC/LTC core concept)* • Promotes alignment across programs, settings, and public and private sector efforts • Addresses specific program attributes • Addresses a measure type not adequately represented in the program measure set • Enables measurement across the person-centered episode of care • Addresses healthcare disparities • Promotes parsimony • Addresses a high-leverage opportunity for dual eligible beneficiaries • Core measure not currently included in the program measure set	*MAP findings will highlight additional considerations raised by the group.*
Support Direction	• 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	*MAP findings will include suggestions for modifications to measures/measure concept, or indicate that the measure is not currently endorsed for the program's setting.*
Phased Removal	• 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) • A 'Supported' measure under consideration addresses a similar topic and better addresses the needs of the program promotes alignment	*MAP findings will indicate the timing of removal.*
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	*MAP findings will refer to the finalized or 'Supported' measure under consideration that is preferred.*

	• A 'Supported' measure under consideration addresses as 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
Insufficient Information	• MAP has insufficient information (e.g., specifications, measure testing, measure use) to evaluate the measure

Descriptions from Strategic Plan:

- **Support** indicates measures for immediate inclusion in the program measure set, or for continued inclusion in the program measure set in the case of measures that have previously been finalized for the program.
- **Support Direction** indicates measures, measure concepts, or measure ideas that should be phased into the program measure set over time.
- **Phased Removal** indicates measures that should remain in the program measure set for now, yet be phased out as better measures become available.
- **Do Not Support** indicates measures or measure concepts that are not recommended for inclusion in the program measure set. These include measures or measure concepts under consideration that do not address measure gaps or programmatic goals as well as previously finalized measures for immediate removal from the program measure set.
- **Insufficient Information** indicates measures, measure concepts, or measure ideas for which MAP does not have sufficient information (e.g., measure description, numerator or denominator specifications, exclusions) to determine what recommendation to make.